

LIFE ENERGY HOLISTIC PARTNERS
CLIENT INFORMATION AND STATEMENT
LHEP ID # (For Office Use Only) _____

Name (Last, First, M.I.) _____ Phone _____

Street Address _____ Apt# _____

City _____ State _____ Zip _____ Ph. () _____

Occupation _____ How Long? _____ DOB (m/d/y) _____

HEALTH INFORMATION

In order to provide you with the best possible service, we request you provide the information below. This information will not be shared with ANY person or organization outside of Life Energy Holistic Partners.

What is your blood type? _____ Are you presently under a physician's care? Yes No; How long? _____

If so, for what condition(s)? (Please list) _____

Please list any medications you are taking (prescription AND over-the-counter):

Please list any nutritional supplements, herbs, or over-the-counter diet products you are taking or have taken:

Do you smoke? Yes No. How long? _____ How much per day? _____

Do you have any food allergies? (Please list) _____

Any medical/environmental allergies? (Please list) _____

Have you ever had a reaction to a vaccination? Yes; No; If so, what type of shot? _____

Last vaccinations you received: Type _____; Year _____

How many flu shots have you had? _____; What reaction? _____

(For women) Are you pregnant? Yes No; **If so, how many months?** ___ **How many prior pregnancies?** ___

Problems with pregnancies? Yes; No; **Any miscarriages?** Yes No; **If yes, how many?** _____;

Post-partum depression? Yes; No; **Problems with cycles when younger?** Yes; No;

Problems with PMS? Yes; No

Are you under a lot of stress? Yes; No; How long? _____

What type of stress? (Check all that apply) Physical; Mental; Emotional; Environmental

Is there significant stress at work? Yes; No; What type? _____

(PLEASE CONTINUE ON REVERSE)

How much water do you drink per day? REALLY! (Please check applicable box)

None; 1-2, 8 ounce glasses; 3-4 glasses; 5-6 glasses; 7-8 glasses; 9-10 glasses; More than 10 glasses.

How frequent are your bowel movements? (Please check applicable box)

Once or twice a week; Less than one a day; One a day; More than one a day.

What is the typical color of your stool? _____; Does it have a strong odor? Yes; No

What is the color of your urine? _____; Does it have a strong odor? Yes; No

How many times a day do you urinate? _____; Does your job place restrictions on your ability to use the rest room as necessary? Yes; No; If so, how? _____

Do you usually eat breakfast? Yes; No; If so, what food(s) or beverages? _____

What are your three favorite foods? (Please list) 1. _____ 2. _____ 3. _____

How often do you eat these foods? (Please check applicable boxes)

Food 1. More than once a day; Once a day; Several times a week; Once a week; Less than once a week.

Food 2. More than once a day; Once a day; Several times a week; Once a week; Less than once a week.

Food 3. More than once a day; Once a day; Several times a week; Once a week; Less than once a week.

What are your three favorite beverages? (please list) 1. _____ 2. _____ 3. _____

How often do you drink these beverages? (please check applicable boxes)

Beverage 1. More than once a day; Once a day; Several times a week; Once a week;

Less than once a week.

Beverage 2. More than once a day; Once a day; Several times a week; Once a week;

Less than once a week.

Beverage 3. More than once a day; Once a day; Several times a week; Once a week;

Less than once a week.

(PLEASE CONTINUE ON PAGE THREE)

Have you ever had or been diagnosed as having problems with any of the following (please check all that apply):

- | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Digestion | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Spine/Back |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Edema | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Spleen |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Fainting | <input type="checkbox"/> Lungs | <input type="checkbox"/> Teeth/gums |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Nerves | <input type="checkbox"/> Throat |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Ovaries | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Circulation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Parasites | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colon | <input type="checkbox"/> Herpes | <input type="checkbox"/> PMS | <input type="checkbox"/> Weight Challenges |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Prostate | <input type="checkbox"/> Other _____ |

PLEASE LIST ALL SIGNIFICANT HEALTH EPISODES/CHALLENGES (ACUTE/CHRONIC ILLNESSES, TOXIC EXPOSURE, INJURIES) YOU HAVE EXPERIENCED THROUGHOUT YOUR LIFE (DO NOT INCLUDE COLDS OR FLU, UNLESS CHRONIC IN NATURE):

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YEAR HEALTH CHALLENGE

CLIENT STATEMENT

I understand that I am here to learn about nutrition and good health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and that this is considered a personal ministry and spiritual counseling.

I fully understand that those who counsel me are not medical doctors or practitioners and that I am not here for medical-diagnostic purposes or treatment procedures. I attest that I am not here, during this visit or any subsequent visit, as an agent for federal, state or local agencies, or on a mission of entrapment or investigation.

I understand that the services performed by the staff of Life Energy Holistic Partners are at all times restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

SIGNATURE _____ DATE _____