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CLIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____, CA zip: _____

Home Phone: _____ Sex: ___M, ___F

Birthdate: _____ Age: _____ Email: _____

Occupation: _____ Employer: _____

Address: _____ City: _____

CA, Zip: _____ Business Phone: _____

Educational level: _____ Degree: _____

In Case of emergency call: _____ Phone: _____

Spouse/significant other: _____ Phone: _____

His/her birthdate: _____ Age: _____

PERSONAL & FAMILY ISSUES:

Current marital status: ___Married, ___years. ___Divorced, ___years.

___In a relationship, ___years. ___Single, ___years.

Do you have children? ___yes, ___no. If so, how many?:___.

Where were you born?: City: _____ State: _____ Country: _____

Where did you grow up?: _____

CURRENT CONDITIONS:

What is your blood type?: ___O, ___A, ___B, ___AB (Please indicate + or - as well)

Height: _____ Weight: _____ Do you feel you are overweight: Y___, N___ Under-weight: Y___, N___

Do you have any current conditions?

Appetite problems

Sleep, too much, too little

Heart palpitations

Stomach problems

Nightmares

Panic Attacks

Headaches

Dizziness

Phobias

Digestive problems

Depressed

Panic / Fear

Angry

Hyperactive

Low Energy

Tense / Uptight

Unable to Relax

Anxious

Fatigue

Fainting spells

PMS

Menopause

Hot Flashes

Overwhelm

Tremors

Rashes / skin conditions

Sexually Trans. Dis.

Pains

Difficulty Concentrating

Other – please list:

Other, please explain:

List any medical or psychological conditions you have been diagnosed with:

Have you ever been hospitalized? If so, please describe:

Have you ever had any operations? ___yes, ___no. If yes explain:

Did you have your tonsils out?: ___yes, ___no If yes, when?: _____

List all prescriptions and medications you have taken regularly:

List vitamins, minerals, etc. that you presently take and dosages: _____

Are you currently under the care of a medical doctor? ___yes, ___no.

If so, list doctor's name: _____ phone: _____

Have you been in psychotherapy previously?: ___yes, ___no.

Do you have any scars on or inside your body?: ie.. operations, teeth removed, deep cuts,

Episiotomy, c-sections, etc.: ___yes, ___no. If yes, where:

Do you know of any viruses, toxins, bacteria, fungus, etc. that you may have or contacted?:

___yes, ___no, If yes, explain: _____

Do you have any mercury (silver fillings) amalgams?: ___yes, ___no. Did you have silver fillings removed?: ___yes, ___no. If yes, when?:_____

Did you do a detox after removal of the fillings?: ___yes, ___no.

Do you have any metal lined caps or bridges in your mouth?: ___yes, ___no

Do you have any root canals?: ___yes, ___no How many:_____

List any other problems with your teeth?:_____

Do you smoke? ___ yes, ___ no. If yes, how many ___ packs a day? ___ cigarettes a day?

WHAT TO YOU TYPICALLY EAT FOR:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Do you crave any specific foods?:_____

COFFEE/CAFFEINE: 8 oz. Cups caffeine per day: ___ Coffee, ___ Chocolate, ___ Tea

ALCOHOL: How many drinks per day? ___ wine, ___ beer, ___ hard liquor.

Have you had a problem with abusing alcohol?:___yes, ___no.

How long?:_____ Is it a problem now?:___yes, ___no.

Timeframe:_____

DRUGS: Have you ever taken drugs?:___yes, ___no. If so, what type?:

How often?:_____ How much?:_____ How long?:_____

Is it a problem now?:___yes, ___no

EATING DISORDER: Have you experienced any of the following?:

Anorexia Bulimia Other: _____

Is it a problem now?: yes, no. If so, when?: _____

DO YOU HAVE ANY COMPULSIVE OR ADDICTIVE BEHAVIORS?:

Workaholism Sex Hand washing Rage addiction

Phobias Constantly checking things Over-thinking

Relationship addiction Stuck on thoughts

Other: _____

What health issues do you want to address: _____

What alternative treatments have you had: _____

Female: Are you still menstruating: yes, no Menopause: yes, no

Age period began: _____ Age period stopped: _____

Do you have painful menses: yes, no. If so explain: _____

Are you taking birth control pills: yes, no. If so, what type: _____

Are you on Bioidentical Hormones: yes, no, if so what type: _____

When did you start taking hormones: _____ Is it a problem: _____

Any other hormonal issues: _____

_____.

ANY OTHER ISSUES:

By signing below you provide permission to contact your medical doctor to obtain any verbal or written information, which would be related to your treatment if necessary. This will be in force through-out the duration of your time in my office and as a client.

Signature: _____ Date: _____

Metabolic Assessment Form

* Please circle the appropriate number “0 - 3” on all questions below. 0 = Least/Never, 1 = Rarely, 2 = Frequently, 3 = Most Always or Often.

Category I – Colon Support

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or “fuzzy” debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II – Intestinal Integrity

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III – Chemical Tolerance

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV – Stomach - L

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits/vegetables; undigested food in stools	0	1	2	3

Category V – Stomach – H

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief using antacids, food, milk, carbonated beverage	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn from spicy foods, chocolate, citrus, peppers, alcohol, caffeine	0	1	2	3

Category VI – Small Intestine / Pancreas

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous, greasy, poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII - Biliary

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		___Yes		___No

Category VIII - Hepatic Detox

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX – Blood Sugar - L

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1		

Category X – Blood Sugar - IR

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category XI – Adrenal - L

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII – Adrenal - H

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII – Electrolyte & pH Balance

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV – Thyroid - L

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV – Thyroid - H

Heart palpitations	0	1	2	3
inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI - Pituitary -L

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII – Pituitary - H

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” - type headaches	0	1	2	3

Category XVIII (Males Only)-Prostate

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX (Males Only)- Andropause

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX (Menstruating Females Only)

Peri-menopausal	___Yes	___No		
Alternating menstrual cycle lengths	___Yes	___No		
Extended menstrual cycle (greater than 32 days)	___Yes	___No		
Shortened menstrual cycle (less than 24 days)	___Yes	___No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3

Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI (Menopausal Females Only)

How many years have you been menopausal?		Years		
Since menopause, do you ever have uterine bleeding?	0	1	2	3
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week?	0	1	2	3
How many caffeinated beverages do you consume per day?	0	1	2	3
How many times do you eat out per week?	0	1	2	3
How many times do you eat raw nuts or seeds per week?	0	1	2	3
List the three worst foods you eat during the average week:	0	1	2	3
List the three healthiest foods you eat during the average week:	0	1	2	3

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____
How many times do you work out per week? _____

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Brain Health & Nutrition Assessment Form (BHNAF)

* Please circle the appropriate number “0 - 3” on all questions below. 0 = Least/Never, 1 = Rarely, 2 = Frequently, 3 = Most Always or Often.

SECTION 1 – Brain Circulation

- | | | | | |
|---|---|---|---|---|
| ○ Low brain endurance for focus and concentration | 0 | 1 | 2 | 3 |
| ○ Cold hands and feet | 0 | 1 | 2 | 3 |
| ○ Must exercise or drink coffee to improve brain function | 0 | 1 | 2 | 3 |
| ○ Poor nail health | 0 | 1 | 2 | 3 |
| ○ Must wear socks at night | 0 | 1 | 2 | 3 |
| ○ Nail beds are white instead of pink | 0 | 1 | 2 | 3 |
| ○ Tip of the nose is cold | 0 | 1 | 2 | 3 |

SECTION 2 – Sugar Metabolism

- | | | | | |
|---|---|---|---|---|
| ○ Irritable, nervous, shaky or light headed between meals | 0 | 1 | 2 | 3 |
| ○ Feel energized after meals | 0 | 1 | 2 | 3 |
| ○ Difficulty eating large meals in the morning | 0 | 1 | 2 | 3 |
| ○ Energy level drops in the afternoon | 0 | 1 | 2 | 3 |
| ○ Crave sugar and sweets in the afternoon | 0 | 1 | 2 | 3 |
| ○ Wake up in the middle of the night | 0 | 1 | 2 | 3 |
| ○ Difficulty concentrating before eating | 0 | 1 | 2 | 3 |
| ○ Depend on coffee to keep going | 0 | 1 | 2 | 3 |

SECTION 3 - Peripheral Utilization of Sugars

- | | | | | |
|--|---|---|---|---|
| ○ Fatigue after meals | 0 | 1 | 2 | 3 |
| ○ Sugar and sweet cravings after meals | 0 | 1 | 2 | 3 |
| ○ Need for a stimulant, such as coffee after meals | 0 | 1 | 2 | 3 |
| ○ Difficulty losing weight | 0 | 1 | 2 | 3 |
| ○ Increased frequency of urination | 0 | 1 | 2 | 3 |
| ○ Difficulty falling asleep | 0 | 1 | 2 | 3 |
| ○ Increased appetite | 0 | 1 | 2 | 3 |

SECTION 4 - Stress & Brain

- | | | | | |
|---|---|---|---|---|
| ○ Always have projects and things that need to be done | 0 | 1 | 2 | 3 |
| ○ Never have time for yourself | 0 | 1 | 2 | 3 |
| ○ Not getting enough sleep or rest | 0 | 1 | 2 | 3 |
| ○ Difficulty getting regular exercise | 0 | 1 | 2 | 3 |
| ○ Feel that you are not accomplishing your life’s purpose | 0 | 1 | 2 | 3 |

SECTION 5 – Essential Fatty Acids

- | | | | | |
|--|---|---|---|---|
| ○ Dry and unhealthy skin | 0 | 1 | 2 | 3 |
| ○ Dandruff or flaky scalp | 0 | 1 | 2 | 3 |
| ○ Consumption of processed foods that are bagged / boxed | 0 | 1 | 2 | 3 |
| ○ Consumption of fried foods | 0 | 1 | 2 | 3 |
| ○ Difficulty consuming raw nuts or seeds | 0 | 1 | 2 | 3 |
| ○ Difficulty consuming fish (not fried) | 0 | 1 | 2 | 3 |
| ○ Difficulty consuming olive oil, avocados, flax seed oil
or natural fats | 0 | 1 | 2 | 3 |

SECTION 6 – Brain Gut Axis

- | | | | | |
|--|---|---|---|---|
| ○ Difficulty digesting foods | 0 | 1 | 2 | 3 |
| ○ Constipation or inconsistent bowel movements? | 0 | 1 | 2 | 3 |
| ○ Increased bloating or gas | 0 | 1 | 2 | 3 |
| ○ Abdominal distention after meals | 0 | 1 | 2 | 3 |
| ○ Difficulty digesting protein rich foods | 0 | 1 | 2 | 3 |
| ○ Difficulty digesting starch rich foods | 0 | 1 | 2 | 3 |
| ○ Difficulty digesting fatty or greasy foods | 0 | 1 | 2 | 3 |
| ○ Difficulty swallowing supplements or large bites of food | 0 | 1 | 2 | 3 |
| ○ Abnormal gag reflex | 0 | 1 | 2 | 3 |

SECTION 7 – Brain Immune Axis

- | | | | | |
|--|-----|----|----|---|
| ○ Brain fog (unclear thoughts of concentration) | Yes | or | No | |
| ○ Pain and inflammation | Yes | or | No | |
| ○ Noticeable variations in mental speed | Yes | or | No | |
| ○ Brain fatigue after meals | 0 | 1 | 2 | 3 |
| ○ Brain fatigue from chemicals/scents/pollutants | 0 | 1 | 2 | 3 |
| ○ Brain fatigue when the body is inflamed | 0 | 1 | 2 | 3 |

SECTION 8 - Gluten Digestion

- | | | | | |
|--|---|---|---|---|
| ○ Grain consumption leads to tiredness | 0 | 1 | 2 | 3 |
| ○ Grain consumption creates difficulty in focusing/concentrating | 0 | 1 | 2 | 3 |
| ○ Feel better when bread and grains avoided | 0 | 1 | 2 | 3 |
| ○ Grain consumption causes the development of any symptom | 0 | 1 | 2 | 3 |
| ○ A 100% gluten free diet | 0 | 1 | 2 | 3 |

SECTION 9 – Intestinal Barrier

- | | | | | | |
|---|---|-----|----|----|--|
| ○ A diagnosis of celiac disease, gluten sensitivity,
Hypo-thyroidism or an auto-immune disease | | Yes | or | No | |
| ○ Family members have been diagnosed with auto-immune disease | | Yes | or | No | |
| ○ Family members have been diagnosed with celiac or gluten sensitivity | | Yes | or | No | |
| ○ Changes in brain function with stress, poor sleep or immune activation | 0 | 1 | 2 | 3 | |

SECTION 10 –Serotonin

○ A loss of pleasure in hobbies and interests	0	1	2	3
○ Feel overwhelmed with ideas to manage	0	1	2	3
○ Feelings of inner rage or unprovoked anger	0	1	2	3
○ Feelings of paranoia	0	1	2	3
○ Feelings of sadness for no reason	0	1	2	3
○ A lack of artistic appreciation	Yes	No		
○ Feelings of sadness in overcast weather	0	1	2	3
○ A loss of enthusiasm for favorite activities	0	1	2	3
○ A loss of enjoyment in favorite foods	0	1	2	3
○ A loss of enjoyment in friendships and relationships	0	1	2	3
○ Inability to fall into deep, restful sleep (mind busy)	0	1	2	3
○ Feelings of dependency on others	0	1	2	3
○ Feeling of susceptibility to pain	0	1	2	3
○ Get stuck on thoughts	0	1	2	3

SECTION 11 – D

○ Feelings of worthlessness	0	1	2	3
○ Feelings or hopelessness	0	1	2	3
○ Self-destructive thoughts	0	1	2	3
○ Inability to handle stress	0	1	2	3
○ Anger and/or aggression while under stress	0	1	2	3
○ Feeling tired, even after hours of sleep	0	1	2	3
○ An unexplained lack of concern for family/friends	0	1	2	3
○ Difficulty in completing tasks	0	1	2	3
○ Decrease in mental alertness	0	1	2	3
○ Decrease in mental speed	0	1	2	3
○ A decrease in concentration quality	0	1	2	3
○ An increase in ability to be distracted	0	1	2	3
○ Feelings of anger or frustration for minor reasons	0	1	2	3
○ Need coffee or caffeine sources to improve Mental function	0	1	2	3

SECTION 12 – A

○ A decrease in visual memory (shapes / images)	0	1	2	3
○ A decrease in verbal memory	0	1	2	3
○ Occurrence of memory lapses	0	1	2	3
○ A decrease in creativity	0	1	2	3
○ A decrease in comprehension	0	1	2	3
○ Increased difficulty calculating numbers	0	1	2	3
○ Increased difficulty in recognizing objects or faces	0	1	2	3
○ A change in opinion about yourself	0	1	2	3
○ Slow mental recall	0	1	2	3

SECTION 14 – G

✚ Feelings of nervousness or panic for no reason	0	1	2	3
✚ Feelings of dread	0	1	2	3
✚ Feelings of a knot in your stomach	0	1	2	3
✚ Feeling of being overwhelmed for no reason	0	1	2	3
✚ A restless mind	0	1	2	3
✚ An inability to turn off the mind when relaxing	0	1	2	3
✚ Disorganized attention	0	1	2	3
✚ Worry over things never worried about before	0	1	2	3
✚ Feelings of inner tension and inner excitability	0	1	2	3
✚ Difficulty sleeping/staying asleep	0	1	2	3
✚ Body feels tense, uptight often	0	1	2	3
✚ Easily upset, frustrated or snappy under stress	0	1	2	3
✚ Feel weak or shaky at times	0	1	2	3
✚ Sensitive to chemical fumes, noise or bright light	0	1	2	3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
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Nancey Kinney, PhDc, Naturopath, Certified Clinical Nutritionist,

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www.naturalhealthctr.net / nanceykin@gmail.com

Explanation of Services

Welcome to my alternative and complementary health center. Please read the following terms and conditions of my services.

Confidentiality:

All sessions are confidential. All information provided to another professional, such as a physician, therapist or agency, will be given only with your written consent.

Emails:

I give my permission for you to contact me by email / text. If I have confidential questions, I will contact you by telephone only.

Appointments:

Please notify the office if you need to reschedule. A 24- hour notice of cancellation is asked; otherwise you will be billed for your missed session. Initial consults are typically two hours and subsequent sessions are 50- 60 minutes. Telephone consultations can be arranged and are billed in 20-minute increments.

Payment & Fees:

Initial sessions are 2 hours and are \$240. Subsequent sessions of 1 hour are \$150. The Hormone Saliva Test is \$350. Smaller Hormone Saliva Test is \$295, 245 & \$195. Heavy Metal and Mineral Hair Analysis is \$150.

Payment is expected at time of service. All billings over 30 days will be charged yearly rate of 12% prorated monthly. I accept credit card payments (Visa, MasterCard, Discover & Debit). If your bill is more than 60 days past due, and/or you are not responding to payment of your bill in a timely fashion, then I will proceed with collection services. All collection and service fees will be added to your bill and will be your responsibility for payment.

Insurance:

Insurance does not pay for my services. Often there are plans attached to your primary health plan that will cover these adjunctive services. Please check with your employer.

Liability:

Please note that I am not a licensed physician and my practice is considered natural, alternative and/or complementary to health. I do not prescribe, diagnose, cure or treat health issues that would require a diagnosis by a medical doctor. My purpose is educating you about nutrition, detoxification and energetic balance and

providing supplementation. The Naturopathic philosophy is that if the body is brought back toward a balanced state, the body can, in most situations, use its innate sense of wisdom to bring about balance. I have been trained as a Naturopath by attending a residence training college in California and have obtained additional certifications and training in Clinical Nutrition, Electro-Dermal Screening (EDS) and BRT (BioResonance), Massage, Aromatherapy, MA in Counseling Psychology and EEG Neurofeedback certification by the BCIA, plus so many others. Please note that sometimes I will refer you to a medical doctor or other healthcare practitioner for evaluation.

While my goal is to support you in improving your physical health, I do not warrant or guarantee results in any manner, and therefore place a limitation on my legal liability. By signing this you agree that any disputes will be handled through arbitration only and you will pay for your portion.

Unopened supplements may be returned within 30 days. Homeopathic Remedies are not returnable.

I encourage you to be a partner in your health and to seek additional advice from other health professionals on your path to wellness.

I thank you for selecting my office and always appreciate your referrals of friends, associates, and relatives. As a thank you for referrals that come in I will apply a discount of \$25 on your next consultation or give you additional time during a session.

Please sign below to acknowledge that you have read, agree to and received a copy of these terms and conditions. Adults/parents, please sign for your son or daughter if underage, or for your dependent. Thank you.

Print Client Name: _____ Date: _____

Authorized Signature: _____