Erin Elizabeth Holistic Health

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TO BE COMPLETED AT LEAST ONE WEEK BEFORE YOUR APPOINTMENT:

The following information is required for your safety, and to benefit your health and welfare. The following details will be treated with the strictest confidence. Your answers will help me get an accurate history of your medical concerns and conditions. Please fill in all of the pages, it is long because it is comprehensive. I really want to know you well so I can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, leave it blank. Thank you!

Full Name:_____Date of Birth:____/____/____Sex:_____

Address:_____

Email:_____Phone:_____

MEDICATIONS, VITAMINS OR REMEDIES YOU ARE CURRENTLY TAKING:

MEDICATION/SUPPLEMENT	DOSE	TIMES PER DAY

Height_____ Weight_____

ALLERGIES OR INTOLERANCE TO MEDICATIONS OR REMEDIES?

HOW WOULD YOU RATE YOUR HEALTH? Excellent____Good____ Fair____ Poor____

Main Complaints in order of importance (listing as many details as possible, such as when you get symptoms, locations, severity, descriptive words of symptoms are very helpful):

Please describe your personality, personal preferences (hot/cold, morning/night), any strong likes/dislikes, emotions, fears, etc.

Are there any traumatic events (surgeries, drug reactions, life trauma) that you feel may have caused or contributed to your health problems?

What is your job? Do you enjoy it? How are the stress levels with your job?

Describe your family relationships and your home environment.

What do you do to relax or destress? Do you handle stress well?

Describe your typical eating habits for breakfast, lunch, dinner and snacks.

HAVE YOU EVER SUFFERED, FROM ANY OF THE FOLLOWING? PUT DATES IF AVAILABLE FOR PAST. PUT MOM, DAD, GP, GM, ETC. FOR FAMILY.

SKIN	**NOW**	**PAST**	**FAMILY**
DRY, ROUGH, SCALY, ITCHY			
RASHES			
MOLES/CYSTS			
LIGHT/DARK PATCHES			
ACNE			
LOSS OF HAIR			
HIVES			
LYMPHATIC/ IMMUNE SYSTEM			
PAINFUL LYMPH NODES			
BRUISE EASILY			
WOUNDS HEAL SLOWLY			
ANEMIA			
SWOLLEN GLANDS			
FLUID RETENTION			
ENDOCRINE			
UNEXPLAINED WEIGHT LOSS/GAIN			
PREFERS HOT WEATHER			
PREFERS COLD WEATHER			
HATE THE HEAT			
HATE THE COLD			
COLD HANDS AND FEET			
FATIGUE LONG TERM			
WEAKNESS			
INCREASED THIRST			
INCREASED HUNGER			

RESPIRATORY	NOW	PAST	FAMILY
UNEXPLAINED FEVER			
CHEST PAIN WHEN BREATHING			
WHEEZING			
DIFFICULTY BREATHING AT NIGHT			
CONGESTION			
SHORTNESS OF BREATH			
CARDIOVASCULAR			
CHEST PAIN WHEN WALKING			
CHEST PAIN WHEN SITTING/LYING			
SWELLING IN ANKLES OR ABDOMEN			
PALPITATIONS			
VARICOSE VEINS			
HEART DISEASE			
GASTROINTESTINAL			
CONSTIPATION			
DIARRHEA			
HEMORRHOIDS			
BLOOD IN STOOL			
# OF BOWEL MOVEMENTS PER DAY			
FREQUENT NAUSEA			
HEARTBURN			
TROUBLE SWALLOWING			
EXCESSIVE BELCHING			
BLOATING			
CRAMPING			
ANOREXIA			
BULIMIA			
ABDOMINAL PAIN			

GASTROINTESTINAL CONT.	NOW	PAST	FAMILY
DISTRESS FROM GREASY FOOD			
BAD BREATH			
INDIGESTION			
CRAVING SWEETS			
CRAVING SALT			
BAD TASTE IN MOUTH			
OVERWEIGHT			
PARASITES			
JAUNDICE			
FEMALE REPRODUCTIVE			
PELVIC PAIN			
HEAVY MENSTRUATION			
MENOPAUSE			
TAKING BIRTH CONTROL			
PERIOD TIMING AND DURATION			
# OF PREGNANCIES, NATURAL OR C-SECTION			
PITUITARY			
FAILING MEMORY			
ABNORMAL THIRST			
ULCERS			
LOW BP			
THYROID			
OVERWEIGHT			
TIRED UPON RISING			
NERVOUSNESS			
THYROID DISEASE			
HYPOTHYROIDISM			
HYPERTHYROIDISM			

ADRENALS	NOW	PAST	FAMILY
EASILY STRESSED			
HOT FLASHES			
WEAK NAILS			
ARTHRITIS			
POOR CIRCULATION			
FACIAL HAIR IN WOMEN			
SYMPATHETIC NERVOUS SYSTEM			
DRY EYES, NOSE, MOUTH			
NERVOUSNESS			
DECREASED URINE OUTPUT			
HEART POUNDS WHEN LYING DOWN			
FREQUENT COLD SWEATS			
PARASYMPATHETIC NERVOUS SYSTEM			
JOINT STIFFNESS RISING			
MUSCLE CRAMPS			
BUTTERFLIES IN STOMACH			
LOW PERSPIRATION			
PROFUSE PERSPIRATION			
SLOW PULSE			
IRREGULAR BREATHING			
PUFFY EYES			
MUSCULOSKELETAL			
JOINT PAIN			
BACKACHES			
MENTAL			
ANXIETY			
EXCESSIVE WORRY			
DEPRESSION			

MENTAL CONT.	NOW	PAST	FAMILY
DISCONTENT/DISPAIR			
SUICIDAL THOUGHTS			
LONELINESS			
MOOD SWINGS			
PREFER TO BE WITH PEOPLE			
PREFER TO BE ALONE			
AFRAID			
CONFIDENT			
CONFUSION			
CONCENTRATION			
DIFFICULTIES SHY			
SELF-CRITICAL			
JEALOUS/SUSPICIOUS			
ORGANIZED			
AFFECTIONATE			
ASSERTIVE			
LIFESTYLE			
# OF CAFFEINATED BEVERAGES PER DAY			
# OF ALCOHOLIC BEVERAGES PER WEEK			
RECREATIONAL DRUG USE (LIST)			
# OF CIGARETTES PER DAY (SECONDHAND TOO)			
# OF SLEEP HOURS PER NIGHT			
TIME EXERCISING PER WEEK			
CHEMICAL EXPOSURE AT WORK			
# OF GLASSES OF WATER PER DAY			
DO YOU HAVE ENJOYABLE HOBBIES?			
DO YOU HAVE A STRONG SUPPORT SYSTEM?			
DO YOU HAVE A SPIRITUAL PRACTICE?			

DISEASES/CONDITIONS	NOW	PAST	FAMILY
HIGH CHOLESTEROL			
HEART ATTACK			
CORONARY ARTERY DISEASE			
DIABETIC			
CANCER, BREAST			
CANCER, COLON			
CANCER, PROSTATE			
CANCER, LIVER			
CANCER, INTESTINAL			
CANCER, UTERINE			
CANCER, LUNG			
CANCER, OTHER (LIST)			
OSTEOPOROSIS			
ALZHEIMER'S			
ASTHMA			
AUTOIMMUNE DISEASE			
BLOOD DISORDER			
EMPHYSEMA			
GENETIC DISORDER			
GLAUCOMA			
HEPATITIS B OR C			
KIDNEY STONES			
MACULAR DEGENERATION			
STROKE			
BONE FRACTURES			
SEIZURES			
SUDDEN CARDIAC DEATH			
SURGERIES			

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WAIVER AND RELEASE OF LIABILITY

NATURAL MEDICINE, FUNCTIONAL MEDICINE AND HOLISTIC NUTRITION

PURPOSE

Functional blood chemistry analysis is designed to assess an individual's overall health and identify subtle imbalances or potential dysfunction by evaluating blood biomarkers, including nutrient levels. This evaluation involves comparing these biomarkers to optimal ranges and clinical goals, going beyond standard blood chemistry ranges. The goal of natural medicine and nutrition is to promote holistic health and well-being through natural remedies, such as homeopathic treatments, herbs, vitamins, and lifestyle changes. This approach emphasizes the body's natural ability to heal itself while addressing both nutritional deficiencies and specific health concerns.

POSSIBLE BENEFITS

Functional blood chemistry analysis can identify subtle imbalances or dysfunctions before they develop into serious diseases, allowing for proactive interventions. By examining a broader range of markers than traditional blood tests, this method aids in creating a customized plan to optimize health through diet, lifestyle modifications, and natural medicine. It offers a holistic view of your body's systems, including organ function, electrolyte balance, and metabolic efficiency, providing a more comprehensive understanding of your health status. This analysis can help identify the root causes of symptoms, offering clearer insights into their underlying mechanisms and leading to more effective solutions. The results can guide personalized recommendations that enhance your well-being, which may include dietary changes, supplementation with natural medicine, or other lifestyle adjustments. By emphasizing nutritional benefits, this approach not only supports health optimization but also reinforces the body's innate healing abilities. Additionally, regular functional blood chemistry analysis allows for the tracking of health changes and identification of trends, ultimately helping to improve health outcomes over the long term.

POTENTIAL FOR NEGATIVE SIDE EFFECTS

FBCA should not be seen as a replacement for traditional diagnostic tests or medical care. The interpretation of FBCA results can be subjective, and different practitioners may draw different conclusions from the same data. Some natural products, like certain herbs or supplements, can cause allergic reactions or other adverse side effects. Herbal medicines and supplements can interact with conventional medications, potentially reducing their effectiveness or increasing the risk of side effects. Certain herbs and supplements have been linked to liver, kidney, or other organ damage, it is essential to always check with your physician before starting any new supplements to ensure they are appropriate for your individual health needs.

INFORMATION AND UNDERSTANDING OF HOLISTIC CARE

I acknowledge that I have voluntarily chosen to participate in natural medicine, functional medicine, and holistic nutrition. I understand that these therapies are designed to assist individuals in addressing their health concerns and improving overall well-being.

ACKNOWLEDGEMENT OF RISKS

I recognize that participation in this therapy involves inherent risks, including but not limited to physical, emotional, or psychological discomfort. I understand that results can vary among individuals, and there is no guarantee of specific outcomes.

RELEASE OF LIABILITY

In consideration of my participation in this therapy, I hereby agree to release and hold harmless Erin Suttle of Erin Elizabeth Holistic Health from any and all liability, claims, demands, or causes of action that may arise from my participation in natural medicine, functional medicine and holistic nutrition. I understand that Erin Suttle is not licensed as a healthcare professional. She is not a physician. The state has not adopted any educational or training requirements for unlicensed complementary or alternative health care practitioners. Erin Suttle cannot diagnose, cure, or treat diseases. Any advice given is for wellness and holistic lifestyle purposes only.

MEDICAL DISCLOSURE

I affirm that the information given above is correct and complete, that I have disclosed all relevant medical information and conditions to the practitioner, and that I have consulted with a healthcare provider before undergoing the therapy, if necessary. I will inform my therapist of any medication, health, or diagnosed changes at any time during my treatment. I understand that there shall be no liability on the therapist's part should I forget to do so. By signing this release, I hereby waive and release my therapist from all liability past, present, and future relating to my therapy treatments.

INFORMED CONSENT

I have read this waiver and release of liability carefully, and I fully understand its contents. I acknowledge that by signing this document, I am waiving certain legal rights, including the right to sue. I consent to participate in natural medicine, functional medicine and holistic nutrition.

Participant Information:
Name: _____ Date of Birth: _____
Address: _____City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

Signature of Participant: _____ Date: _____
If the participant is under 18, a parent or guardian must sign
Signature of Parent/Guardian: _____ Date: _____ Relationship to Participant:_____

Professional Wellness Alliance

Membership Agreement

Who We Are: The Professional Wellness Alliance is an ecclesiastical association on a mission to provide service protection for providers and bring individuals and families together to learn and share knowledge of self-care and holistic health education and concepts.

How it Works: Individuals and families join in community with PWA licensed missionary members to share the services defined below. The PWA is structured as a private community and requires membership to assure protection for providers, good community order, member conduct and quality of services.

Services Provided: The PWA mission is to educate, enlighten and empower members through self-care and holistic health education and instruction.

Services Not Provided: Providers do not offer any state licensed health service under PWA license and DO NOT take responsibility for the health of any person or for the diagnosis, treatment or resolution of any symptom or condition.

How Do I Enroll as a Member: You must enroll through a PWA licensed provider and you must agree to be accountable to regular member rules as follows;

1. Agree that Provider Members (PWA Licensees) provide the services described above under "Services Provided" and that these are self-help and educational services not medical services.
2. Agree that all records of services you receive are available to you upon request as "private member educational records" and not medical records;
3. Agree that the Professional Wellness Alliance does it's best to assure the integrity and competence of Provider Members (Licensees) and while Licensees represent the PWA mission, that they are independent educators that do not work for the PWA. Therefore, you agree to hold the PWA and affiliates harmless in all matters related to your association with PWA, affiliates or Provider Members;
4. Agree to make your best efforts to resolve any and all complaint you may have with another member with them personally and in the event you are unable to resolve satisfactorily, agree to settle any dispute or complaint through binding arbitration through a mutually agreed arbitrator;
5. Agree that any and all content on the PWA website, newsletters, writings, affiliate links or otherwise are for educational purposes only and are not intended as medical advice.

Term and Cancellation: Membership in the PWA shall begin when you agree to this Membership Agreement and shall terminate with written notice from you to the PWA or from the PMA to you. The PWA reserves the right to deny or terminate membership of any member without cause. Termination shall not waive or relieve you of any obligations or agreements made while you were an enrolled member.

By placing your signature below or agreeing to membership though the PWA on-line electronic system you accept membership and agree that this agreement is a "contract" binding you to follow the herein terms.

_____	_____	_____
Member Name	Date	Address
_____	_____	_____
City / State / Zip	Email	Member Signature

Enrolled Into Membership By: Erin E. Suttle_____ PWA Provider #4679361_____