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:
_____
_____
_____

LIFESTYLE:

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 exercise?_____

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

Water_____glasses/day

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_____