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.

Payment and No Show Policy:

Payment is due at the time of the appointment. 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)

About the practitioner: Dr. Vladimira Dragnea has a Ph.D degree in Biochemistry (Orsay, France) and a Master Herbalist certificate from the Global Institute for Alternative Medicine, an accredited school in state of California. She is a Certified Holistic Health Practitioner by an American Association of Drugless Practitioners. She holds a Natural Wellness Certificate and Doctor of Naturopathy for Healthcare Professionals certificate from Clayton College of Natural Health. She is Eden Energy Medicine Certified Advanced Practitioner and authorized EM101/102 teacher. She has attended seminars on Meridian Response Technique, nutrition, brain and neurotransmitters, Functional Blood Analysis, complex homeopathy and she is also trained in Korean Hand Energetics.

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)?

_____
_____

Currently taking – Supplements/Medications:

_____
_____

LIFESTYLE:

Which areas of your lifestyle would you like to improve:

□ My level of anxiety □ My pace of living □ More quiet time or rest

□ My diet and nutrition program □ My weight □ My exercise program

□ More time spent in nature □ My creative expression

□ My feelings around career □ My social and family life

□ My communication skills

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?_____

BioEnergetic Health Survey

Instructions: Indicate the symptoms which apply to you using the following scale
(**0**) if "never" (**1**) if "rarely" (**2**) if "time to time" (**3**) if "often"

Patient: _____Age: ____ M/F ____ Practitioner: _____

Date _____

SECTION A: DIGESTIVE

_____ 1. Lower bowel gas several hours after eating
_____ 2. Burning stomach sensation, eating relieves
_____ 3. Coated tongue
_____ 4. Indigestion 1/2-1 hr after eating: (may be up To 3/4 hrs)
_____ 5. Carbonated drinks 3+ per week?
_____ 6. Difficult bowel movements
_____ 7. Ulcers?/Colitis?/ Gastritis?
_____ 8. Stomach bloating after eating
_____ 9. Excessive belching/burping
_____ 10. Bad breath
_____ 11. Alternating diarrhea/constipation
_____ 12. Have pets eg. dogs, cats, farm animals, etc.
_____ 13. Rectal itching
_____ 14. Can't gain weight
_____ 15. International travel
_____ 16. Stomach/intestinal cramping/diarrhea

Total: _____

SECTION B: SUGAR HANDLING PROBLEMS

_____ 17. Afternoon headaches
_____ 18. Get "shaky" if hungry
_____ 19. Faintness if meals delayed
_____ 20. Heart palpitates if meals missed or delayed
_____ 21. Eat when nervous
_____ 22. Awaken after few hours of sleep
_____ 23. Hard to get back to sleep
_____ 24. Crave candy or coffee in afternoon
_____ 25. Abnormal craving for sweets or snacks
_____ 26. Thirsty much of the time
_____ 27. History of diabetes
_____ 28. Excessive frequent urination
_____ 29. Blurred vision/failing eyesight
_____ 30. Breath smells sweet
_____ 31. Tingling, numbness, prickling sensation in extremities.

Total: _____

SECTION C: CARDIAC

_____ 32. Bruise easily, "black & blue spots"
_____ 33. Sigh frequently
_____ 34. Aware of "breathing heavily"
_____ 35. Open window in closed room
_____ 36. Susceptible to colds & fevers
_____ 37. Swollen ankles, worse at night
_____ 38. Muscle cramps, worse during night
_____ 39. Shortness of breath on exertion
_____ 40. Nosebleeds
_____ 41. Ringing in the ears
_____ 42. Heart palpitations
_____ 43. Dull pain in chest or radiating into left arm, worse on exertion
_____ 44. Hands & feet go to sleep easily
_____ 45. Numbness in extremities
_____ 46. Tendency to anemia
_____ 47. Tension under breastbone or feeling of tightness, worse in exertion
_____ 48. Blushing with no apparent cause
_____ 49. Black stool (no iron supplementation)
_____ 50. Poor concentration
_____ 51. Slurred speech
_____ 52. Headaches
_____ 53. Weakness/fatigue
_____ 54. Out of breath frequently e.g., going up stairs
_____ 55. Nervousness

Total: _____

SECTION D: LIVER & GALL BLADDER

_____ 56. Pain under right side of rib cage
_____ 57. Frequent skin rashes
_____ 58. Bitter metallic taste in mouth in morning
_____ 59. Bowel movements painful and difficult
_____ 60. Low energy, weakness, exhaustion
_____ 61. Upset from greasy/fatty foods
_____ 62. Bruises easily
_____ 63. Frequent headaches
_____ 64. Stools light coloured
_____ 65. Pain between shoulder blades
_____ 66. Laxatives used often
_____ 67. History of gall bladder attacks or gallstones
_____ 68. History of hepatitis
_____ 69. History of jaundice
_____ 70. Sneezing attacks
_____ 71. Itchy skin, worse at night
_____ 72. Dry flaky skin, hair
_____ 73. General feeling of poor health
_____ 74. Aching muscles
_____ 75. Swollen feet and/or legs

Total: _____

SECTION E: THYROID

_____ 76. Impaired hearing
_____ 77. Decrease in appetite
_____ 78. Ringing in ears
_____ 79. Constipation
_____ 80. Puffy hands/face
_____ 81. Tired/sluggish
_____ 82. Miscarriages
_____ 83. Infertility
_____ 84. Mental sluggishness/forgetfulness
_____ 85. Headache upon rising; wears off during day
_____ 86. Slow pulse, below 65
_____ 87. Cold hands and feet
_____ 88. Gains weight easily
_____ 89. Weight gain around hips
_____ 90. Outer third eyebrow thinning
_____ 91. "Emotional"
_____ 92. Flush easily
_____ 93. Night sweats
_____ 94.Hair loss

Total: _____

SECTION F: BONE DEVELOPMENT/MINERALS, ETC.

_____ 95. Hip and joint pain
_____ 96. Receding gums and/or dental cavities
_____ 97. Tendency towards slouching/weak
_____ 98. Bone loss/osteoporosis in family
_____ 99. Crunching, creaking joints

Total: _____

SECTION G: ENVIRONMENTAL

_____ 100. Exposure to fumes e.g., paint, salon, car
_____ 101. Use pesticides on garden
_____ 102. Live near power lines/high tension wires
_____ 103. Have mercury amalgams (silver) in mouth
_____ 104. Skin disorders e.g., psoriasis, eczema etc.
_____ 105. Loss of hair
_____ 106. Hormone disorders
_____ 107. History of cancer/personal or familial

Total: _____

SECTION H: MUSCLE AND LIGAMENT

_____ 108. Muscle aches, stiffness, cramping and pains
_____ 109. Chiropractic adjustments don't hold
_____ 110. Whiplash and/or ligamental trauma/strain
_____ 111. Fatigue, sluggishness
_____ 112. Upper or lower back pain
_____ 113. Stiff neck and shoulders

Total: _____

SECTION I: ADRENAL

_____ 114. Low blood pressure
_____ 115. Chronic fatigue
_____ 116. Low energy, lack of stamina
_____ 117. General malaise, unhappiness
_____ 118. Tendency to hives
_____ 119. Arthritic tendency
_____ 120. Excessive perspiration
_____ 121. Colds/flu often
_____ 122. Weakness after illness
_____ 123. Dark circles under the eyes
_____ 124. Crave salty foods
_____ 125. Feeling unrefreshed upon awakening
_____ 126. Allergies
_____ 127. Exhaustion—muscular & nervous
_____ 128. Respiratory disorders
_____ 129. Swollen ankles
_____ 130. Dizzy when stand up "too fast"
_____ 131. Decreasing appetite
_____ 132. Irritable
_____ 133. Bright lights irritate

Total: _____

SECTION J: FEMALE & MALE

Female Only

_____ 134. Painful menses
_____ 135. Premenstrual tension
_____ 136. Very easily fatigued
_____ 137. Depressed feeling
_____ 138. Menstruation excessive and prolonged
_____ 139. Painful breasts (monthly)
_____ 140. Lumpy breasts/worst at menses
_____ 141. Have taken birth control pills
_____ 142. Menopause, hot flashes, etc.
_____ 143. Menses scanty or irregular
_____ 144. Acne, worse at menses
_____ 145. Vaginal discharge/yeast, etc.

Male Only

_____ 146. Tired too easily
_____ 147. Urination difficult
_____ 148. Night urination frequent
_____ 149.Pain on inside of legs or heel
_____ 150. Feeling of incomplete bowel evacuation
_____ 151. Prostrate trouble
_____ 152. Leg nervous at night
_____ 153. Diminished sex drive

Female Total_____

Male Total _____

SECTION K: LUNG

_____ 154. Chronic cough
_____ 155. Pain around ribs
_____ 156. Shortness of breath
_____ 157. Chest pain
_____ 158. Difficulty breathing
_____ 159. Post nasal drip
_____ 160. Sinus and nasal congestion
_____ 161. Coughing up phlegm
_____ 162. Coughing up blood
_____ 163. Bronchitis (frequent)
_____ 164. Infections settle in lungs
_____ 165. Sensitive to smog
_____ 166. Asthma
_____ 167. Wheezing
_____ 168. Smoker
_____ 169. Chronic lung congestions
_____ 170. Breathes through mouth
_____ 171. Shallow breather

Total _____

SECTION L: IMMUNE

_____ 172. Throat infections
_____ 173. Poor wound healing
_____ 174. Slow to recover from colds or flu
_____ 175. Gets boils or sties
_____ 176. Swollen lymph glands
_____ 177. Catch colds or flu easily
_____ 178. Bumpy skin on arms
_____ 179. Inflamed or bleeding gums
_____ 180. Cough with mucus
_____ 181. Swollen tongue
_____ 182. Dark areas under the eyes/cheeks
_____ 183. Sore throat
_____ 184. Post nasal drip
_____ 185. Ear aches and infections
_____ 186. Herpes/cold sores

Total: _____

SECTION M: KIDNEYS

_____ 187. Frequent urination	_____ 196. Strong smelling urine
_____ 188. Rose-coloured (bloody) urine	_____ 197. Mild back pain
_____ 189. Dripping after urination	_____ 198. Interrupted urine stream
_____ 190. Difficulty passing urine	_____ 199. Tingling in joints
_____ 191. Cloudy urine	_____ 200. Joint and muscle pain/cramping
_____ 192. Rarely need to urinate	_____ 201. Can't hold urine
_____ 193. Frequent bladder infections	_____ 202. Dark circles under eyes
_____ 194. Painful/burning when urinating	_____ 203. Frequent urge to urinate but passes only small amounts
_____ 195. Urination when cough or sneeze	

Total: _____

SECTION N:

Medications you are currently taking:

_____

_____

205. How often do you take (or have taken) antibiotics? #____ Y / N

206. Reactions to vaccinations? Y / N

207. How many silver amalgams do you have in your mouth?_____ Root canals? _____ Crowns/bridges? Y / N

208. Were your wisdom teeth impacted? Y / N Other Dental Problems? Y / N

209. Allergies? Y / N (List main)

210. Are you experiencing bone loss or osteoporosis? Y / N

211. Do you smoke? Y / N

212. Diagnosed for parasites? Y / N

213. Diagnosed or history of Candida? Y / N

214. Exposure to pesticides Y / N

215. Drink 6-8 glasses of water daily? Y / N

216. Hormone replacement medications? Y / N

IMPORTANT: Please list your five main health complaints in the *order of importance:*

1. _____

2. _____

3. _____

4. _____

5. _____