709 West Leuda St.
Fort Worth, TX 76104
Phone: (817) 927-5111
Fax: (817) 927-7112

6221 Colleyville Blvd, Suite 100
Colleyville, TX 76034
Phone: (817) 421-2922
Fax: (817) 416-8397

Client Information

First Name: _____ M.I.: ____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / ____ / _____ Sex: M / F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Fax Number: (_____) _____ - _____

Email Address: _____

Emergency Contact Name: _____

Phone: (_____) _____ - _____ Relationship: _____

Referred By (name and phone #): _____

Drug Allergies: _____

Parental Information (if patient is a minor)

Name:_____ Date of Birth: _____ / _____ / _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email Address: _____

Employer Name: _____ Position: _____

Address:_____ City: _____ State: ____ Zip: _____

Work Phone: (_____) _____ - _____

Financial Policy

Fees for all services and products are due at the time of service. I understand that insurance is not accepted at this office. Payment may be made in the form of cash, check or credit card. Unopened supplements may be exchanged or returned for office credit within 30 days of purchase.

Appointments

As a courtesy to other patients, please be on time for your scheduled appointment. Should you need to cancel or reschedule your appointment, please give 24 hours notice to avoid a cancellation or no show fee.

I have read the above statement and I agree to all terms and conditions.

Signature:_____ **Date:** _____ /_____ / _____

Past Medical History

Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

☐ AIDS/HIV	☐ Crohn's / Colitis	☐ High Blood Pressure	☐ Scarlet Fever
☐ Alcoholism	☐ Diabetes	☐ IBS	☐ Seizures
☐ Allergies	☐ Diverticulosis	☐ Measles	☐ Stroke
☐ Appendicitis	☐ Emphysema	☐ Multiple Sclerosis	☐ Thyroid Disorders
☐ Arteriosclerosis	☐ Epilepsy	☐ Mumps	☐ Tuberculosis
☐ Asthma	☐ Goiter	☐ Pacemaker	☐ Thyroid Fever
☐ Birth Trauma (your birth)	☐ Gout	☐ Pleurisy	☐ Ulcers
☐ Cancer	☐ Heart Disease	☐ Pneumonia	☐ Venereal Disease
☐ Celiac disease	☐ Hepatitis	☐ Polio	☐ Whooping Cough
☐ Chicken Pox	☐ Herpes	☐ Rheumatic Fever	☐ Other _____

List medications you are currently taking:

Medications/Supplements	Strength	How many per day	For how long

List substances, medications and/or supplements you are allergic to:

_____

_____

List any major surgeries you have had:

Date	Reason

List significant trauma you have had (auto accident, falls, etc):

_____

_____

List significant family history:

_____

_____

Your Diet: Appetite: ☐ Strong / ☐ Weak ☐ Sugar ☐ Salty Foods ☐ Coffee (# of cups per day: _____)
☐ Thirst for water: Y / N (# of glasses per day: _____) ☐ Soft Drinks (# of glasses per day: _____)

Your Lifestyle: ☐ Alcohol ☐ Recreational drugs ☐ Tobacco ☐ Marijuana ☐ Stressful ☐ Occupational Hazards
☐ Regular Exercise: Type: _____ Frequency: _____ Type: _____ Frequency: _____

General Symptoms:	☐ Poor appetite	☐ Poor Sleep	☐ Cold hands or feet
☐ Sweats easily	☐ Strong appetite	☐ Restful sleep	☐ Shortness of breath
☐ Muscle cramps	☐ Strongly like cold drinks	☐ Dream-disturbed sleep	☐ Poor circulation
☐ Vertigo / dizziness	☐ Strongly like hot drinks	☐ Fatigue	☐ Fever
☐ Bleed / bruise easily	☐ Recent weight loss/weight gain	☐ Lack of strength	☐ Chills
☐ Peculiar taste	☐ Frequently skip meals	☐ Bodily heaviness	☐ Night sweats

☐ Other: _____

Head, Eyes, Ears, Nose, and Throat

- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Poor hearing
- ☐ Color of phlegm: _____
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Glasses / contacts
- ☐ Ringing in ears
- ☐ Eye pain
- ☐ Red Eyes
- ☐ TMJ
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Glaucoma
- ☐ Eye Strain
- ☐ Teeth problems
- ☐ Grind teeth
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Other head/neck
- ☐ Thrush
- ☐ Excessive Saliva
- ☐ Cataracts
- ☐ Excessive phlegm
- ☐ Earaches
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Itchy eyes

Respiratory

- ☐ Tight chest
- ☐ Asthma/wheezing
- ☐ Pneumonia
- ☐ Coughing blood
- ☐ Difficulty breathing when lying down
- ☐ Shortness of breath
- ☐ Color of phlegm: _____
- ☐ Cough: wet or dry? _____

Cardiovascular

- ☐ Low blood pressure
- ☐ Phlebitis
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Other: _____
- ☐ Fainting
- ☐ Heart palpitations
- ☐ Tachycardia
- ☐ Blood clots
- ☐ Irregular heartbeat
- ☐ Difficult breathing

Gastrointestinal

- ☐ Bloating
- ☐ Diverticulosis
- ☐ Intestinal pain/cramping
- ☐ Rectal pain
- ☐ Acid regurgitation
- ☐ Burning anus
- ☐ Diarrhea
- ☐ Itchy anus
- ☐ Anal fissures
- ☐ Celiac disease
- ☐ Gas
- ☐ Laxative use
- ☐ Bad breath
- ☐ Crohn's/Colitis
- ☐ Hemorrhoids
- ☐ Mucous stools
- ☐ Black stool
- ☐ Constipation
- ☐ Hiccups
- ☐ Nausea/vomiting

Bowel movements: Color: _____ Odor: _____ Texture/form: _____

Musculoskeletal

- ☐ Muscle pain
- ☐ Rib pain
- ☐ Neck/shoulder pain
- ☐ Joint pain
- ☐ Other: _____
- ☐ Lower back pain
- ☐ Limited use
- ☐ Limited range of motion
- ☐ Upper back pain

Skin and Hair

- ☐ Ulceration
- ☐ Nail fungal infection
- ☐ Rashes
- ☐ Dandruff
- ☐ Change in hair/skin texture
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hair loss / excessive hair loss
- ☐ Itching
- ☐ Other hair/skin problems: _____
- ☐ Acne
- ☐ Hives

Neuropsychological

- ☐ Numbness
- ☐ Seeing Therapist
- ☐ Seizures
- ☐ Anxiety
- ☐ Poor memory
- ☐ Depression / seasonal depression
- ☐ Considered/attempted suicide
- ☐ Easily stressed
- ☐ Abuse survivor (physical/sexual)
- ☐ Tics
- ☐ Other: _____
- ☐ Irritability

Genitourinary

- ☐ Incontinent
- ☐ Urgent urination
- ☐ Premature ejaculation
- ☐ Bedwetting
- ☐ Gallstones
- ☐ Wake to urinate
- ☐ Increased libido
- ☐ Venereal disease
- ☐ Kidney stones
- ☐ UTI (frequent __)
- ☐ Frequent urination
- ☐ Decreased libido
- ☐ Nocturnal emission
- ☐ Other: _____
- ☐ Pain on urination
- ☐ Incomplete urination
- ☐ Impotence
- ☐ Blood in urine

Gynecological

Age menses began: _____ Age at menopause: _____ Date last period began: _____

Date of last PAP: _____ # of pregnancies: ____ # of live births: _____ # of premature births: _____

Duration of flow: _____ Length of cycle (from day 1 to day 1) _____

- ☐ Breast lumps
- ☐ PMS
- ☐ Vaginal odor
- ☐ Vaginal discharge
- ☐ Clots
- ☐ Irregular periods
- ☐ Painful period
- ☐ Vaginal sores
- ☐ Yeast infections

Daily Food, Exercise and Supplement Log

(Please keep a food/exercise log to further help us!)

Day 1	*Day 2*	*Day 3*	*Day 4*
Meal 1	**Meal 1**	**Meal 1**	**Meal 1**
Meal 2	**Meal 2**	**Meal 2**	**Meal 2**
Meal 3	**Meal 3**	**Meal 3**	**Meal 3**
Meal 4	**Meal 4**	**Meal 4**	**Meal 4**
Meal 5	**Meal 5**	**Meal 5**	**Meal 5**
Meal 6	**Meal 6**	**Meal 6**	**Meal 6**
Exercise Log and Notes:	**Exercise Log and Notes:**	**Exercise Log and Notes:**	**Exercise Log and Notes:**

Important: On your first visit, please bring a list of supplements and prescription medications that you are currently taking. If you desire, you may bring a copy of your blood work done within the last 12 months. Please keep this 4-day food diary of everything that you eat and drink. Do not modify any of your food intake it is necessary for you to be as candid as possible in all areas for an accurate assessment of your current nutritional status.

Disclosure of Patient Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

_____

_____

_____

Also, please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Phone #: (_____) _____ - _____

Name: _____ Phone #: (_____) _____ - _____

Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information if other than your home or work number (such as a cell phone number*):
(_____) _____ - _____. (* I am fully aware that a cell phone is not a secure and private line.)

Patient Name (please print): _____

_____ _____

Signature of Patient or Representative **Date**

Acknowledgement of Review of Notice of Privacy Practices

I, _____ have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Representative **Date**

Disclaimer

I, _____ (name) herby attest to the following:

1. I fully understand that the Energy Health nutritionists are not medical doctors and that I am not here for medical diagnostic or treatment procedures.
2. The services preformed by the Energy Health nutritionists are at all times restricted to consultation on the subject of natural health and are intended of the maintenance of the best possible state of health and do not involve the diagnosing, prognosticating, or treatment of disease.
3. I am here, on this and any subsequent visit, solely on my own behalf.

_____ _____

Signature of Patient or Representative **Date**

We are delighted that you have chosen the path of health and wellness. It is a journey that we will make together by educating, motivating, and supporting you as you begin the journey to better health and wellness.

Thank you for choosing Energy Health Centre as your partner for health and wellness. Together we help build healthy, happy, active lives. Accountability and structured programs, along with your commitment and follow thru, will help ensure a positive partnership.

Consent for Nutritional Counseling

I realize that optimum nutritional results are obtained when I honestly share my nutrition and lifestyle habits with my nutritionist and commit to their recommended programs. I understand Energy Health Centre nutritionists are not physicians or licensed health care practitioners and therefore do not dispense medical advice, prescribe treatment or prescriptions, nor advise on starting, adjusting dosages, or ceasing prescription use. I will continue to follow the advice of my medical provider.

I understand that nutritional services are not a substitute for medical care and not intending to medically treat, alleviate, or care for disease(s). Nutritional assessments serve as guides to help develop an appropriate nutrition program tailored to my individual needs and also to help monitor my progress in achieving health goals. I accept full responsibility for deciding what foods and supplements I put in my body.

Personal information I give to Energy Health Centre will be kept strictly confidential unless I consent to sharing it. I understand that any inaccurate information I supply may affect my nutrition assessment.

I agree that all the information I receive from Energy Health Centre is for the sole use by me and my health care team and that no part of this information may be reproduced or transmitted in any form or by any means (electronic, digital, mechanical, photocopying, recording, or otherwise) without the prior written permission of Energy Health Centre. I agree that I will not participate in or encourage electronic piracy of copyrightable materials.

Appointments: I will make every effort to keep all scheduled appointments. I will contact Energy Health Centre to reschedule if I cannot keep my appointment. I understand that there will be no rescheduling fee if my request is received 24 business hours prior to the scheduled appointment time. I also understand that I will be charged the full fee for any canceled or missed appointments if I do not leave a message or have a conversation with an Energy Health Center employee within 24 hours of my scheduled appointment.

Fees: I understand that fees for services are due at the time the service is provided. Energy Health Centre's forms of payment include cash, check, and credit card. I will receive a receipt for possible reimbursement from my health spending account, though no guarantee is implied.

I understand my rights and responsibilities as an Energy Health Centre client and agree to abide by them. I consent to nutritional counseling and understand that I may withdraw my consent in writing at any time.

Client Name (please print)_____

Signature _____ Date _____