Intake Form

Kristi Lea Holistic Health LLC

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

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

Your Health Concerns Diagnosis/Year Medications/Supplements

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you have all your organs? Y or N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you take the COVID Vaccine? Y or N Brand?/ How Many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flu Vaccine? Y or N

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

**Digestion / Pancreas / Liver / Gallbladder**

|  |  |  |  |
| --- | --- | --- | --- |
| Gas/Bloating/Indigestion | Diverticulitis | Loss taste for meat | Vegan/Vegetarian |
| Acid Reflux | Diabetes I or II | Feel like skipping breakfast | Eats fast food |
| Intestinal pain | High blood pressure/cholesterol | Hemorrhoids/ Varicose Veins | Consumes alcohol |
| Constipation | Family history of heart disease | History of motion or morning sickness | Consumes Gluten/Dairy/ Sodas |
| Diarrhea shortly after meals | Overweight; especially in middle | Pulse speeds after eating | Coated tongue |
| Stool has corners, ridges, flat or ribbon like | Excessive appetite | Foul smelling Gas/Breath | Sinus Congestion |
| Light or clay colored stool | Sleepy after meals | Dark circles under eyes | Allergies/ Rashes/ Acne |
| Greasy or shiny stool | Need to snack frequently | Chemical hypersensitivity | Autoimmune issues |
| Blood, mucous or Undigested food in stool | Nausea/ feel worse after eating | Easily intoxicated/hung over | Chronic fatigue/ exhaustion |
| Stomach upset by greasy food | Headache if meals are delayed | Dry, cracked heels, skin | Asthma/ exercise induced asthma |
| Gallbladder attacks/Removed/ Pain Under Right Ribcage | Hypoglycemia: Shaky/lightheaded/irritable, “Hangry” if meals are delayed | Yeast symptoms increase with sugar or alcohol consumption | Eat 5 servings of fruit and vegetables a day |

**Cardiovascular: Family History of high blood pressure/ Heart Disease Y or N A1C: \_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| Stroke or heart attack | Air hunger/sigh frequently | Ankles swell | Sleep apnea |
| Enlarged heart/ congestive heart failure | Heart palpitations/ Irregular heartbeat/ heart races | Muscle fatigue/ cramps with exertion | Shortness of breath/ feel exhausted with moderate exertion |
| Dull pain or chest tightness | Aware of heavy or irregular breathing | Can hear heartbeat on pillow | Slow or weak pulse |

**Vitamin and Mineral needs**

|  |  |  |  |
| --- | --- | --- | --- |
| Stinky feet | Loss of muscle tone | Birth defects in children | Vulnerable to insect bites |
| Decreased sense of taste or smell | Numbness/tingling in hands and feet | MTHFR snp’s | Pain or swelling in joints |
| White spots on fingernails | Ringing in the ears (tinnitus) | Cracks in corners of your lips (Cheilosis) | Calf, foot or toe cramps at rest |
| Restless leg syndrome | History of anemia | Morning stiffness | Nosebleeds/bruise easily |
| Night sweats | Carpal tunnel syndrome | Arthritis | Crave chocolate |
| Whole body jerks as falling asleep | Arteriosclerosis | Heavy metal toxicity | Bursitis or tendonitis |
| Small bumps on back of arms | History of dental cavities, root canals, crowns, dentures, gum disease | Bone loss /osteopenia /osteoporosis | Vitamin D level: \_\_\_\_\_\_ |

**Histamine Intolerance**

|  |  |  |  |
| --- | --- | --- | --- |
| 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**

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

**Adrenals/ Emotional**

|  |  |  |  |
| --- | --- | --- | --- |
| Big reaction if startled | Slow starter in the morning | Calm on the outside, troubled inside | Tendency to need sunglasses |
| Always feel cold | Clench or grind teeth | Stressful job | Pain on inner side of knee(s) |
| Difficulty falling asleep | Tend to be a night owl | Irritability/anxiety/nervousness | Unable to forgive yourself/others |
| Chronic fatigue /drowsy frequently | Chronic low back pain | Have to please others excessively | Feel like a victim |
| Crave salty foods | Poor memory /concentration | Difficult relationship(s) | Low self-esteem/ self -worth |
| Anxiety/ Depression | Acute childhood stress(es) | Feel need to be sneaky/tell “white lies” | Rarely touch or get touched |
| Low blood pressure | Phobias /PTSD /Severe Stress /Anxiety that limits you | Unable to ask for what you need or want | Unresolved anger, bitterness or resentment |
| Become dizzy when standing up suddenly | Unable to allow yourself to relax or have fun | Unable to confront or say no without guilt | Unable to express sadness, fear or anger |
| Slow recovery from stress, infections, trauma, surgery, exercise | Impacted by alcoholism, addiction, Mental Illness in Childhood | Addictions to alcohol, drugs, sex, work, food, etc. | 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 |
| Hashimoto’s/ Grave’s disease | 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 I/II |
| Chronic fatigue | Frequent colds or flu | Coated tongue | Multiple Sclerosis/Lupus |
| Rheumatoid arthritis | Ulcerative Colitis | Eczema/ Psoriasis | History of Lyme disease |
| Autoimmune diagnosis | Cancer diagnosis | History of fibromyalgia | Frequent infections (sinus, UTI, strep, ear infection) |
| History of Mold Exposure | Cold sores, fever blisters or herpes lesions | Do you have any implants? Y or N | Have you had a blood transfusion? Y or N |

**Women; Have you ever had:**

|  |  |  |  |
| --- | --- | --- | --- |
| 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/ Night Sweats |
| Migraines | Breast fibroids | Clotting disorder (Factor 5) | Sexually transmitted disease |
| Uterine fibroids | Breast tenderness | Endometriosis | 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 | Family history of cancer/hysterectomy | Neurological symptoms with birth control pill | Abuse in the home: physical, emotional, sexual, financial, verbal |

**Men: PSA Level\_\_\_\_\_**

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

**Background information**

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

|  |  |
| --- | --- |
| Were there any complications in pregnancy and birth of you? | 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: | |
|  | |
|  | |
|  | |
|  | |
|  | |

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kristi Lea Holistic Health LLC

1002 Judge Court W.

West River, MD 20778