Intake Form

Kristi Lea Holistic Health LLC

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_

Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_

Your Health Concerns Any Diagnosis/When Medications/Supplements

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**Please circle and indicate the frequency of any symptom. \_\_= Never, 1= Sometimes, 2= Almost always, S= Severe**

**Digestion / Pancreas / Liver / Gallbladder**

|  |  |  |  |
| --- | --- | --- | --- |
| Gas/Bloating/Indigestion | Gallbladder attacks/Removed | Loss taste for meat | Vegan/Vegetarian |
| Acid Reflux | Use Zantac/Prilosec/Tums etc | Pulse speeds after eating | Eats fast food |
| Intestinal pain | Sleepy after meals | Hemorrhoids | Consumes alcohol |
| Constipation | Stomach upset by taking vitamins | Intestinal pain | Easily intoxicated/hung over |
| Uses laxatives regularly | Blood or mucous in stool | Foul smelling gas | Consumes Gluten/Dairy/ Sodas |
| Diarrhea shortly after meals | Light or clay colored stool | Varicose veins | Sinus Congestion |
| Stool has corners, ridges, flat or ribbon like | Undigested food in stool | Bad breath/strong body odor | Diverticulitis |
| History of motion or morning sickness | Greasy or shiny stool | Dark circles under eyes | Autoimmune issues |
| Nausea/ feel worse after eating | Pain between shoulder blades | Feel like skipping breakfast | Coated tongue |
| Stomach upset by greasy food | Hypoglycemia | Chemical hypersensitivity | Asthma/ exercise induced asthma |
| Pain under right rib cage | Overweight; especially in middle | Dry, cracked heels, skin | Chronic fatigue/ exhaustion |
| Allergies/ Rashes/ Acne | Family history of heart disease | Taken prescriptions regularly | Crave sugar |
| Diabetes I or II | High blood pressure/cholesterol | Excessive appetite | Need to snack frequently |
| Irritable/ “Hangry” if meals are delayed | Shaky/lightheaded/weakness if meals are delayed | Headache if meals are delayed | Feel better after eating |
| Yeast symptoms increase with sugar or alcohol consumption | Painful to press along outer thighs (illiotibial bands) | 1 or more bowel movements daily | Eat 5 servings of fruit and vegetables a day |

**Cardiovascular**

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| --- | --- | --- | --- |
| Stroke or heart attack | Air hunger/sigh frequently | Ankles swell | Cough at night |
| Enlarged heart/ congestive heart failure | Aware of heavy or irregular breathing | Muscle fatigue/ cramps with exertion | Blush or face turns red for no reason |
| Dull pain or chest tightness | Slow or weak pulse | Irregular heartbeat/ heart races | Sleep apnea |
| Family History of high blood pressure | Heart palpitations | Shortness of breath/ feel exhausted with moderate exertion | Can hear heartbeat on pillow |

**Vitamin and Mineral needs**

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| --- | --- | --- | --- |
| Stinky feet | Loss of muscle tone | Cold sores, fever blisters or herpes lesions | Vulnerable to insect bites |
| Decreased sense of taste or smell | Numbness/tingling in hands and feet | Joints pop, click | Pain or swelling in joints |
| Cracks in corners of your lips (Cheilosis) | Ringing in the ears (tinnitus) | History of bone spurs | Calf, foot or toe cramps at rest |
| Restless leg syndrome | History of anemia | Morning stiffness | Hoarseness |
| Night sweats | Carpal tunnel syndrome | Bleeding gums when brushing teeth | Crave chocolate |
| Whole body jerks as falling asleep | Strong light at night irritates eyes | Difficulty swallowing | Bursitis or tendonitis |
| Small bumps on back of arms | Birth defects in children | Gag easily | Excessively flexible joints |
| Poor night vision | Bone loss /osteopenia /osteoporosis | White spots on fingernails | Dry mouth, eyes and/or nose |
| Arthritis | Arteriosclerosis | Polyps or warts | Skin rashes |
| MTHFR snps | Heavy metal toxicity | Lump in throat | Low vitamin D level |
| History of dental cavities, root canals, crowns, dentures, gum disease | Wake up without remembering dreams | Shorter than you used to be | Nosebleeds/bruise easily |

**Histamine intolerance**

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| --- | --- | --- | --- |
| History of nosebleeds | Difficulty falling asleep | Unable to tolerate Ibuprofen | Cannot tolerate seafood |
| History of chronic hives/rashes | Anxiety | Anaphylaxis reactions | Exercise induced asthma |
| Facial or limb swelling | Frequent headaches /migraines | Bug bites turn into large, itchy welts | Flushing or warmth with alcohol |
| Acid reflux/intestinal pain after eating | unable to tolerate red wine, salad bars, alcohol | Cannot tolerate fermented foods | Unable to tolerate leftovers |

**Sleep**

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| --- | --- | --- | --- |
| Difficulty falling asleep | Difficulty staying asleep | Awaken without feeling rested | Awaken at the same time every night |

**Adrenals/ Emotional Stress**

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| --- | --- | --- | --- |
| Big reaction if startled | Always feel cold | Calm on the outside, troubled inside | Tendency to need sunglasses |
| Phobias /PTSD /severe stress /anxiety | Tend to be a night owl | Clench or grind teeth | Pain on inner side of knee(s) |
| Difficulty falling asleep | Slow starter in the morning | afternoon exhaustion /headache | Low blood pressure |
| Chronic fatigue /drowsy frequently | Low blood pressure | Become dizzy when standing up suddenly | Chronic low back pain |
| Crave salty foods | Irritability/anxiety/nervousness | Hypoglycemia | Poor memory /concentration |
| Anxiety | Depressio0n | Difficult relationship(s) | Stressful job |
| Impacted by alcoholism or addiction | Acute childhood stress(es) | Feel need to be sneaky or tell “white lies” | Feel like a victim |
| Impacted by mental illness | Low self-esteem/ self -worth | Have to please others excessively | Rarely touch or get touched |
| Unable to allow yourself to relax or have fun | Severe phobias or fears that limit you | Unable to confront or say no without guilt | Unable to express sadness, fear or anger |
| Unable to ask for what you need or want | Unable to forgive yourself/others | Unresolved anger, bitterness or resentment | Addictions to alcohol, drugs, sex, work, food, etc. |
| Slow recovery from stress , infections, trauma, surgery, exercise | Lonely, isolated, lacking meaningful relationships |  |  |

**Thyroid**

|  |  |  |  |
| --- | --- | --- | --- |
| Weight gain/loss | Coarse hair/dry skin | Depression | Flush easily |
| Difficulty losing weight | Forgetful | Decreased libido | Intolerant to high temperatures |
| Excessive fatigue | Cold hands & feet/Always feel cold | Insomnia | Mood swings/ emotional |
|  | Constipation | Loss of lateral 1/3 of eyebrows | Seasonal sadness |

**Kidney/Bladder**

|  |  |  |  |
| --- | --- | --- | --- |
| Pain in mid-back region | History of kidney stones | Puffy around the eyes | Dark circles around the eyes |
| Cloudy, bloody or darkened urine | Bubbles or frothy urine | Retaining water | Urine has a strong odor |

**Immune system**

|  |  |  |  |
| --- | --- | --- | --- |
| History of Epstein Barr/ Mono | Yeast overgrowth | Chronic inflammation | Diabetes |
| Chronic fatigue syndrome | Frequent colds or flu | Coated tongue | Multiple Sclerosis |
| Hashimoto’s/ Grave’s disease | Lupus | Eczema/ Psoriasis | History of Lyme disease |
| Rheumatoid arthritis | Ulcerative Colitis | History of fibromyalgia | Frequent infections (sinus, UTI, strep, ear infection) |

**Women**

|  |  |  |  |
| --- | --- | --- | --- |
| PMS | Can focus on a task for hours | Thinning skin | Painful intercourse |
| Irregular periods | Prone to anxiety or depression | Miscarriage(s) # | Vaginal discharge |
| Heavy, clotty periods | Abnormal pap smear | Headaches with birth control pill | Hot flashes |
| Migraines | Crave chocolate | Clotting disorder (Factor 5) | Night sweats |
| Uterine fibroids | Breast tenderness | Difficulty falling asleep | Weight gain around the middle |
| Excess facial or body hair | Skipped or absent periods | Cancer diagnosis | Hysterectomy |
| Menopause | Vaginal dryness | Infertility | Adrenalin junkie |
| Morning sickness in pregnancy | Endometriosis | Breast fibroids | Craves carbs |
| Family history of cancer/hysterectomy | Sexually transmitted disease | Neurological symptoms with birth control pill | Abuse in the home: physical, emotional, sexual, financial, verbal |

**Men**

|  |  |  |  |
| --- | --- | --- | --- |
| Prostate problems | Erectile dysfunction | Decreased libido | Waking up to urinate |
| Autoimmune diagnosis | Interrupted stream during urination | Cancer diagnosis | Sexually transmitted disease |
| Difficulty with urination; dribbling | Abuse in the home: physical, emotional, sexual, financial, verbal |  |  |

**Background information**

**For your mother’s pregnancy with you…**

|  |  |
| --- | --- |
| Were there any complications in pregnancy and birth? | Were you born vaginally or Cesarean? |
| Were you a healthy baby? | Were you breastfed? |
| How was mom’s dental during the pregnancy with you? Fillings/ cavities/Crowns/Root canals/ Dentures/ Extractions | Do you have a history of…Strep throat/ asthma or ear infections? |
| Mom’s health history: | |
| Dad’s health history: | |
| Grandparent’s Health: | |
| Grandparent’s Health: | |
| Grandparent’s Health: | |
| Grandparent’s Health: | |
| Sibling’s health history: | |
| Additional information: | |
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**Kristi Lea Holistic Health LLC**

**1002 Judge Court W. West River, MD 20778**

**(301) 318-5130**

# Kristi Lea Holistic Health LLC ,

# CNC, Nutritional Consultant AUTHORIZATION FORM

I, , in affixing my signature to this instrument do thereby agree to and understand the following:

1. That Kristi Lea, is a natural health counselor who is legally able to instruct and educate others in self-help methods of health such as the use of proper exercise, diet, nutritional supplements, water, sunshine, fresh air, rest and attitude;
2. That Kristi Lea, in no context of the phrase “Practices medicine” and therefore does not diagnose, prescribe, treat, administer, cure, heal or otherwise perform a duty that is reserved for those who are licensed to do so;
3. That the instruction concerning a healthful lifestyle is incidental to any particular illnesses or diseases I may have and is therefore not made in direct references to these;
4. Any healing of illnesses or diseases I may experience as a result of following the instructions of Kristi Lea, was purely the result of the body itself once a naturally correct way of living was employed, for it is only the body that heals itself, not any person;
5. That no claims or guarantees have been made as to any health benefits that may result from my following the instruction given by Kristi Lea, concerning a naturally correct way of living;
6. That the instruction given by Kristi Lea, in no way replaces proper medical care, and that I am free to choose a naturally right lifestyle;
7. That under penalty of perjury I am not an agent of any branch of the federal, state or local government for any agency thereof, with intent to entrap or entice Kristi Lea, her staff, employees and/or associates into breaking any federal, state or local law whatsoever, acting either on my own behalf or on behalf of the agency of the government or on behalf of any government agency directly;

Signed

Date

Kristi Lea Holistic Health LLC

1002 Judge Court W.

West River, MD 20778

# PERMISSION & AUTHORIZATION FORM

**REGARDING THE USE OF NUTRITIONAL DETERMINATION TESTING PLEASE READ BEFORE SIGNING**

I specifically authorize Kristi Lea, Nutritional Consultant, to perform nutritional determination testing to develop a natural complementary health improvement program for me that may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health **and not for the treatment or “cure” any disease.**

I understand that nutritional determination testing is safe, non-invasive and uses natural methods of analyzing the body's physical and nutritional needs, and the deficiencies or imbalances in these areas could cause or contribute to various health problems.

# I understand that nutritional determination testing are not methods of “diagnosing” or the “treatment” of any disease or medical condition.

No promise or guarantee has been made regarding the results any tests or any natural health, nutritional or dietary programs recommended, but rather I understand that these tests are ways by which the body's responses can be used as an aid to determine possible nutritional imbalances, so that safe, natural programs can be developed for the purpose of bringing about a better state of health.

I have read and understand the foregoing

This permission form applies to subsequent visits and consultations.

Print Name

Address

City State Zip Code

Phone(s)

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If minor, signature of parent or guardian required)

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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