OptimumSolutions
HOLISTIC HEALTH CONSULTANTS

NATURAL HEALTH SURVEY

Date :_____

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

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

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

Are you:

- ☐ Pregnant or possibly pregnant
- ☐ Having problems getting pregnant
- ☐ Using any method of birth control
  What kind: _____

Age at menopause: _____

Date last period began: _____

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
☐ Laxatives
☐ Antacids
☐ Aspirin and cold medicines
☐ Sleeping pills
☐ Diet pills
☐ Cortisone
☐ Estrogen
☐ Thyroid (grains per day)

List any other medications you are currently taking:

7) HABITS / ENVIRONMENT

Do you:

☐ Awaken feeling unrested
☐ Have trouble sleeping
☐ Have problems with constipation
☐ Exercise: (how much – how often?)
☐ Have problems at work, home
☐ Have trouble relaxing or enjoying your spare time
☐ Drink alcohol (how much?)
☐ Drink coffee (cups per day)
☐ Smoke tobacco (packs per day)

Have you been treated for:

☐ Alcoholism
☐ Drug abuse
☐ Eating disorder

8) DIET

Do you:

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

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)

MORE:

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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, 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 16+ 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 Registered as a Naturopathic Diplomate by the Council on Naturopathic Registration and Accreditation, Inc. 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 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: A**ll 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: _____