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

862 S Pleasantburg Dr STE D, Greenville, SC 29607 Ph. 864-309-0392

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

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