PERMISSION AND AUTHORIZATION FORM

I authorize Blooming Health LLC, to perform evaluation and set up a program for the purpose of enhancing my health. I understand that all recommendations concerning diet, lifestyle changes, suggested dietary supplements and homeopathic remedies are meant to naturally correct body imbalances and to improve one's physical and emotional wellbeing. They are not intended being a substitute for regular medical care.

I understand that Blooming Health LLC doesn't diagnose or treat any disease. No promise or guarantee has been made regarding the results of the evaluation or of the proposed program. A chronic health condition usually takes several years to develop and can take many months to heal. For best results, please, commit to regular visits every 3-4 weeks for a period of at least several months to observe improvement.

I understand that natural healing sometimes provokes a healing reaction. This is not a side effect. A healing reaction means your body is trying to eliminate toxins (that were stored in your body probably for a very long time) and it can manifest as temporary aggravation of your symptoms, or new symptoms may appear. Such symptoms usually disappear within few days. If the healing reaction is severe, decrease the recommended doses of supplements to ¼ for few days and increase water intake. Then return slowly to the full dose over the period of several days.

Privacy Statement

.All the information you provide Blooming Health LLC about your health is kept private unless you request the release of information to a third party in written. If another member of your family is in our care, you need to discuss confidentiality issues with this family member prior to starting my services. Confidentiality will be broken if there are signs of abuse to a child/elderly person or if a person seems to be in imminent danger of hurting self or someone else.

Payment and No Show Policy:

Payment is due at the time of the appointment. Regular consultation fee is $95 (1h), shorter rechecks $65 (30-40 min), and Energy medicine sessions $110 (75 min). Combination of consultation or re-check and energy session is also available ($140-160). Discounts are available to students, children and seniors (>65). The cost of remedies is extra and ranges usually between $50-100. It will be added to the consultation fee. In case of financial hardship, please, notify us in advance and a monthly plan may be worked out. Appointments can be re-scheduled at least one day before the scheduled appointment by phone, e-mail or through online scheduler. If the appointment is cancelled during the day of the appointment or you don't "show up", you will be charged $50 fee.

Date:_______________

Print name:_____________________________

Signed:_______________________________

(for minor child, signature of parent or guardian)

Questionnaire

Date:___________

Name:______________________________ Date of birth:____________ Age: ________

Address:____________________________ City:____________________State/Zip_____

Contact Telephone:_________________E-mail:__________________________________

Occupation:____

□ Fulltime □ Part time □ Unemployed □ Self-employed □ At home

Employer ______________________

Sex: F M Height:_____________Weight:________3 years ago_________

Living situation: □ Alone □ Partner □ Spouse □ Friends □ Parents □ Children □ Pets

Current diagnosis:

____

____

Family Doctor: ____ Tel: ________________

Last physical exam:____

Medical History: list all surgeries &dates:

____

____

____

Family History: describe any major health issues in the family:

Mother:____

Father:____

Siblings:____

Grand-parents: ____

____

What treatments have you attempted previously (conventional/alternative)?_____________

____

____

Medications currently taking and for what condition:

____

____

____

Natural supplements currently taking:____

____

____

LIFESTYLE:

Which areas of your lifestyle would you like to improve:

□ My level of anxiety
□ My diet and nutrition program
□ More time spent in nature
□ My feelings around career
□ My communication skills
□ My pace of living
□ My weight
□ My creative expression
□ My social and family life
□ More quiet time or rest
□ My exercise program

Are you on any special diet?____

Do you know your blood type? □ A □ B □ AB □ O Don't know □

Do you use artificial sweeteners? □ YES □ NO Do you use margarine? □ YES □ NO

Do you buy organic food? □ YES □ NO How many times a week do you eat fish?______

What type of cooking oil do you use at home?___________________________________

How many hours per week do you work out?__________

How many hours do you watch TV in a week? _____________________________

Favorite recreational activities:____

How many hours of sleep do you get each night?_________Do you wake up rested?____

Level of stress : 1-10 (10 = highest)________

Coffee _____________cups/day

Alcohol_____________drinks/ week

Typical breakfast:____

Typical lunch:____

Typical dinner:____

Drinks during the day:____

Snacks during the day:____

TOXIC EXPOSURE:

Do you drink - ☐ tap water ☐ bottled water ☐ purified water?
Have you recently remodeled your house?______________________________________
Do you work with X-rays, computers or other sources of radiation?__________________
Do you have mold in your house?____
Do you smoke?____
How often have you taken anti-biotics?____
Reactions to vaccinations?____
Dental problems? ________________number of fillings__________root canals__________

Metabolic Assessment Form™

PART I

Please list your 5 major health concerns in order of importance:

1. ______________________________ **4.** ______________________________

2. ______________________________ **5.** ______________________________

3. ______________________________

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Symptom	Rating
Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category XIII

Symptom	Rating
Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under a high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category XIV

Symptom	Rating
Edema and swelling in ankles and wrists	0 1 2 3
Muscle cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Frequent thirst	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel regularity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

Category XV

Symptom	Rating
Tired/sluggish	0 1 2 3
Feel cold—hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XVI

Symptom	Rating
Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3

Category XVI *(Cont.)*

Symptom	Rating
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XVII *(Males Only)*

Symptom	Rating
Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel emptying	0 1 2 3
Leg twitching at night	0 1 2 3

Category XVIII *(Males Only)*

Symptom	Rating
Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Difficulty maintaining morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decreased physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XIX *(Menstruating Females Only)*

Symptom	Rating
Perimenopausal	Yes No
Alternating menstrual cycle lengths	Yes No
Extended menstrual cycle (greater than 32 days)	Yes No
Shortened menstrual cycle (less than 24 days)	Yes No
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XX *(Menopausal Females Only)*

Symptom	Rating
How many years have you been menopausal?	_______ years
Since menopause, do you ever have uterine bleeding?	Yes No
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness, or itching	0 1 2 3

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Symptom	Rating
Bruise easily	0 1 2 3
Sigh frequently	0 1 2 3
Aware of breathing heavily	0 1 2 3
Open window in closed room	0 1 2 3
Short of breath on exertion	0 1 2 3
Nosebleeds	0 1 2 3
Ringing in the ears	0 1 2 3
Hand and feet go to sleep easily	0 1 2 3
Numbness in extremities	0 1 2 3
Weakness, fatigue	0 1 2 3
Slurred speech	0 1 2 3
Dull pain in chest or radiating into left arm	0 1 2 3
Tendency to anemia	0 1 2 3
Headaches	0 1 2 3
Nervousness	0 1 2 3
Tension or tightness under breastbone	0 1 2 3
Blushing with no apparent cause	0 1 2 3
Swollen ankles, worse at night	0 1 2 3

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Category XXII

Throat infections	0 1 2 3	Cough with mucus	0 1 2 3
Poor wound healing	0 1 2 3	Swollen tongue	0 1 2 3
Slow to recover from colds/flus	0 1 2 3	Dark areas under the eyes	0 1 2 3
Gets boils/sties	0 1 2 3	Sore throat	0 1 2 3
Swollen lymph glands	0 1 2 3	Post-nasal drip	0 1 2 3
Catches colds/flu often	0 1 2 3	Ear aches and infections	0 1 2 3
Bumpy skin on arms	0 1 2 3	Herpes/cold sores	0 1 2 3
Bleeding/inflamed gums	0 1 2 3		

Category XXIII

Frequent urination	0 1 2 3	Strong smelling urine	0 1 2 3
Bloody/rose colored urine	0 1 2 3	Mild back pain	0 1 2 3
Dripping after urination	0 1 2 3	Interrupted urine stream	0 1 2 3
Difficulty passing urine	0 1 2 3	Tingling in joints	0 1 2 3
Cloudy urine	0 1 2 3	Joint and muscle pain/cramping	0 1 2 3
Frequent urinary infections	0 1 2 3	Can't hold urine	0 1 2 3
Painful/burning while urinating	0 1 2 3	Dark circles under the eyes	0 1 2 3
Urinating when cough or sneeze	0 1 2 3	Frequent urge but pases small amount	0 1 2 3

Category XXIII

Chronic cough	0 1 2 "3	Bronchitis (frequent)	0 1 2 3
Pain around ribs	0 1 2 "3	Infections settle in lung	0 1 2 3
Shortness of breath	0 1 2 "3	Sensitive to smog	0 1 2 3
Chest pain	0 1 2 "3	Asthma	0 1 2 3
Difficulty breathing	0 1 2 "3	Wheezing	0 1 2 3
Sinus/nasal congestion	0 1 2 "3	Smoker	0 1 2 3
Coughing up phlegm	0 1 2 "3	Chronic lung congestion	0 1 2 3
Coughing up blood	0 1 2 "3	Shallow breather	0 1 2 3

Category XXIV

Osteoporosis/bone loss	0 1 2 3	Live near power lines/smart meters	□YES □NO
Hip and joint pain	0 1 2 3	Exposure to fumes/pesticides	□YES □NO