

## 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. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## PART II

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

<b>Category I</b>				<b>Category VII</b>					
Feeling that bowels do not empty completely	0	1	2	3	Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3	Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Decreased gastrointestinal motility, constipation	0	1	2	3
Diarrhea	0	1	2	3	Increased gastrointestinal motility, diarrhea	0	1	2	3
Constipation	0	1	2	3	Alternating constipation and diarrhea	0	1	2	3
Hard, dry, or small stool	0	1	2	3	Suspicion of nutritional malabsorption	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3	Frequent use of antacid medication	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3	Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/Diverticulitis, or Leaky Gut Syndrome?	Yes	No		
More than 3 bowel movements daily	0	1	2	3					
Use laxatives frequently	0	1	2	3					
<b>Category II</b>				<b>Category VIII</b>					
Increasing frequency of food reactions	0	1	2	3	Greasy or high-fat foods cause distress	0	1	2	3
Unpredictable food reactions	0	1	2	3	Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3	Burpy, fishy taste after consuming fish oils	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3	Unexplained itchy skin	0	1	2	3
<b>Category III</b>				<b>Category IX</b>					
Intolerance to smells	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Intolerance to jewelry	0	1	2	3	Stool color alternates from clay colored to normal brown	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3	Reddened skin, especially palms	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
Constant skin outbreaks	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
<b>Category IV</b>				<b>Category X</b>					
Excessive belching, burping, or bloating	0	1	2	3	Have you had your gallbladder removed?	Yes	No		
Gas immediately following a meal	0	1	2	3					
Offensive breath	0	1	2	3	Acne and unhealthy skin	0	1	2	3
Difficult bowel movements	0	1	2	3	Excessive hair loss	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Overall sense of bloating	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3	Bodily swelling for no reason	0	1	2	3
<b>Category V</b>				<b>Category XI</b>					
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3	Fatigue after meals	0	1	2	3
Use of antacids	0	1	2	3	Crave sweets during the day	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3	Irritable if meals are missed	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Depend on coffee to keep going/get started	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3	Get light-headed if meals are missed	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3	Eating relieves fatigue	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3	Feel shaky, jittery, or have tremors	0	1	2	3
<b>Category VI</b>				<b>Category XI</b>					
Difficulty digesting roughage and fiber	0	1	2	3	Agitated, easily upset, nervous	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3	Poor memory, forgetful between meals	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3	Blurred vision	0	1	2	3
Excessive passage of gas	0	1	2	3					
Nausea and/or vomiting	0	1	2	3	Fatigue after meals	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3	Crave sweets during the day	0	1	2	3
Frequent loss of appetite	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

<b>Category XII</b>			
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
<b>Category XIII</b>			
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
<b>Category XIV</b>			
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
<b>Category XV</b>			
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
<b>Category XVI</b>			
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

<b>Category XVI (Cont.)</b>			
Night sweats	0	1	2 3
Difficulty gaining weight	0	1	2 3
<b>Category XVII (Males Only)</b>			
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
<b>Category XVIII (Males Only)</b>			
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
<b>Category XIX (Menstruating Females Only)</b>			
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
<b>Category XX (Menopausal Females Only)</b>			
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 foginess	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

#### Category XXI

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

**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/flu	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 passes 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	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hip and joint pain	0 1 2 3	Exposure to fumes/pesticides	<input type="checkbox"/> YES <input type="checkbox"/> NO