

Date: _____

Creative Health & Herbal Nutrition

Name: _____ Age: _____ DOB: _____

Phone: (H) _____ (C) _____ (W) _____ Email: _____

Address: _____ Apt # _____ City _____ State: _____ Zipcode: _____

Employment: _____

What would you like to achieve in your visit with us? _____

What are your top 3 health goals?

1. _____

2. _____

3. _____

General Information

Height: _____ Weight: _____ Weight 6 months ago: _____ Weight 1 year ago: _____

Highest adult weight: _____ Desired weight: _____ Blood Type: _____

History of eating disorder: Yes No If yes, please explain: _____

Medical History (ie: surgeries with dates, childhood and adult diseases): _____

Allergies: _____

Rate your digestive function: Good Fair Poor

Comments: _____

Recent Labs (if known): _____

Family History (if known): _____

Women (check all that apply): Regular periods Painful periods PMS Post-Menopausal Fertility

Comments/Concerns: _____

Medications and Nutritional Supplements

(Include name or brand of supplement, dosage, frequency)

Medications: _____

Vitamins/Minerals: _____

Herbs/Botanicals: _____

Other: _____

Food Profile

General

Concerns: _____

Food allergies or intolerances: Yes No

Comments: _____

Percentage of food cooked at home: 90-100% 75% + 50% + < 50%

Where do you eat out and what do you order? : _____

Food cravings: _____

List personal "barriers/challenges" to eating well: _____

Lifestyle

What do you do to nourish yourself (fun, hobbies, relaxation): _____

Life Stressors: _____

Any healing arts/therapies that you partake in on a regular basis: _____

Spiritual/Religious Affiliation: _____

Marital Status: _____ Spouse Name: _____

Children (names and ages): _____

Sleep: 8+ hours 6-8 hours <6 hours

Sleep problems: Yes No

Comments: _____

Exercise/Movement Activities (please list): _____

How often? _____ x per day _____ per week _____ per month

Rarely exercise due to: _____

Typical Day

Please list the foods consumed during each meal, the time of the meal and if you usually skip a particular meal.

Breakfast: _____	Lunch: _____	Evening meals: _____	Snacks: AM or PM?	Typical Beverages

Have you been diagnosed by a licensed physician with any of the following? Check all that apply.

- | | | | |
|------------------------------------|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Low Thyroid | <input type="checkbox"/> Ulcers |

Do You Suffer from any of the following? Check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Puffiness under eyes |
| <input type="checkbox"/> Absent-mindedness | <input type="checkbox"/> Frequent thirst | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Acid indigestion or heartburn | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> General weakness or chronic illness | <input type="checkbox"/> Restless dreams or nightmares |
| <input type="checkbox"/> Allergies, food | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Allergies, respiratory | <input type="checkbox"/> Headaches | <input type="checkbox"/> Scant or excessive urination |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sensation of lump in throat |
| <input type="checkbox"/> Anger, excessive | <input type="checkbox"/> Heavy periods (females only) | <input type="checkbox"/> Sinusitis or sinus congestion |
| <input type="checkbox"/> Anxiety, nervousness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sinus headaches |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Skin problems (acne, rashes, etc.) |
| <input type="checkbox"/> Bad breath or body odor | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stiff, aching or painful muscles |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stomachache |
| <input type="checkbox"/> Brittle fingernails | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Swollen lymph glands |
| <input type="checkbox"/> Burning or painful urination | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Impotency (males only) | <input type="checkbox"/> Underweight or unable to gain weight |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Urinating at night |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Infertility | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Congested air passages | <input type="checkbox"/> Intestinal gas or bloating | <input type="checkbox"/> Waking up frequently at night |
| <input type="checkbox"/> Constipation or dry stools | <input type="checkbox"/> Irritability | <input type="checkbox"/> Water retention or edema |
| <input type="checkbox"/> Coughing, chronic | <input type="checkbox"/> Itchy nose or ears | <input type="checkbox"/> Weak legs, knees or ankles |
| <input type="checkbox"/> Cravings for fats or fried foods | <input type="checkbox"/> Itching, skin | <input type="checkbox"/> Wheezing or shortness of breath |
| <input type="checkbox"/> Cravings for sugar | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Wounds will not heal in extremities |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Joint pain or gout | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Leg cramps or pains | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loose stool or diarrhea | |
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Loss of appetite or poor appetite | |
| <input type="checkbox"/> Difficulty getting to sleep | <input type="checkbox"/> Loss of taste | |
| <input type="checkbox"/> Dizziness or light-headedness | <input type="checkbox"/> Loss of sexual desire | |
| <input type="checkbox"/> Dry skin or eyes. | <input type="checkbox"/> Loss of smell | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Loss of taste | |
| <input type="checkbox"/> Erection difficulty (males only) | <input type="checkbox"/> Migraine headaches | |
| <input type="checkbox"/> Excess mucus production | <input type="checkbox"/> Mood swings | |
| <input type="checkbox"/> Excess weight | <input type="checkbox"/> Muddled thinking, confusion or mental sluggishness | |
| <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Muscle tension | |
| <input type="checkbox"/> Fatigue in the afternoons | <input type="checkbox"/> Panic attacks | |
| <input type="checkbox"/> Fatigue, chronic or excessive | <input type="checkbox"/> PMS (females only) | |
| <input type="checkbox"/> Fear, excessive | <input type="checkbox"/> Poor appetite | |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Prostate problems (males only) | |
| <input type="checkbox"/> Food sits heavy on stomach after eating | | |

RELEASE STATEMENT

I know Terry Lynne Hall has not, does not, or will not attempt to treat, prevent, cure, or relieve a human disease, ailment, defect, complaint, or other condition, whether physical or mental, by attendance or by a device, diagnostic test or other means, or to offer, undertake, attempt to do so, or to hold oneself out as able to do any of these acts.

I know Terry Lynne Hall is a Doctor of Naturopathy, Master Herbalist, Certified Nutritional Consultant, Certified Natural Health Professional, Professional member of the American Naturopathic Medical Association, Professional member of the American Association of Nutritional Consultants, and is proficient in Iridological Analysis. Her sole purpose is to educate as to the historical use of foods, minerals, vitamins, and herbs.

I understand that any suggested minerals, vitamins, and herbs are sold as food and nutritional products only. They are not sold for the prevention, cure, treatment, or mitigation of disease.

I understand that I MUST COMMIT MY OWN PERSONAL EFFORTS to the services provided, and that the success of any program in which I enter will depend on a large degree to my understanding, determination, and perseverance.

I acknowledge that my signature indicates that I have read, understand, and agree with all of the above statements.

Signature _____ Date _____

How did you hear about us? _____

Would you like to be informed of upcoming events at Creative Health? (If yes)
How do you prefer we contact you?

Phone _____

Email _____