

# 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## 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



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



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## 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 is a Doctor of Naturopathy, Certified Natural Health Professional, Certified Digestive Health Specialist, and is proficient in Iridological Analysis and Herbology . Her sole purpose is to educate as to the historical use of foods, minerals, vitamins, enzymes and herbs.

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?