



NATURAL HEALTH SURVEY

Date : _____

Name: _____ Cell Phone : _____
 Home Phone: _____ Address: _____
 City: _____ State: _____ Zip: _____
 Occupation: _____ Referred by : _____
 E-Mail Address: _____
 Height: _____ Weight: _____ Birthdate: _____ Age: _____

Marital status: (circle) Married Single Divorced Widowed

Do you wish to receive Dr. Marie's health E-Newsletter? Y / N (send to: _____)

Can we use your email address to contact you concerning your care? Y / N

Instructions: *Put a check in those boxes applicable to you. When necessary write in your answer.*

1) REASON FOR TODAY'S VISIT (please tell us why you're here):

2) PAST or CURRENT ILLNESSES / INJURIES

- | | | |
|--|---|--|
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Head injury | <input type="checkbox"/> Cold body temp |
| <input type="checkbox"/> Neck injuries | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Liver issues |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recurring headaches | |
| <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Prostate issues | <input type="checkbox"/> List any other illness or injuries: |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Heart problems | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Peptic ulcer / Acid reflux | |
| <input type="checkbox"/> Liver/gallbladder disease | | |
| <input type="checkbox"/> Venereal disease (VD) | <input type="checkbox"/> Hemorrhoids | |
| <input type="checkbox"/> Frequent colds or infection | <input type="checkbox"/> Kidney problems | |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Parasites | |

3) WOMEN ONLY: MENSTRUAL HISTORY / PREGNANCIES

Do you have:

- Irregular periods
- Cramps or pain with period
- Tension or depression
- Breast tenderness
- Hot flashes at any time
- Pain during intercourse
- Any unusual bleeding or discharge

Age at menopause: _____

Date last period began: _____

Are you:

- Pregnant or possibly pregnant
- Having problems getting pregnant
- Using any method of birth control

What kind: _____

Number of :

- ____ children born alive
- ____ caesarian sections
- ____ premature births
- ____ stillborn
- ____ miscarriages
- ____ abortions

4) SURGERY / HOSPITALIZATIONS

Have you had removed:

- Tonsils Appendix Gallbladder Hysterectomy Other: _____

5) ALLERGIES

Are you allergic to any: Foods Drugs or medication Other substances
List:

6) MEDICATIONS

Do you regularly take:

- Sedatives Sleeping pills
 Laxatives Diet pills Thyroid (grains per day)
 Antacids Antidepressants
 Aspirin and cold medicines Estrogen
List any other medications you are currently taking:

7) HABITS / ENVIRONMENT

Do you:

- Awaken feeling unrested Drink alcohol (how much?)
 Have trouble sleeping Drink coffee (cups per day)
 Have problems with constipation Smoke tobacco (packs per day)
 Exercise: (how much – how often?)
 Have problems at work, home
 Have trouble relaxing or enjoying your spare time
Have you been treated for:
 Alcoholism
 Drug abuse
 Eating disorder

8) DIET

Do you:

- Skip breakfast
 Eat at irregular intervals Regularly salt your food
 Eat in a hurried atmosphere Regularly eat fried foods
 Eat quickly and forget to chew Use sugar on your food or in drinks
 Eat between meals Drink _____ ounces of water daily
 Drink soft drinks Eat foods with artificial coloring
 Eat out often (more than once a week) Or flavoring, preservatives
 Follow a special or restricted diet
 Avoid certain foods
List any vitamin, mineral or other dietary supplements you are taking:

What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Circle level of commitment: 0% 1 2 3 4 5 6 7 8 9 10 (100%)

Are you willing to follow a supplement regimen (2-3X daily) based on your testing results?

Please list all Major mental/emotional traumas: (loss of loved one, divorce, career change, miscarriage, major disease, etc.)

Please list hormones or medications you are currently taking:

1. _____ Name (Daily Dose)
2. _____ Name (Daily Dose)
3. _____ Name (Daily Dose)
4. _____ Name (Daily Dose)
5. _____ Name (Daily Dose)

Additional:



Legal Consent and Disclosure Statement - Initial each section marked:

___ I understand that I am financially responsible for all charges for services rendered by Optimum Solutions, LLC. **I understand that Optimum Solutions Holistic Health does not file insurance claims nor accept insurance as payment for any services or products. I understand they are NOT a medical clinic, and that Marie Pace is a Traditional Naturopathic doctor/Consultant, NOT a medical doctor.** I do understand and acknowledge that for any return of un-opened products or un-used testing kits within 30 days of purchase that I will receive in-house credit ONLY due to the personalized nature of service and products. If any un-used products or un-used testing kits are returned there is a 15% restocking/admin fee, which will be subtracted from the total credit given in-house. Shipping charges and taxes are not re-credited.

___ I request that Marie Pace, DNM, HHP, CNC do a nutritional and/or hormonal evaluation and educate me on a program of diet, nutritional supplements and/or natural bio-identical hormones and lifestyle changes for the purpose of reducing stress and enhancing my health. I understand that Marie Pace, DNM, HHP, CNC has degrees as a "Certified Nutritional Counselor"; "Holistic Health Specialist "; and "Doctor of Naturopathic Ministries" (equivalent to a doctorate degree) from Trinity School of Natural Health in Warsaw, Indiana (a national professionally accredited school by the American Naturopathic Medical Certification and Accreditation Board, Inc. for natural health). I understand that she has 18+ years of experience and over 1200+ hours of training and has worked with over 1500 clients. I understand that she is board certified as a Holistic Health Practitioner by the American Association of Drugless Practitioners and is a member of the American Naturopathic Medical Association and is approved to deliver saliva hormone testing kits from various labs, Hair Tissue Mineral Analysis, Food allergy testing, etc.

___ I authorize by my signature below, any laboratory utilized to share any & all test results, including their recommendations, with Optimum Solutions, LLC. I also authorize by my signature below, any medical doctor I work with, at my discretion, to send copies of all test results to Optimum Solutions Holistic Health, LLC for their review.

___ I understand that Marie Pace (nor any employee at Optimum Solutions) is NOT a medical doctor and cannot prescribe controlled medicines, diagnose diseases, nor do invasive practices. I understand that a natural health care consultation is NOT intended as a diagnosis, prescription, treatment nor cure for any disease, mental or physical and is not a substitute for regular medical care by a licensed, ethical medical doctor. The information I receive is for the reduction of stress in my life and body. It is not intended as treatment or prescription for any disease nor as a substitute for regular medical care. The goal is to enhance and compliment good medicine with the support of natural remedies. I understand that I should not adjust nor discontinue any medicine/drug that has been prescribed to me by my regular medical doctor without their express permission and instruction. I understand that Optimum Solutions LLC and any employee of stated LLC is not giving me any guarantee, warranty or assurances, expressed or implied, concerning the services/products provided just as no medical doctor can guarantee their services or medications. I understand that the two methods should work hand in hand. I agree to legally hold harmless any employee or owner of Optimum Solutions, L.L.C or the corporation itself., and realize that I alone am responsible for my health. If I choose to administer any information obtained by the employees or owners of Optimum Solutions, L.L.C., I do so under my own will.

___ The State of Louisiana does not license natural health consultants. The food and dietary supplements that might be recommended are not pharmaceutical drugs and, therefore, have not been subjected to, nor need, approval by the FDA by law. Yet all of the supplements we might suggest are manufactured in FDA approved labs. Under the Ninth Amendment to the Constitutional the United States Government of America, I retain the right to freedom of choice in health care. This includes the right to choose my diet and hormone supplementation and to obtain, purchase and use any therapy, regimen, modality, remedy or product recommended by the therapist, consultant, doctor or any practitioner of my choice. The enumeration in this declaration of these rights shall not be construed to deny or disparage other rights retained by me, or my right to amend this declaration in writing at any time.

___ **Cancellation / Re-Schedule NOTICE:** All clients will be charged accordingly if they cancel their appointment in less than 24 hours prior to their scheduled appointment. If you have an appointment on a Monday, you will need to cancel on the Friday morning before the appointment so that you will not be charged (no later than 9:00 a.m.). We've had an increasing amount of clients who are cancelling in 6 hours or less. This stops us from having enough notice to schedule someone else in that time slot. We have numerous clients who want to be seen but can't make it in on such short notice. Please be courteous and give us enough time to help others if you cannot make your appointment. We understand that life can throw you a curveball... but you do have an appointment for your health and should make it priority. It will be required for you to have a valid credit card on file and you will be charged \$70.00 for the cancellation if you cancel in less than 24 hours.

___ I have read the above and had the opportunity to ask any questions necessary concerning this document. I have received, to my satisfaction, answers to any questions I have had prior to service. I understand my records will be kept confidential and will not be released without my written consent. I intend this consent form to cover the entire course of any holistic program designed for my present condition and for any future condition(s) for which I seek assistance. I understand that I am free to withdraw my consent at any time and agree to do so in writing. Your signature below denotes your clear understanding and agreement of the above.

Client's Signature _____ **Date** _____ **PRINT NAME:** _____