Authentic Health *It's a lifestyle!*

Date: _____

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.

- ☐ AIDS
- ☐ Arthritis
- ☐ Asthma
- ☐ Colitis
- ☐ Cancer
- ☐ Cirrhosis of the Liver
- ☐ Diabetes
- ☐ Irritable Bowel Syndrome
- ☐ Fibromyalgia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Low Thyroid
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Ulcers

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

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

RELEASE STATEMENT

I know Brenda Baker has not, does not, or will not attempt to treat, cure or relieve a human disease, ailment, defect, complaint, or other condition, whether physical or mental, by attendance or 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 Brenda Baker has over a decade of experience in natural health. She is a Board-Certified Drugless Practitioner and Board-Certified Alternative Health Medical Practitioner. Brenda is a traditional naturopath and graduated from Trinity College of Natural Health with a doctorate in Naturopathy. Brenda also holds specialties as an advanced Loomis Digestive Health Specialist, Enzyme Nutritionist, Master Herbalist, Certified Natural Health Professional, Certified Nutritional Consultant, Certified Iridologist, Certified RECODE specialist (reversing cognitive decline) and Certified Bioenergetic Specialist.

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_____

24 Hour Appointment Cancellation Policy

AUTHENTIC HEALTH, LLC. Adheres to a 24 hour cancellation / rescheduling policy. If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $45.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Authentic Health, LLC as described above. Thank you for your understanding and cooperation.

Signature_____

How did you hear about us?

Would you like to be informed of upcoming events?