

HEALTH HISTORY

The answers you provide are confidential. Please be as accurate as possible. Please print clearly.

Name: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Height:_____ Weight:_____ Email (for client communication only):_____

Who were you referred by? _____ Are you married? _____

Name/Phone of Your Primary Care Physician: _____

Complaints/Challenges: What are the primary reasons for your visit? (Please rate the severity between 1-10 (10 being worst)).

[illegible]

Medications: Please list all medications you are taking (including all Over the Counter medications), how long you've been taking them, and what they're used for:

[illegible]

Vitamins & Supplements: Please list all vitamin supplements you are currently taking:

Surgeries: Please list **ALL** major and minor surgeries you've had, including out-patient and in-office procedures, cosmetic and elective surgeries, Dental surgeries, and **list any foreign materials in the body** (such as pins, rods, plates, implants). Please list all ectomies:

Allergies & Sensitivities: Please list all known allergies or sensitivities, including foods, alcohol, grasses, trees, molds, chemicals, medications, etc.:

Digestion: Please list any digestive problems, including acid reflux, burping, burning/pain in stomach, bloating, nausea, feeling full for too long, colitis, lactose intolerance, Crohn's disease, Irritable Bowel, Spastic Colon, Diverticulitis, Colitis, Constipation, Diarrhea and any other problems:

Bowel Activity: Please describe your bowel movements, including how often and if you have a complete evacuation daily. List any abnormalities concerning your bowel movements, including unusual color:

Have you ever had a blood transfusion? If so, give dates:_____

Vaccinations: Please list all vaccinations you have ever had and when you received them:_____

Smoking: Do you currently smoke?_____ How long have you smoked? _____

Have you ever smoked in the past?_____ For how long?_____

For Practitioner Use:

Notes: _____

Authorization and Release Form

Please read the following carefully and completely. If you understand and agree with the information, sign and date at the bottom.

- I fully understand that Lisa Setser (hereinafter referred to as the attending consultant) is not an allopathic doctor (MD), and does not pretend to be, but is a traditional naturopath, providing services that are not allopathic, but that are within the parameters of a natural health and wellness philosophy.
- I fully understand that the attending consultant does not offer allopathic drugs, surgery, chemical stimulants or radiation therapy, but is providing natural therapies, information and recommendations for natural products to restore balance and optimum conditions for health and wellness.
- I fully understand that the attending consultant is not diagnosing or treating any illness or disease, and that if I am seeking a diagnosis of disease, it is my responsibility to pursue this with my Primary Care Physician or other Licensed Medical Doctor.
- I fully understand that the attending consultant is in no way encouraging me to terminate or modify any previous or ongoing therapies under the direction of any licensed practitioner, and that the attending consultant will not dissuade me from seeking allopathic attention, recommendations or modes of therapy from a licensed physician.
- I presently seek consultation, advice, opinions and/or programs, evaluations, therapies and product recommendations within the scope of the attending consultant's wellness practice based upon the principles of holistic health and wellness. I have solicited the attending consultant's services in good faith, exerting my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.
- I authorize the attending consultant to provide her services to me on my behalf, and hereby release her from any and all claims and potential claims arising out of my actions or failure to act upon her advice.
- I give full faith that I have read and understand this document entirely, that I have received verbal explanation for any questions or misunderstandings of this document and/or that she has answered satisfactorily all of my questions regarding the information on this document.
- **I certify that I am NOT pregnant, I do NOT have an organ transplanted into me and I do NOT have a pacemaker implanted in me.**
- I am willing to declare under oath all of the above statements by request of the attending consultant.

I hereby consent to and authorize the above described evaluation and consultation:

Member's Signature

Date

Parent or Guardian's Signature if Member is under age 18

Date