Nutritional Balancing Program

INITIAL INTAKE FORM

GENERAL INFORMATION

NAME_____

STREET_____ CITY_____ STATE_____ ZIP_____

PHONE (H OR CELL)_____ EMAIL ADDRESS_____

OCCUPATION _____ REFERRED BY_____

DATE OF BIRTH_____ HAIR COLOR _____ HEIGHT _____ WEIGHT _____ SEX: M F

HEALTH HISTORY

	Diabetes		AIDS/HIV Positive		Developmental Delay
	Kidney Disease		Pneumonia		Substance Abuse
	Liver Disease		Menstrual problems		Skin Conditions
	Obesity		Infertility		Food Allergies
	Ulcer		Osteoporosis		Environmental Allergies
	Intestinal problems		Arthritis		Chemical Sensitivities
	Hypertension		Fibromyalgia		Asthma
	High Cholesterol		Anxiety		Other
	Cardiovascular Disease		Depression		
	Heart Attack		Chronic Fatigue		
	Stroke		Headaches		
	Cancer		ADD/ADHD		

PLEASE LIST ILLNESSES IN YOUR FAMILY SUCH AS HEART DISEASE, CANCER, TB, DIABETES OR ARTHRITIS: _____

PRESENT HEALTH INFORMATION

PLEASE LIST *ALL* MEDICATIONS *AND* NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY RECENT MEDICAL TEST RESULTS YOU HAVE, SUCH AS BLOOD TESTS:

PLEASE LIST YOUR MAIN HEALTH CONCERNS/CONDITIONS IN ORDER OF IMPORTANCE:

PLEASE LIST YOUR MAIN HEALTH GOALS IN ORDER OF IMPORTANCE:

DO YOU SMOKE? IF SO, HOW MANY/DAY?
DO YOU DRINK ALCOHOL? IF SO, HOW MANY DRINKS/DAY?
DO YOU HAVE A HIGH LEVEL OF STRESS?
AVERAGE HOURS OF SLEEP PER NIGHT? DO YOU TAKE NAPS DURING THE DAY?

DO YOU EXPERIENCE CONSTIPATION OR DIARRHEA? HOW MANY BOWEL MOVEMENTS DO YOU HAVE/DAY?

HOW OFTEN AND WHAT KIND OF EXERCISE DO YOU DO?

IS THERE ANYTHING ELSE ABOUT YOUR HEALTH THAT YOU WOULD LIKE TO SHARE?

DIET

WHAT ARE EXAMPLES OF TYPICAL BREAKFASTS FOR YOU? FOOD | BEVERAGES

MID-MORNING SNACKS:

WHAT ARE EXAMPLES OF TYPICAL LUNCHES FOR YOU? FOOD | BEVERAGES

AFTERNOON SNACKS:

WHAT ARE EXAMPLES OF TYPICAL DINNERS FOR YOU? FOOD | BEVERAGES

_____ | _____

_____ | _____

_____ | _____

EVENING SNACKS:_____ | _____

DO YOU CRAVE CERTAIN FOODS? IF SO WHAT ARE THEY?_____
WHAT KIND OF WATER DO YOU DRINK?_____
DO YOU USE WELL-WATER FOR ANYTHING?_____

FEE SCHEDULE & PAYMENT INFORMATION

INITIAL HAIR MINERAL ANALYSIS: $250
INITIAL HAIR MINERAL ANALYSIS UNDER 18YEARS OLD: $200
REPEAT HAIR MINERAL ANALYSIS: $150
ADDITIONAL PHONE/EMAIL CONSULTATION: $60 PER HOUR

THERE ARE FOUR WAYS TO MAKE YOUR PAYMENT – circle the one you choose:
1. I WOULD LIKE TO RECEIVE AN EMAIL INVOICE WHICH I CAN PAY SECURELY ONLINE
2. I AM SENDING YOU MY PAYMENT THROUGH PAYPAL TO invoices@healingaia.com
3. I AM INCLUDING A CHECK PAYABLE TO HEALINGAIA (adds 3 to 5 business days for processing)
4. I AM ENTERING MY CREDIT CARD DETAILS BELOW

FIRST NAME:_____ LAST NAME:_____

CARD TYPE: VISA MASTER CARD CARD NUMBER: _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _

EXP DATE: MONTH _ _ YEAR _ _ 3 DIGIT SECURITY CODE: _ _ _ AMOUNT AUTHORIZED: $_____

BILLING ADDRESS: _____

COUNTRY:_____ EMAIL:_____ HOME PHONE: _____

AUTHORIZED SIGNATURE:_____ DATE:_____

CONSENT & DISCLOSURE

I request that Melissa Navarro/Julien Griffault perform a nutritional evaluation and set up a diet, supplement, detoxification and lifestyle program for the purpose of enhancing health and improving well-being. I understand that all testing, techniques and supplements are recommended/provided for the purpose of reducing stress and balancing body chemistry. None of the services/products recommended or provided are intended as diagnosis, prevention, treatment or prescription for any mental or physical disease, and are not intended as substitute for regular medical care.
I authorize Analytical Research Labs of Phoenix, Arizona to perform a hair mineral analysis of my hair sample (if given). I further authorize the sharing of my personal information, analysis and/or other testing results with Dr. Lawrence Wilson, and/or any other advanced health practitioner Melissa Navarro/Julien Griffault may consult for the purpose of designing my nutritional program.

SIGNATURE:_____ DATE:_____

PLEASE FILL OUT ALL FOUR PAGES AND MAIL THEM BACK WITH YOUR HAIR SAMPLE AND PAYMENT TO:
Whole System Healing P.O. BOX 1188 - Ojai, CA 93024

SYMPTOMS SHEET

CIRCLE any conditions or symptoms that presently describe you
PLACE A STAR next to the symptoms most important to you

Joint pain
Joint stiffness
Arthritis, osteo
Arthritis, rheumatoid
Muscle pain
Muscle weakness
Muscle cramps
Bursitis
Fractures
Osteoporosis
Gout
Sweet cravings
Sugar reactions
Irritable before meals
Can't skip meals
Hypoglycemia
Crave starches
Fat cravings
Other food cravings
Food allergies
Excessive hunger
No hunger
Diabetes
Rapid heart rate
Skipped heart beats
Heart palpitations
Heart attack
Poor circulation
Dizziness
Low or high blood pressure
Angina
Arteriosclerosis
High cholesterol_____
High triglycerides_____
Cough
Bronchitis
Asthma
Post-nasal drip
Sinus congestion
Allergies
Emphysema
Fatigue
Hypothyroidism
Low body temperature
Cold in winter/dry skin
Hyperthyroidism

Acne
Eczema
Fungal infections/candida
Psoriasis
Hives
Hair loss
Slow wound healing
Cataracts
Glaucoma
Meniere's disease
Tooth decay
Excessive plaque on teeth
Gum disease
Infections/viruses
Tumors/cancer
Multiple sclerosis
Parkinson's disease
Scleroderma
Fear
Anger
Anxiety
Bipolar disorder
Brain fog
Confusion
Depression
Irritability
Mind races
Mood swings
Obsessive/compulsive
Panic attacks
Poor memory
Schizophrenia
Trouble sleeping
Suicidal thoughts
Autism
Attention deficit
Hyperkinesis
Dyslexia
Seizures
Learning disability
Mental retardation
Delayed development
Bladder infections
Kidney infections
Trouble urinating
Frequent urination
Painful urination
Kidney stones
Water retention

Sinus headaches
Tension headaches
Migraine headaches
Neuritis
Eye diseases
Constipation
Diarrhea
Intestinal gas
Bloating
Heartburn
Ulcer
Stomach pain
Colitis
Gall stones
Fissures
Hemorrhoids
Cirrhosis
Diverticulitis
Tend to gain weight
Tend to lose weight
Anemia
Easy bruising
Dental amalgams
Drug addiction
Alcoholism
Smoking

WOMEN:
Premenstrual syndrome
Cramps
No menstruation
Heavy periods
Light/irregular periods
Ovarian cysts
Fibroid tumors
Abnormal pap smear
Menopause
Fibrocystic breasts
Breast tumors
Yeast infections
Hot flashes
Infertility

MEN:
Prostate problems
Impotence
Infertility