

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 6-12 months to observe improvement.

I understand that Systems Survey Maestro nutritional evaluation software was developed by Standard Process and is based on years of experience of nutritional experts and experts in Functional Medicine. It will give me a valuable analysis of my symptoms and suggest Standard Process supplements that may be helpful to my symptoms. This evaluation is not a replacement for regular medical care

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.

Payments for online services:

Payment for online services is due before the services are being offered.

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

Please, list your main health complaints in the order of importance

1. _____
2. _____
3. _____
4. _____
5. _____

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

Medical History: list all surgeries & dates:

Allergies:

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

Currently taking – Supplements/Medications:
