Name:_____

Date of Birth:_____

Phone Number:_____

Email:_____

Country/ State:_____

Height:_____

Weight:_____

Please list your top health concerns/ symptoms:

_____

_____

_____

_____

_____

Have you done any detox protocols, heavy metal cleansing, candida cleansing, or parasite cleansing, etc? And if so, what did you use and how did you feel/react to the cleanse or detox protocol?

_____

_____

_____

_____

Tell me about your lifestyle (do you work full-time, are you a stay at home parent, do you work out regularly, are you sedentary, etc)?

_____

_____

_____

Do you feel heard & supported in your home/ family life and/or at work?

_____

Please list anything you have officially been diagnosed with:

_____

_____

Please list any surgeries you've had (gallbladder removal, breast implants, titanium implants, mesh, etc):

_____

_____

Have you had any recent testing and/or bloodwork done and if so, what did it reveal? Or, do you have a history of certain things like anemia, etc?

_____

_____

Do you regularly use alcohol, nicotine, vape pens, cannabis, CBD, etc?

_____

_____

Tell me about your vaccination history (childhood vaccines, covid vaccines, flu shots, etc)….and if you've had the covid vaccine, do you feel your symptoms have worsened since then?

_____

_____

Tell me about your hormone history (low testosterone, other hormonal imbalances, PMS, PMDD, PCOS, heavy or irregular periods, menopause, etc):

_____

_____

If you are a female, have you had any c-sections, vaginal births, trauma around birth, abortions, DNCs, etc):

_____

_____

Do you have an IUD, or use birth control; or have you used either in the past?

_____

Tell me about the condition of your hair, skin, & nails (hair-loss, brittle hair, dry skin, itchy skin, rashes, psoriasis, eczema, nail breakage, nail ridges, nails fungus, etc):

_____

_____

Do you have any joint or muscle pain and if so, where?

_____

_____

Tell me about your eye health (do wear glasses, contacts, have you had corrective eye surgeries, do you have eye floaters, dry eyes, itchy eyes, eye pain, sensitivity to the sun or bright lights, have you noticed your vision getting rapidly worse, etc?):

_____

_____

_____

Tell me about your ears, nose, throat, & respiratory system (chronic ear infections, ear ringing, sinus infections, asthma, etc):

_____

_____

_____

Tell to me about your dental history (root canals, silver fillings, history of cavities, wisdom teeth removed, other teeth pulled out, braces, permanent retainer, implants, etc):

_____

_____

How many times per day do you have a bowel movement? Is it easy for you to go, or do you have diarrhea/constipation, etc?

_____

Are you easily able to work up a sweat, during a work out, or sauna?

_____

Do you deal with night sweats, or excessive sweating?

_____

How is your sleep (do you struggle to fall asleep, struggle to stay asleep all night, etc)?

_____

_____

Do you wake up at night to pee and if so, about what time are you waking up?

_____

Do you snore, or breath through your mouth, when you sleep?

_____

How are your energy levels during the day (do you feel fatigued, do you take naps, etc)?

_____

Did you have any health issues as a child/ teen, or were you on a lot of antibiotics as a child/teen?

_____

Is there a family history of health issues, or certain diagnoses?

_____

Do you have a history of being bitten by ticks, mosquitoes, spiders, fleas, etc, or was there a time in your life that you were covered in a lot of insect bites?

_____

_____

Have you ever lived, or worked in a place that had leaks in the celling, under the sink, smelled musty/moldy, or you could see mold/mildew growing anywhere (like the window sills, or bathroom tile? Think back to your childhood home, as well…did you have a leaky, or musty smelling basement, or attic?

_____

_____

Do you keep your wifi router on 24 hours a day?

_____

Do you sleep with your cellphone next to you?

_____

Do you live next to cellphone towers, or large power lines?

_____

Do you have a smart meter?

_____

Do you have a microwave that you use regularly?

_____

Do you often keep your cellphone tucked in your pocket?

_____

How many hours per day do you estimate you're on your smart devices?

_____

Before bed, do you dim the lights, shut down electronics, wear blue blocking glasses, avoid looking at your smart devices, etc?

_____

Do you use conventional brands of beauty and cleaning products around the house, or are you using non-toxic products?

_____

_____

Have you currently using, or have you ever used over the counter antacids, or prescription antacids, or PPIs?

_____

List any prescription/OTC medications you are using:

_____

_____

_____

List any supplements you regularly take:

_____

_____

_____

What kind of water do you drink (tap water, bottled water, reverse osmosis, distilled, alkaline, etc)?

_____

Do you use a filter on your shower, or bath water and if so, do you know if it removes, or reduces contaminants by at least 90%?

Do you put trace mineral drops, sea salt, or electrolytes into your water and if so, what brand do you use/how much per day?

Do you drink coffee, tea, or energy drinks regularly and if so how much per day?

Do you drink your coffee, or other caffeinated drinks, on an empty stomach, before you've had a meal?

Including water, coffee, juice, etc, about how many ounces of liquid do you drink per day?

Do you feel hungry in the morning?

Do you skip breakfast regularly, because you're not feeling hungry, or are you practicing intermittent fasting?

How many hours after waking up do you eat your first meal?

Is there a certain diet you follow (vegan, vegetarian, carnivore, keto, paleo, etc)?

Do you avoid certain foods, because of allergies, or sensitivities and if so, what are those foods?

Are there any foods you crave?

Do you, or a close family member have a history of dieting, eating disorders, or negative feelings about certain foods, etc?

What was your childhood like? While growing up, did you experience any abuse, or trauma?

Have you had any recent traumas or stressful events, in the last few years, or is there anything you've been struggling with, emotionally or mentally, that you'd like to address?

Is there anything you'd like to learn more about, regarding your emotions, patterns, or belief systems that might be holding you back from fully healing (the more detailed the better)?

Practitioner/Client Terms and Conditions (by purchasing ANY of my services or products, or having a free consultation with me, you are agreeing to the following):

1) I understand that my Practitioner is NOT claiming that she can cure, treat, or diagnose my issues, as this is beyond her scope of practice. I understand that all information she gives me is for educational purposes only and nothing is to be used as a diagnostic tool. Any holistic methods I choose to incorporate are done under my own free will and not under the diagnosis of my Practitioner.

2) I understand that NO REFUNDS are given on anything I purchase; no exceptions!

3) I agree to the following, regarding payments: If I have signed up for a recurring/monthly package, I agree to make my payments on time. I understand that recurring/monthly packages will automatically be charged from the card I have on file with my Practitioner. I understand that payment is due, whether or not I progress toward my goals at my desired pace.

4) I understand that my Practitioner is not going to be constantly glued to her smart device and will respond to my messages within her normal business hours of Tuesdays, Wednesdays, & Thursdays from 10am-2pm (Arizona Time). I understand that any responses from her outside of these business hours are an exception. I understand that I am free to message my Practitioner with questions *anytime* (day, or night), but she will *only* reply to business-related messages during her normal business hours.

5) Due to copyright laws and legal ramifications, I agree that I will not share the PDFs, courses, or videos, created by my Practitioner, with anyone else. I understand the videos, courses, and PDFs that my Practitioner shares with me are *only* for paying clients.

6) I will keep up regular communication with my Practitioner, if I am working with her one-one-one through a Thrive or Q&A package. I will be open and honest about all things relevant to my healing journey, medications/supplements being used, changes in diet, etc. I also agree and to inform my Practitioner of any changes in life circumstances, stress load, changes in supplements/medications, changes in daily routines, or any other changes that might significantly impact my ability to reach my health goals. If I'm currently being treated by a physician, I agree to let him/her know about any new herbs/supplements I want to try and any other new changes I want to incorporate.

7) I understand that my Practitioner will honor my unique story, will remain open to constructive criticism from me, and will provide a safe space for me to express my feelings. She will provide me with educational tools to empower me to heal my own body and she will refer me to an outside source (like a doctor, counselor, etc), when we run into any issues that are beyond her scope of practice.

I hereby agree to the terms above, by signing, or adding my initials:

Date signed, or initialed: _____

Signature, or initials: _____