New Client Information

I. Personal Information (Please Print)

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone: Cell _____ Home _____ Occupation _____

Email _____ Referred by _____

Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____ Blood Type _____

II. Purpose of Visit: (Check all that apply)

[ ] Nutritional Counseling
[ ] Supplements (Herbs/Vitamins, Etc.)
[ ] Aromatherapy
[ ] Weight Management
[ ] Mental/Emotional Wellness
[ ] Other: _____

III. Please take a moment to carefully read the following information and sign where indicated.

I understand that I may consult a licensed health professional prior to consultation sessions if I have any questions or concerns regarding the session or other health issues. I further understand that Jackie Stevens is not a medical doctor or licensed health care provider and does not directly dispense medical advice or prescribe the use of herbs or supplements as a form of treatment for illness. The information provided from the consultation session, and at any classes, is for educational purposes only to empower individuals with knowledge to take care of their own health. I understand that Jackie Stevens disclaims any liability if the reader uses or prescribes any remedies, natural or otherwise, for him/herself or another. Historically, all of these herbal and vitamin supplements may nutritionally support the body's biological systems.

I have read and understand the above information. The information I have provided is complete, true, and accurate. I release Jackie Stevens and/or Enchanted Herb Pantry LLC from any and all liability arising from this session or any further sessions, whether any claim arises during or after the session.

Client Signature _____ Date _____

Consent to Treatment of a Minor: By my signature below, I hereby authorize Jackie Stevens, Doctor of Natural Health, to conduct a health analysis service to my child or dependent as necessary.

Parent/Guardian Signature _____ Date _____

Nutrition & Dietary Information

Please circle anything that applies to your eating habits and fill in the blanks:
(1 = Eaten Daily; 2 = Weekly; 3 = Occasionally; 4 = Never) If there is a choice in items–circle the items that apply:

Pork or Shellfish	1 2 3 4	Caffeine (coffee, soda, or tea): I drink ____ cups each (day, week, month)
Red Meat	1 2 3 4	Soda Pop: I drink ____ ounces each (day, week, month)
Chicken or Turkey	1 2 3 4	I use (refined sugar, raw sugar, stevia, xylitol, _____) as a sweetener
Eggs (1, 2 or 3 at a meal)	1 2 3 4	I use (white flour, wheat flour, _____)
Dairy – I drink ____ cups	1 2 3 4	Typical Breakfast: _____
Cheese, Yogurt, Ice Cream	1 2 3 4	Typical Lunch: _____
Fried Foods	1 2 3 4	Typical Dinner: _____
Fresh Vegetables (___) servings per)	1 2 3 4	I eat out _____ meals per week
Fresh Fruits (____) servings per)	1 2 3 4	I eat breakfast (every day, most days, rarely, or never) I eat lunch (every day, most days, rarely, or never)
Whole Grains	1 2 3 4	I eat dinner (every day, most days, rare, or never)
Fresh Fish	1 2 3 4	Alcohol: (every day, most days, rarely, or never)
Sweets	1 2 3 4	Drink of choice is _____
Water	1 2 3 4	My snack preference is: _____

Lifestyle Information

Who lives with you (people & pets)?: _____.

How much sleep do you get each night (on average)? _____ hours. Describe your sleep: _____.

What is your energy level like? _____.

Where would you say your stress is greatest? _____.

How often do you exercise? ____ hours per _____. Describe the type of exercise you do: _____.

Do you work (paid or unpaid)? _____ What is your job?: _____. How long is your drive time each day? _____.

How many hours a day/week do you work? _____. Most of the time I _____ my job.

During the day I take time to (circle all that apply): Meditate, take breaks, stretch, walk, read, socialize, other _____.

For relaxation I _____( ) hours per day.

Things that stress me out are: _____.

If you use tobacco, how often per day? _____ (smoke, chew, snuff); (cigars, pipe cigarettes or chewing tobacco; marijuana).N/A _____

Each day I (circle which applies): Journal; read inspirational books; listen to/watch positive thinking-based media; or _____

Health History/Information

List any nutritional supplements you take: _____

_____

List the problems/conditions/diagnosis	Which medication are you taking for it?	List any other treatment/therapy you are doing

List any serious illnesses or surgeries you have had in the past (not affecting you today): _____

_____

What would you like help with today (please try to list in order of importance)?

I have seen the following for the above concern(s): Medical Doctor; Chiropractor; Therapist (Massage, physical or mental/emotional)

How many bowel movements do you have each day? _____. Are they (circle all that apply) natural, forced, hard, watery?

How many ounces of water (not tea, energy drinks or vitamin water) do you drink per day? _____

What type of water do you drink~bottled, tap, purified by reverse osmosis, filtered, distilled or alkaline water.

List any other information you think might be helpful:

I fully understand that Jackie Stevens is a Doctor of Natural Health; and is not a medical doctor, and therefore does not treat disease nor prescribe medicine for any conditions.

□ I would like as much information about my concern as possible.
□ I would like to know how I can help other people by learning more.
□ I would like to have a guest speaker for my group.
□ I would like to host a Healthy Habits class.
□ I would like to earn an income sharing supplements.

Signature: _____ Date: _____