

**Remedy Rebuild CONFIDENTIAL**

[www.RemedyRebuild.com](http://www.RemedyRebuild.com)

RemedyRebuild@gmail.com **CLIENT INFORMATION**

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| --- |
| Please return these forms prior to your appointment (drop off or email) to allow your practitioner to review them thoroughly before your appointment. – Any Forms needing to be filled out at the time of the appointment will carry an additional $30 fee. |

250-524-0333 **& QUESTIONNAIRE**

1. **Client Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname |  | First Name | | Blood Type |
| Date of Birth | Age | Gender Identification: | | |
| Occupation : |  | Marital Status | | |
| Tel (H) |  | Cell |  | |
| E-Mail: |  | Emergency contact: | | |
| Mailing Address |  |  | | |
| Allergies: |  |  | | |

1. **Current Medication & Supplements – use back of page if necessary**

|  |  |  |
| --- | --- | --- |
| Medicine | Daily dosage | Date commenced |
| Medicine | Daily dosage | Date commenced |
| Medicine | Daily dosage | Date commenced |
| In the last 5 years have you taken any antibiotics? Y / N followed with a course of probiotics? Y / N | | |

1. **Main Complaint(s) (Prioritize Goals and Concerns for your health)**

|  |  |
| --- | --- |
| a) | When did it start? |
| How often do you experience the symptom? |  |
| What relieves and aggravates the condition? |  |
| b) | When did it start? |
| How often do you experience the symptom? |  |
| What relieves and aggravates the condition? |  |
| c) | When did it start? |
| How often do you experience the symptom? |  |
| What relieves and aggravates the condition? |  |

1. **Medical History**

|  |  |  |
| --- | --- | --- |
| Diagnosis | Date diagnosed | Current □ / Previous □ |
| Diagnosis | Date diagnosed | Current □ / Previous □ |
| Diagnosis | Date diagnosed | Current □ / Previous □ |
| Diagnosis | Date diagnosed | Current □ / Previous □ |

1. **Hospitalizations (overnight stays/Emergencies etc. Including Surgical History )**

|  |  |
| --- | --- |
|  | Date |
|  | Date |
|  | Date |

|  |  |
| --- | --- |
| Any special diet or food avoidance? Any Food Cravings? | |
| Typical daily diet: |  |
|  |  |
|  |  |
|  |  |

1. **Family Medical History**

|  |
| --- |
| Father |
| Mother |
| Grandfather (paternal) |
| Grandmother (paternal) |
| Grandfather (maternal) |
| Grandmother (maternal) |
| Siblings |
| Children |

1. **General Health**

|  |  |
| --- | --- |
| Energy levels (please rate): excellent □ good □ fair □ poor □ | Lowest at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (time) |
| Sleep (please rate): excellent □ good □ fair □ poor □ | No of hours: |
| Appetite (please rate): good □ poor □ | No meals per day |

1. **Diet & Digestive System**

|  |  |  |  |
| --- | --- | --- | --- |
| (Please specify how often the following foods are consumed per week - | | |  |
| Alcohol | Gluten | Sugar | Cheese |
| Coffee per day | Fried foods | Fruit | Junk foods |
| Meat | Dairy | Vegetable | Soft drinks |
| Water per day |  | |  |

***Systems Survey***

Please check the appropriate box for any of the following symptoms which you now have, or have had previously. We need as many facts as possible about your health to assist us in your care.

Left box- Occasional/Mild Middle Box – frequent/moderate Right box – Constant/Severe

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **General**                                                                            **Genito**                                     | Alcoholism  Cancer  Chills  Convulsions  Dizziness  Diabetes  Epilepsy  Fainting  Fatigue  Headache  Hyperactivity  Learning Disability  Loss of sleep  Weight Loss  Mental Disorder  Nervousness  Depression  Neuralgia  Numbness  Sweats Tremors  **-Urinary**  Bed-Wetting  Blood in Urine  Frequent urination  Kidney Infection  Kidney Stones  Painful Urination  Prostate trouble  Pus in Urine  Venereal Disease |                                                               **Cardio-**                                           | **Skin**  Boils  Bruise easily  Dryness  Hives/ Allergy  Itching  Skin/Eruptions/Rash Varicose veins  **Men Only**  Pain in Testicles  Dribbling  Burning on Ejaculation  Impotence  Blood in Urine  Blood in Semen  Vasectomy  Penile Discharge  **vascular**  Hardening of arteries High/Low Blood pressure  Pain over heart  Poor circulation  Rapid heart beat  Slow heart beat  Stroke  Swelling of ankles  Chest pain  Cold fingers/toes | **Women Only**     Congested Breasts     Cramps/Backache     Excessive Menstrual  Flow     Hot flashes     Irregular cycle     Lumps in breast     Menopausal symptoms     Painful menstruation     Vaginal discharge     Yeast infection     Irritability     Bloating     Clotting     Acne at Menses  Color of blood \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Age of Menarche \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Flow : Light Medium Heavy  Length of Cycle in Days: \_\_\_\_\_\_\_\_\_\_\_  Number of days of flow: \_\_\_\_\_\_\_\_\_\_    **Respiratory**     Chronic cough     Difficult breathing     Spitting up blood     Spitting up phlegm     Wheezing | |
| **Gastro**                                                                 | **-Intestinal**  Belching - Gas  Colitis  Colon trouble  Constipation  Diarrhea  Difficult digestion  Distension of abdomen  Excessive Hunger  Hemorrhoids  Hepatitis  Intestinal Worms  Liver trouble  Nausea  Pain  Poor Appetite  Ulcers |                                                   | **Muscle & Joint**  Arthritis  Bursitis  Hernia  Back pain  Lumbago  Neck/Stiffness  Pain between  Shoulders  Pain or Numbness  Painful Tailbone  Poor posture  Sciatica  Spinal Curvature  Swollen Joints |                                                            | **Eyes, Ears, Nose**  **& Throat**  Asthma  Colds  Crossed eyes  Deafness  Dental Decay  Earache  Ear Discharge  Ringing in ears  Enlarged glands  Enlarged Thyroid  Eye pain  Failing vision  Hay fever  Hoarseness  Nasal obstruction  Sinus Infection |
|  | |  | |    | Tonsilitis |

**Consent and Indemnity**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to have capillary blood drawn and my blood analyzed by the live blood analysis practitioner.

I understand that the practitioner has received some formal training in blood analysis and that all necessary infection control measures are followed as stipulated by the Department of Health.

I understand that live blood analysis is not a medical diagnostic procedure, that it does not replace the advice of a medical practitioner and that it is utilized as a nutritional assessment and education tool to assist with dietary and lifestyle recommendations.

I hereby indemnify the practitioner against any claim regarding my analysis, excluding those arising from malpractice.

Signature of client / guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| If you have any specific contact requests please list them here:    If you wish to receive any of the following email please indicate below:   I wish to receive the regular monthly **newsletter** –   I wish to receive information regarding **promotions and offers** - |

**Statement of Acknowledgment :** I understand that:

* Your practitioner is not a medical doctor; we use non invasive, natural methods of assessment and treatment of body dysfunction in attempts to bring the body back into a state of balance.
* Holistic medicine takes time to search for the underlying causes of your issue/illness/disorder and not just provide symptomatic relief. We come up with an individualized treatment plan for you. If you have any difficulties understanding or following through with your treatment plan, we encourage you to call us, so that we can help you appropriately.
* The methods used in this practice have a clinical foundation, yet may not be accepted by standard

(allopathic) medicine, these include but are not limited to: dietary guidance and nutritional supplementation, botanical or herbal medicine, bio-energetic medicine, exercise recommendation and lifestyle counseling, reflexology, Live /Dry blood analysis.

* We may perform a physical examination on patients depending on circumstances
* You are not an agent of any private or governmental agency attempting to gather information without so stating your intentions
* You are accepting or rejecting this care of your own free will
* The ultimate responsibility for your health care is your own, and that we are here to support you in this. We reserve the right to discontinue our services where it is apparent that your expectations and what we provide are not in agreement.
* I understand that if I correspond by e-mail or texting with Maggie’s Herbs & Holistic Health Practice , that email and texting source is not always secure and any information I choose to share could be compromised.
* Our Natural Health Care is a joint responsibility .We welcome teamwork with medical Doctors and other Health Practitioners.
* We will explain procedures, probably outcomes and possible risks associated with our treatments in advance. We work alongside, not in place of, medical treatments, and if you choose to forgo such medical approaches in favour of natural healing you assume responsibility for any potential risk that may entail
* Prescription medications – please discuss any change in the dose of prescription drugs or any other prescribed medical treatment with the doctor who prescribed them. The decision to discontinue prescription drugs or any other prescribed medical treatment is **your responsibility**.
* Your records will be held in the strictest confidence; Any and all health information you provide to your health care practitioner(s) on the intake forms and any notes made by the practitioner during a treatment session is confidential and will be used solely by that individual health practitioner. At times in difficult cases the information may be run by a third party (another practitioner) for additional input (it will not be disclosed to other practitioners or to outside parties unless you provide explicit written consent)

I have read and understand the above: I, have read, understood and acknowledge the above. (print name) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (signature of client or guardian)

The purpose of this questionnaire is to assist you in identifying the sources and causes of your health challenges. As such, it focuses on questions relating to any symptoms you may be experiencing, lifestyle, treatments and conditions you have been diagnosed for. Answer all questions as best as you can to assist us in helping you on your path towards restored and better health.