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 $110 (1h), shorter rechecks $75 (30-40 min), and Energy medicine sessions $130 (75 min). Combination of consultation or re-check and energy session is also available ($170-200). 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 or cancelled at least 24 h before the scheduled appointment by phone, e-mail or through the link in the appointment confirmation e-mail. If the appointment is cancelled during the day of the appointment or you miss it, you will be charged the entire appointment 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/main symptoms I would like to address:

_____
_____
_____

Family Doctor: _____ Tel: _____
Last physical exam:_____

Medical History: list all surgeries &dates:

_____
_____
_____

Allergies: _____

Family History: major health issues in the family (mother, father, siblings):

_____
_____

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

_____
_____

Medications currently taking and for what condition:

_____
_____
_____

Natural supplements currently taking:

_____
_____
_____

My health goals:

_____

Check how do you feel during a typical day: (1 = worst, 10 = best), you can check a range (e.g.4 – 6)

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

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

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_____

Recreational drugs?_____

Exposure to fumes/chemicals/pesticides?_____

Current symptoms most or some of the time:

□ Frequent gas/bloating
□ Frequent indigestion
□ Constipation
□ Diarrhea
□ Stomach pain after eating
□ Nausea/Vomiting
□ Fatty foods cause problem
□ Loss of appetite

□ Pain under the ribcage □ left □ right
□ Frequent heartburn/use of antacids
□ Unusual stool consistency or color
□ Intolerance to fatty foods
□ Gallbladder attacks/GB removed
□ White/yellow coated tongue
□ Food reactions – which ones if known:_____

□ Sugar cravings
□ Irritable if meals missed
□ Eating relieves fatigue
□ Nervous, agitated

□ Blurred vision
□ Fatigue after meals
□ Frequent urination
□ Increased thirst

□ Crave salt
□ Cannot fall or stay asleep
□ Slow starter in the morning
□ Dizzy if stand up quickly

□ Headaches (afternoons, or stress related)
□ Perspire easily
□ Wake up tired
□ Weight gain under stress

□ Tired/sluggish
□ Feel cold (hands, feet, all over)
□ Needs a lot of sleep
□ Gain weight even on low calorie diet
□ Depression/mental sluggishness
□ Outer third of eyebrows thins

□ Thinning of hair
□ Heart palpitations
□ Inward trembling
□ Nervous/emotional
□ Insomnia
□ Night sweats

□ Intolerance to smells, chemicals, cosmetics
□ Skin outbreaks/acne
□ Foul smelling sweat
□ Edema/swollen ankles or wrists

□ Muscle cramping
□ Osteoporosis
□ Joint pain, where?_____

□ Frequent cold sores
□ Get sick often
□ Sinus/nasal congestion
□ Chronic cough
□ Asthma
□ Shallow breathing
□ Sensitive to smog
□ Sore throat
□ Bleeding gums

□ Bumpy skin on arms
□ Gets boils/sties
□ Chest pain
□ Nosebleeds
□ Tendency to anemia
□ Bruise easily
□ Shortness of breath
□ Numbness in extremities
□ Weakness/fatigue

□ Ringing in the ears
□ Frequent urination
□ Painful urination
□ Strong smelling urine
□ Lower back pain
□ Dark circles under eyes
□ Frequent infections? Where?_____

MEN:
□ Decreased libido/problem with erection
□ Pain inside of legs
□ Legs twitching at night
□ Inability to concentrate
□ Muscle soreness
□ Decreased physical stamina

WOMEN:
□ Irregular, too short or too long menstrual cycle
□ Painful period/cramping
□ PMS
□ Heavy bleeding
□ Mood swings
□ Hot flashes/night sweats