BioEnergy Health Specialties, LLC Initial Intake Form

GETTING TO KNOW YOU…

Welcome…please fill out this form to the best of your ability. If you get stuck, don't worry…we will review this form together. We will utilize this information in your consultation. Relax…you are in the right place.

Name: _____ **Today's Date:** _____

Address: _____ **Birthdate:** _____

_____ **Sex:** ☐ M ☐ F

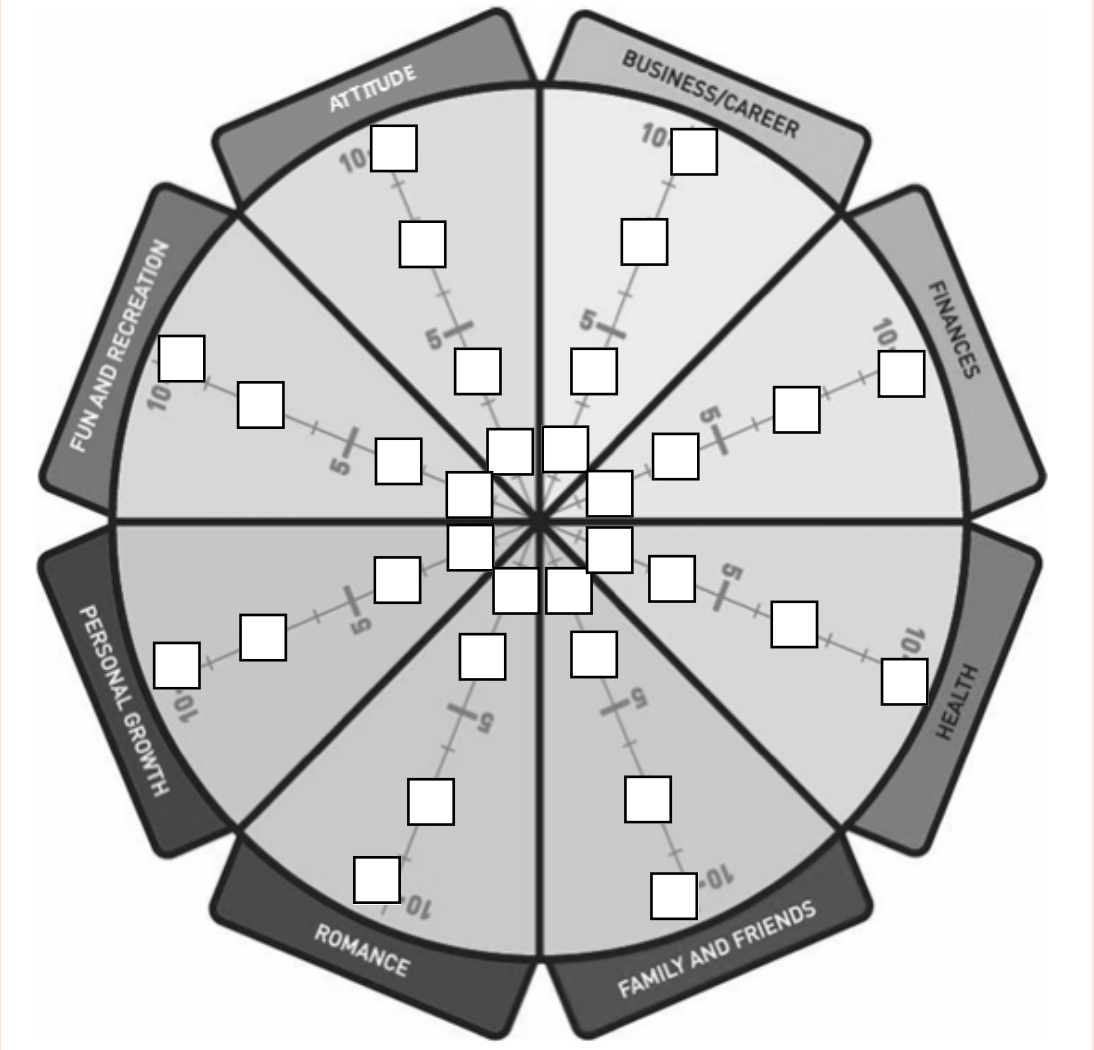
Phone: _____ **Email:** _____

Occupation: _____

How did you find us? _____

YOUR WHEEL OF LIFE

- Please circle your current level of satisfaction in each area of life. 0 = Horrible, 5 = Okay, 10 = Terrific!



Defy Your DNA™

DETOXIFY
NOURISH
ADAPT

Our holistic approach is designed to help you express your greatest genetic potential and creating lasting improvements in your health and wellbeing. We call it Defying Your DNA. We will help you detoxify and clean out your system, nourish and strengthen your body, and help you more effectively adapt to stress.

THE MOST IMPORTANT QUESTIONS

1. Before we dive into the details of your health history, what are the 3 most important things we can help you with to improve your health and quality of life?

A. _____

B. _____

C. _____

2. What is most important to you in a health practitioner team? _____

3. If you have tried therapies to help these issues in the past, what was successful? What wasn't?

4. On a scale of 1-10, how important is your health to you? *Scale is: 1 = low, 10 = highest importance*

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

5. On a scale of 1-10, how willing are you to make lifestyle changes to gain greater health? Please circle...

Scale is: 1 = I don't want to change anything, 5 = I will make moderate changes, 10 = I will do anything it takes!

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

YOUR CURRENT NUTRIENT REGIMEN

Please list the supplements you take on a regular basis: _____

Can you swallow capsules? ☐ Yes ☐ No

MEDICATIONS

Please list any medications you are currently taking and the condition for which you are taking them:

DETOXIFY

TOXIC BURDEN

Please check off the symptoms you are regularly experiencing under each category heading and please check off any toxin groups which you are concerned about and if you have a reason, please list why...

BACTERIA
- ☐ Yellow/green discharge
- ☐ Fever gets worse with time
- ☐ Symptoms persist longer than 10-14 days
- ☐ Focal area of illness (sinuses, lungs, throat, etc...)

☐ I am concerned about this group.
Why? _____

VIRUSES
- ☐ Clear discharge
- ☐ Low-grade fevers/chills
- ☐ History of chronic viral infection (EBV, HPV, Herpes, HIV, etc...)
- ☐ Body-wide aches/fatigue

☐ I am concerned about this group.
Why? _____

MOLD/FUNGUS
- ☐ Frequent antibiotic usage
- ☐ Fungal rashes/eczema/psoriasis/yeast infections
- ☐ White, coated tongue
- ☐ Strong cravings for sugars and starches

☐ I am concerned about this group.
Why? _____

LYME
- ☐ History of tick bite
- ☐ Neurological symptoms/confusion/heavy feeling in head
- ☐ Diagnosis of Lyme, MS, Lupus, Autism
- ☐ Excruciating joint pain, non-related to arthritis

☐ I am concerned about this group.
Why? _____

HEAVY METALS
- ☐ Currently have silver fillings/recently had them removed
- ☐ Exposure through vaccinations/job
- ☐ Memory difficulties
- ☐ Tremors/Alzheimer's/Parkinson's

☐ I am concerned about this group.
Why? _____

CHEMICALS
- ☐ Chemical exposure at home or work (hair salon, nail salon, etc...)
- ☐ Use commercial cleaning products
- ☐ Use commercial personal care products
- ☐ Currently smoke or exposed to smoke

☐ I am concerned about this group.
Why? _____

PESTICIDES
- ☐ Eat non-organic produce and animal products
- ☐ Use fertilizer and pesticides on yard
- ☐ Drink/bathe in unfiltered tap water
- ☐ Pesticide exposure through occupation

☐ I am concerned about this group.
Why? _____

PARASITES
- ☐ History of digestive upset
- ☐ Bloating/gas
- ☐ Itching skin, especially at night
- ☐ Irritable bowel/Crohn's/Celiac

☐ I am concerned about this group.
Why? _____

PREVIOUS CLEANSING EXPERIENCE

- ☐ Colon
- ☐ Liver/Gallbladder
- ☐ Kidney
- ☐ Lymph/Whole Body

What benefits or difficulties did you experience?

_____

_____

AM I READY TO DETOX?

Detoxification requires energy of the body. Please check off the following criteria which must be met before starting a detoxification program:

- ☐ I am having a daily bowel movement
- ☐ I am willing to stay hydrated (drink at least half of my body weight in ounces of water daily)
- ☐ I am not currently pregnant or breastfeeding
- ☐ I can handle a temporary reduction in energy or short-term flare in my symptoms during detox
- ☐ I am willing to measure my 1st-morning urinary pH to make sure that my pH is between 6.5 - 7.25.

Please let us know in confidence what additional information you think is important for your practitioner to know:

NOURISH

Our next step is to find out how we can better nourish your body through nutrition & lifestyle.

You are not what you eat…you are what you DIGEST!

- ☐ Acid reflux/heartburn
- ☐ Belching after fatty meals
- ☐ Bloating after eating carbs/sugar
- ☐ Constipation or bowel most less than 1x/day
- ☐ General indigestion after eating
- ☐ Hard, small, or stringy stools

Please check the symptoms which you experience:

- ☐ I am 25+ years old and want to optimize my digestion
- ☐ Mild sensitivity to gluten and/or dairy
- ☐ Stools float or light in color
- ☐ Took antibiotics without probiotics
- ☐ Ulcer or pain after eating
- ☐ Other: _____

FOOD SENSITIVITIES

Please check all that apply:

- ☐ Casein
- ☐ Corn
- ☐ Dairy
- ☐ Egg
- ☐ Gluten
- ☐ Peanuts
- ☐ Shellfish
- ☐ Soy
- ☐ Wheat
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

MEAL PREPARATION

Do you prepare meals at home?	☐ Y	☐ N
Do you eat out at restaurants?	☐ Y	☐ N
Do you use artificial sweeteners?	☐ Y	☐ N
Do you use a microwave?	☐ Y	☐ N
Do you have a blender?	☐ Y	☐ N
Do you have a juicer?	☐ Y	☐ N

YOUR TYPICAL DIET

Please list the foods you commonly eat for each meal. Don't worry about looking good here…we will just start where we are at and move from here. It is helpful to get a realistic look at your day.

BREAKFAST (Typical time eaten:_____) _____

LUNCH (Typical time eaten:_____) _____

DINNER (Typical time eaten:_____) _____

SNACK (Typical time eaten:_____) _____

BEVERAGES (include amount of each) _____

THE BASICS

1. SLEEP

How many hours do you sleep at night? _____ Do you feel refreshed when you wake up? ☐ **Y** ☐ **N**

What time do you go to sleep? _____ Is your room completely darkened? ☐ **Y** ☐ **N**

If it is less than ideal, how would you describe your sleep?

_____

2. EXERCISE

What kind of exercise do you do? _____

How often? _____

3. SUNLIGHT

Do you get outside daily for at least 20 minutes with no sunscreen, glasses, contact lenses? ☐ **Y** ☐ **N**

4. HYDRATION

How many glasses of water do you drink daily? _____

Do you drink tap water? ☐ ☐ Yes / No Do you use a water filter at home ☐ ☐ Yes / No if yes, what brand?_____

Do you drink any of these diuretics on a daily basis? ☐ **Coffee** ☐ **Caffeinated Drinks** ☐ **Alcohol**

5. FRUITS & VEGGIES

How many servings of fruits and vegetables do you get on a daily basis *(1 serving = 1 piece of fruit or 1/2 cup)*

☐ **None** ☐ **1 to 2** ☐ **3 to 4** ☐ **5+**

Food Stressors. Please indicate how many **days per week** you consume the following foods:

Stimulants	***Toxic Oils***	***Commercial Dairy***	***Highly Heated Foods***
☐ Coffee	☐ Fried foods	☐ Cow's milk	☐ Bread
☐ Black Tea	☐ Fast food	☐ Yogurt	☐ Crackers
☐ Soft drinks	☐ Potato chips	☐ Ice cream	☐ Bagels
☐ NutraSweet drinks	☐ Roasted nuts	☐ Cottage cheese	☐ Muffins
☐ Alcohol	☐ Mayonnaise	☐ Sour cream	☐ Cookies-pastries
☐ Chocolate	☐ Margarine	☐ Cheese	
☐ Candy or sweets	☐ Peanut butter		

6 SMOKING

Do you currently smoke? ☐ ☐ Yes / No, if yes, how much?_____

How long have you smoked (currently or in the past?)_____

7 DRUGS

Do you currently use recreational drugs (ex. Marijuana, cocaine, uppers, downers)? ☐ ☐ Yes / No

If yes, which ones, and how often? *Reminder: This is strictly confidential information.*

8 ELECTROMAGNETIC EXPOSURE

Do you live or work near high voltage power lines? ☐ ☐ Yes / No

How many hours do you spend daily:

☐ Watching TV	☐ Wearing a pager	☐ In a car
☐ Working on a computer	☐ Wearing a wrist device (i.e. watch, etc.)	☐ Near electrical equip.
☐ Talking on a phone	☐ Wearing a hearing aid	☐ Near a clock radio

MEAL HABITS

Do you: Yes / No Skip meals often? Yes / No Have irregular eating times? Yes / No Eat food past 6pm?

What percentage of the produce you purchase is organic?_____

PERSONAL CARE AND HOME PRODUCTS:

Please check all that you use:

- Hair permanent
- Antiperspirants
- Facial make-up
- Hair spray
- Air fresheners (spray)
- Air fresheners (plug-ins)
- Hair gel
- Dryer sheets
- Roach/ant spray (in home)
- Hair dye
- Toilet freshener
- Fingernail polish
- Perfume/Cologne
- Lawn Fertilizer (non-organic)

WOMEN-ONLY

Are you currently pregnant or breastfeeding? Y N Do you get a monthly period? Y N

Are you experiencing any of the following hormonal symptoms?

- Hot flashes, night sweats
- Drop in libido
- Difficulty losing weight
- Insomnia
- Painful periods, cramping
- Cysts/fibroids
- PMS
- Other:_____

Have you struggled with fertility/miscarriage? Y N Have you had a hysterectomy? Y N

Do you take birth-control pills/hormones? Y N List: _____

How many children have you delivered? _____ Have you had an episiotomy or C-section? Y N

MEN-ONLY

Have you experienced a drop in muscular strength, drive, or libido? Y N

Do you have difficulty urinating or have an enlarged prostate? Y N

ADAPT

PHYSICAL STRESS

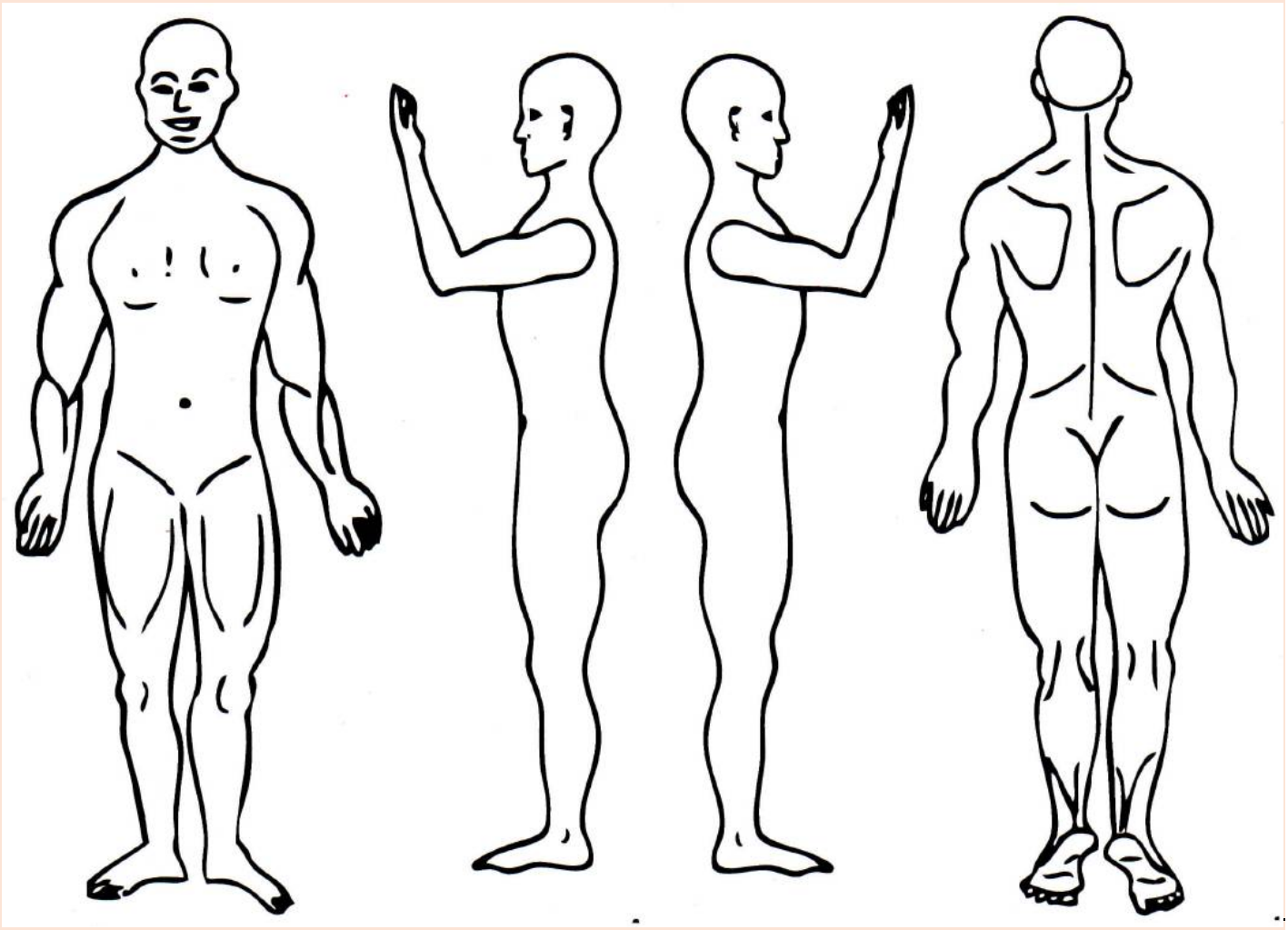
Please list major illnesses, surgeries, injuries, accidents, and/or diagnoses:

SCAR/INJURY CHART

On the illustration below, please mark areas of your body where you are concerned and/or experiencing symptoms.

piercings, episiotomy, and C-section scars. Please be thorough…

Please also indicate where you have scars or trauma sites. Don't forget concussions, tattoos



SYMPTOMS

Please circle your response to the following questions. Scale is:

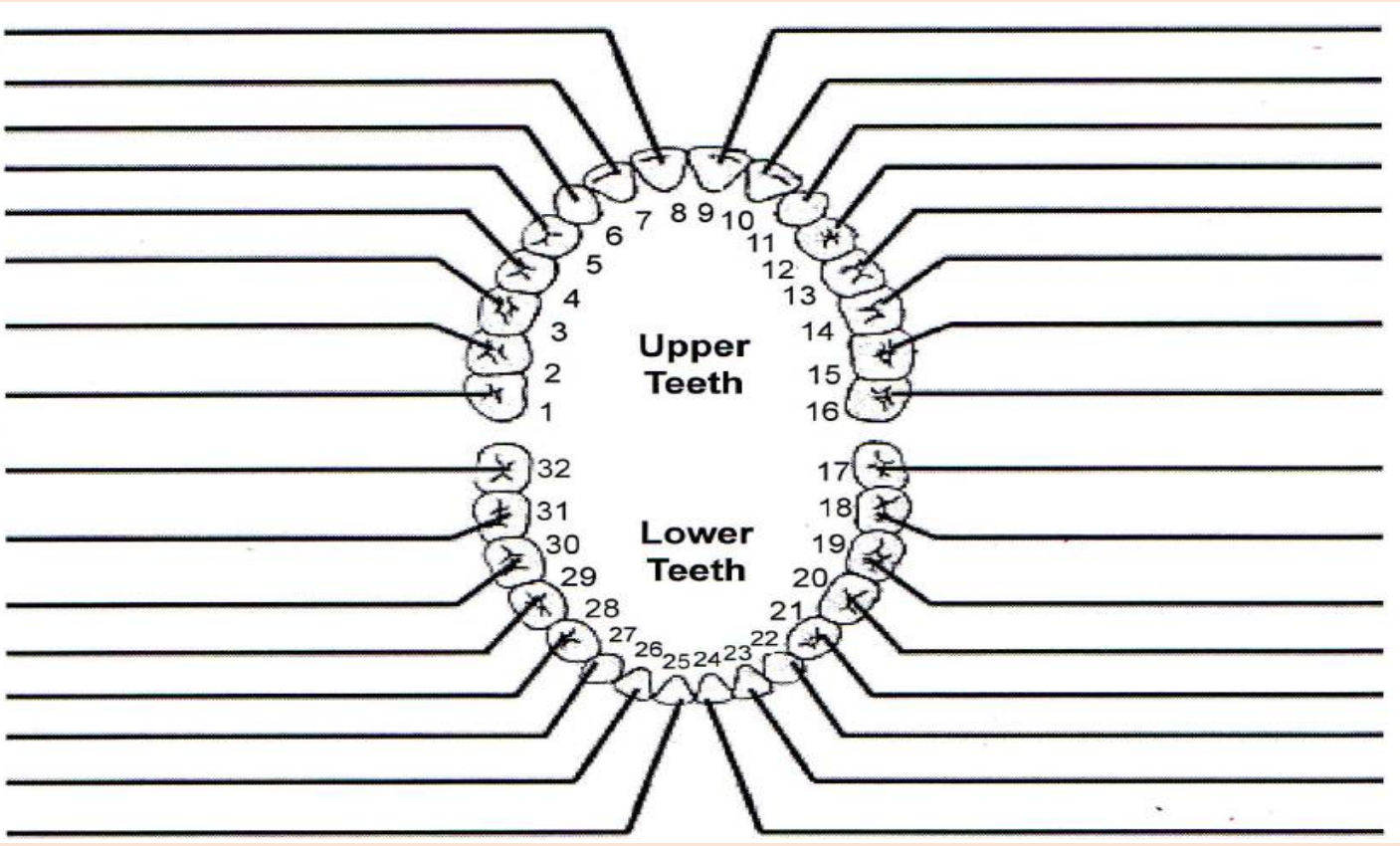
1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Frequently, 5 = Daily

LY	I experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes…	1 2 3 4 5
LU	I experience recurrent respiratory infections, coughs, bronchitis, pneumonia asthma…	1 2 3 4 5
LI	I experience bouts of diarrhea/constipation/gas/bloating…	1 2 3 4 5
NE	I experience irritability, nervousness, trembling, anxiety, memory problems…	1 2 3 4 5
CI	I have cold fingers/toes, blood pressure problems, varicose veins, circulation issues…	1 2 3 4 5
AL	I react to pollens, molds, foods, seasonal irritants, perfumes, animal dander…	1 2 3 4 5
TH	I have a slow metabolism, am always hungry, have low energy at specific times of day…	1 2 3 4 5
TW	I have mood swings, problems sleeping, am always cold, have chemical imbalances…	1 2 3 4 5
HT	I experience heart palpitations, pain in my chest, irregular beating…	1 2 3 4 5
SI	I have recurrent yeast infections, frequent antibiotic use, poor diet…	1 2 3 4 5
JT	I experience joint pain, stiffness, inflammation in my body…	1 2 3 4 5
PA	I have diabetes, blood sugar issues, irritability, shaking if I skip a meal…	1 2 3 4 5
SP	I experience chronic fatigue, recurring infections, get sick easily…	1 2 3 4 5
LV	I experience high cholesterol, wake up between 2-4am, indigestion after fatty meals…	1 2 3 4 5
SK	I have rashes, dryness or cracking, scaly patches, eczema, acne, psoriasis…	1 2 3 4 5
GD	I struggle with impotence, libido, miscarriages, sterility…	1 2 3 4 5
UB	I have recurring urinary tract infections, painful urination, leaking, urinary frequency…	1 2 3 4 5
KI	I experience swelling, gout, pain in the lower back, history of kidney stones…	1 2 3 4 5

DENTAL CHART

On the chart below, please mark any teeth or areas where you have silver fillings, root canals, infection, irritated gums,

Right Side Left Side



EMOTIONAL STRESS

Please list any psychological and/or emotional conditions you are experiencing:

How would you describe your overall mood?

YOUR INSIGHTS

Do you have any insights regarding the root cause of your issues (related symptoms, emotional events, things that

IMPORTANT

Do NOT consume any *nutritional supplements* the day of your appointment. We ask that you bring any medications and/or nutritional supplements (vitamins, herbs, oils, etc.,) you are currently taking.

INFORMED CONSENT

We apologize in advance for the legal jargon which follows. We live in a crazy time, where the pressure of government, economic, and legal agencies weigh heavily on those working to provide quality natural healthcare. Please read the informed consent below and sign to acknowledge your understanding. If you have any questions, please feel free to ask us!

I acknowledge that BioEnergy Health Specialties, LLC team are not medical doctors serving only members of Pastoral Medical Association (signed Pastoral Medical Association Agreement for Wellness Services attached to this intake form) with NO implanted devices including NO implanted electronic devices (i.e. pacemakers, cardioverter defibrillators, CIEDs, etc.). **This is to certify that to the best of my knowledge I have NO implanted device and I am not pregnant and associates of BioEnergy Health Specialties, LLC have my permission to provide care services.** I understand that BioEnergy Health Specialties, LLC staff members provide nutritional and other health-related information to help me attain my best health. All recommendations are designed to help me keep and enjoy my best state of health through personalized recommendations in lifestyle, exercise, health habits, and advanced nutrition. **I understand that BioEnergy Health Specialties, LLC team and staff members do NOT diagnose, treat, cure, or claim to cure any disease.** All questions regarding BioEnergy Health Specialties, LLC objectives pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of BioEnergy Health Specialties, LLC care have been explained to me to my satisfaction. I have read and fully understand the above statements and

I agree to pay the full amount due (cash, check, Visa, and Master Card are accepted) before the time of the service. I understand and agree that all of my payments made to BioEnergy Health Specialties, LLC are NOT refundable for any reason. I agree to pay the full charge for any missed appointment unless I cancel it within 24 hours. I have read this informed consent along with the Pastoral Medical Association Agreement for Wellness Services and I understand it. I am not a minor (under the age of 18) and the electronic transmission of this intake form or/and the Pastoral Medical Association Agreement for Wellness Services via electronic mail or otherwise attests and confirms my true signature.

Client's signature (or guardian) Date