

Erin Elizabeth Holistic Health

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TO BE COMPLETED AT LEAST ONE WEEK BEFORE YOUR APPOINTMENT:

This form helps me better understand your health history, lifestyle, and wellness goals so I can provide personalized educational guidance. It is comprehensive because I want to understand the bigger picture of your wellness. Please complete as much as you can. If you don't remember something, your best guess is fine. If you're uncomfortable answering a question, you may leave it blank. Your information will be kept confidential. Thank you for taking the time to share your story!

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			

WAIVER AND RELEASE OF LIABILITY

FUNCTIONAL & NATURAL WELLNESS EDUCATION AND COACHING

PURPOSE

Educational Lab Review helps you better understand your bloodwork and health information by looking at relevant biomarkers in the context of your overall wellness and goals. Our Functional & Natural Wellness approach provides education about nutrition, lifestyle, vitamins, herbs, supplements, and other natural wellness practices that may support overall well-being. This information is educational and is not intended to diagnose, treat, cure, or prevent disease or replace medical care.

POSSIBLE BENEFITS

Educational Lab Review helps you better understand your bloodwork and health information by looking at relevant biomarkers in the context of your overall wellness, lifestyle, and goals. Rather than focusing on a single result, we look at the bigger picture and discuss patterns and areas you may want to explore further. This may include information related to nutrition, energy, metabolism, hydration, and other aspects of overall wellness. Your results can provide helpful information to support informed lifestyle choices. Depending on your goals, wellness education may include discussion of nutrition, vitamins, herbs, supplements, healthy habits, and other natural wellness approaches.

POTENTIAL FOR NEGATIVE SIDE EFFECTS

Educational Lab Review is not a replacement for traditional diagnostic testing, medical evaluation, or medical care. Lab information can be interpreted in different ways, and educational wellness perspectives are not intended to provide a medical diagnosis or determine treatment. Vitamins, herbs, supplements, and other natural wellness products may cause side effects, allergic reactions, or interactions with medications. Always discuss new supplements or significant changes to your health routine with your physician or other appropriately licensed healthcare professional.

INFORMATION AND UNDERSTANDING OF HOLISTIC CARE

I acknowledge that I have voluntarily chosen to participate in Functional & Natural Wellness Education and Coaching. I understand that these services are intended to provide general wellness education, lifestyle guidance, and support for overall well-being.

ACKNOWLEDGEMENT OF RISKS

I understand that participation in Functional & Natural Wellness Education and Coaching may involve physical, emotional, or psychological discomfort. I understand that individual experiences and results may vary, and that no specific outcomes are guaranteed.

RELEASE OF LIABILITY

In consideration of my voluntary participation in Functional & Natural Wellness Education and Coaching, I agree to release and hold harmless Erin Suttle and Erin Elizabeth Holistic Health from claims or liability arising from my voluntary participation in these educational wellness services, to the extent permitted by law. I understand that Erin Elizabeth Holistic Health provides educational wellness information, lifestyle guidance, and wellness coaching. These services are not medical care and are not intended to diagnose, treat, cure, or prevent disease. I understand that Erin Suttle is not a physician or other state-licensed healthcare provider, and that the information and guidance provided are for educational and general wellness purposes only. I understand that I should seek appropriate medical care from a qualified, licensed healthcare professional for medical concerns, diagnosis, treatment, or other healthcare needs.

MEDICAL DISCLOSURE

I affirm that the information I provide is accurate and complete to the best of my knowledge. I understand that providing accurate information about my health history, medications, supplements, lifestyle, and wellness goals helps support the educational wellness services provided.

I agree to inform Erin Suttle of any significant changes to the information I have provided, including changes in medications, supplements, health circumstances, or wellness goals. I understand that I am responsible for seeking appropriate medical care from a qualified, licensed healthcare professional when needed. By signing this agreement, I acknowledge my voluntary participation in wellness education and coaching and agree to the terms of this waiver and release to the extent permitted by law.

INFORMED CONSENT

I have read this Waiver and Release of Liability carefully and fully understand its contents. I acknowledge that by signing this document, I am waiving certain legal rights, including the right to sue or bring a claim, to the extent permitted by law. I voluntarily consent to participate in Functional & Natural Wellness Education and Coaching and understand that these services are educational in nature and are not medical care.

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_____