4426 Austell Road, Austell, GA 30106
Tel: 770-485-3805; E-mail: info@amazingnaturalhealth.com

WELCOME TO AMAZING NATURAL HEALTH CENTER!

CLIENTS / PATIENTS' ASSESSMENT FORM:

Personal Information:

Today's Date: **Date Of Birth:** **Age:**

Full Legal Name:

Social Security #:

Home phone: **Cell Phone:**

Blood Type:

E-Mail:

Current Postal Address:

Profession/Occupation:

Current Marital Status:

Daily Physical Exercise:

Emergency Contact Person and Phone Number:

Background Information:

Health/Medical History:
(Give details of every ailment and treatment)

Allergies and intolerances (Food, chemicals, drugs, vitamins, materials, etc.)

Family Health/Medical History:

Health/Medical History of Spouse (if applicable):

Social/Emotional History:

Familial and Personal Relationship History:

Diet History:

Herbal and Vitamin Supplements:

Current Medications:

<u>Present Problems/Concerns</u>:

Duration:

Signs and Symptoms:

Treatment Attempted Previously:

To Our Clients/Patients:

Thank you for choosing Amazing Natural Health and Wellness to assist you in determining the source of your personal health issues. We pledge to you a caring, professional and sharing environment dedicated to getting you back on the right track in as natural a manner as possible. Your wellness is our goal! Health is Wealth.

Your visit to our wellness facility will involve a thorough review of your medical history in order for us to evaluate proper advice in educating you on how to maintain good health, naturally.

In the course of your visits here, some of the previously ordered tests might indicate the need for further assessment and, therefore, other studies might be ordered. Once more, these will be explained to you, staying true to our standard of always keeping the client/patient fully informed. Your participation in all decisions pertinent to your care is the most vital part of our integrated advice process.

First Initial Visit Payments are as Follows:

Office visit, onetime payment is $50.00, within one year.

Advanced Body Assessment is $300.00, but you will pay $200.00.

Basic Body Assessment with Emotions is $450.00, but you will pay $250.00

Full Body Assessments with Emotions is $650.00, but you will pay $350.00

Advanced Food Assessment is $150.00

Basic Food Assessment is $100.00

Evox Therapy is $150.00 Per Session

A Session of Lipo Suction without Surgery for Weight Loss is $250.00, but you will pay $200.00

Other Treatment Services will be explained to you by the ND, after initial consultation.

At any time in the process, if you desire to speak with our financial counselor for more details on costs, payments, we will be pleased to consult with you. It is our desire that you will be very comfortable with all of our professional expertise. We want you to feel at ease and confident with all of the members of Amazing Natural Health Center. To avoid any inconvenience for our clients/patients, Amazing Natural Health Center has developed procedures for payment arrangements when necessary. The mission and purpose of Amazing Natural Health Center is to work in harmony with our clients/patients on all levels to address health challenges or concern and move toward a healthier state in life naturally.

If you have any other questions, please feel free to ask any of our staff.

_____ _____ ----------

Client/Authorized Person Signature **Witness** **Date**

Notice to Clients/Patients:

Dr. Florence Akin, ND, DNH, PHD

This notice is provided to you pursuant of law. The practitioner above is a Doctor of Natural Health. The ND is also a Christian Counselor in Marriages, etc and also Addiction Counselor, and under the scope of practice for Natural Health, she is not practicing as a licensed medical doctor and therefore do not practice "the application of scientific principles to prevent, diagnose and treat physical and mental diseases, disorders, and conditions and to safeguard the life and health of any person."

A person registered to practice naturopathy or naturopathic healing under the law may counsel individuals on human conditions with "naturally occurring substances."

The underlying causes of disease may be improper diet, unhealthy habits and environmental factors that cause biological imbalance. A classic naturopath specializes in wellness; the teaching of natural lifestyle approaches to facilitate the body's healing and health building potential.

I fully understand that the above name is not a Medical Doctor. The Doctor may counsel me on nutrition, supplements, and better health practices, but will not diagnose or prescribe remedies for disease.

_____	_____	_____
Client/Authorized Person Signature	**Witness**	**Date**

Symptom and Ailments Questionnaire #1
Please check the appropriate box for each question.

Symptoms	**Frequently**	**Occasionally**	**Rarely**	**Never**
Cold hands, feet, low body temperature				
Fatigue/ tiredness				
Inability to lose weight despite dieting				
Poor memory				
Mucus in your stool				
Poor concentration				
Constipation				
Diarrhea				
Hair loss				
Depression				
Anxiety/ nervousness				
Irregular heart beats				
Trouble sleeping				
Muscle weakness				
Muscle aches				
Joint pain				
Headaches				
Early morning stiffness				
Easy fatigue from exercising				
Sleepiness in the afternoon				
Excessive thirst				
Sugar cravings				
Dizzy/ lightheaded				
Shaky or irritable when hungry				
Easily full when eating				
Belching/ burping				
Rectal itching/ nasal itching				
Toe fungus, jock itch, or athlete's foot				
High sensitivity to smells				
Chronic or long term hives				
Excessive body or foot odor				
Bad breath				
Sinus problems				
Sore throat				
Loss of voice / hoarseness				
Burning or tearing of the eyes				
Easy bruising				
Slow wound healing				
Average bowel movements per day?	(1)	(2)	(3)	(4+)

_____ _____ _____

Client/Authorized Person Signature **Witness** **Date**

Symptom and Ailments Questionnaire #2

Please check the appropriate box for each question.

Symptoms	**Frequentl**	**Occasionall**	**Rarely**	**Never**
Bloating, belching or intestinal gas				
Vaginal burning, itching or discharge				
Endometriosis or infertility				
Cramps or menstrual irregularities				
Attacks of anxiety or crying				
Thyroid disease				
Shaking or irritability when hungry				
Bladder / kidney infections				
Drowsiness				
Irritability				
Poor concentration				
Trouble sleeping				
Sinus or breathing problems				
Tendency to bruise easily				
Eczema or psoriasis				
Itchy skin or eyes				
Chronic hives (urticaria)				
Indigestion or heartburn				
Decreased body hair				
Sensitivity to milk, wheat or foods				
Decreased sex drive				
Dry mouth or throat				
Bad breath				
White tongue				
Excessive foot, hair or body odor				
PMS pre-menstrual syndrome				
Frequent sore throats				
Laryngitis, loss of voice				
Recurring bronchitis				
Pain or tightness in the chest				
Shortness of breath				
Burning or tearing eyes				
Ear pain or ringing				

_____ _____ _____

Client/Authorized Person Signature **Witness** **Date**

Symptom and Ailments Questionnaire #3

Please check the appropriate box for each question.

Symptoms and Ailments	***YES***	***NO***
Have you taken multiple courses of a broad-spectrum antibiotic drug—even in a single dose?		
Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems		
Are you bothered by memory or concentration problems e.g. do you sometimes feel 'spaced out'?		
Do you feel 'sick all over' yet, in spite of visits to many different physicians, no cause has been		
Have you been pregnant?		
Have you taken birth control pills longer than 2 years?		
Have you taken steroids orally, by injection or inhalation?		
Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke symptoms?		
Does tobacco smoke *really* bother you?		
Are your symptoms worse on damp, muggy days or in moldy places?		
Have you had athlete's foot, ringworm, 'jock itch' or other chronic fungus infections of the skin or		
Do you crave sugar?		
Do you have high blood pressure?		
Have you ever had angina or a heart attack?		
Have you ever had a stroke?		
Do you have diabetes?		
Do you have swelling that is not known to be the result of another health issue?		
Do you smoke?		
Do you have high cholesterol?		
Have you ever had coronary bypass surgery?		
Is there history of heart disease in your family?		
Are you using any prescription medications or supplements? Please list below:		
Medications: Supplements:		

What did you have for breakfast: _____?
Lunch (yesterday or today):_____
Dinner (yesterday):_____
Snacks (past 24 hours):_____
Beverages (past 24 hours):_____

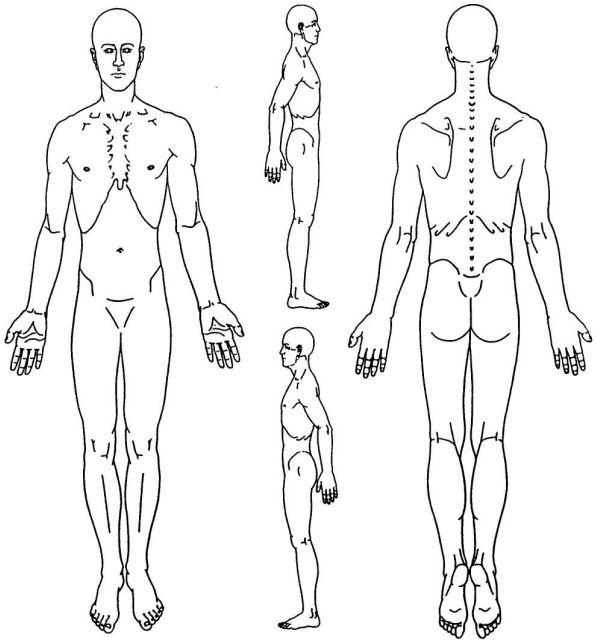
_____ _____ _____ _____
Client/Authorized Person Signature **Witness** **Date**

Pain Symptoms Questionnaire

Please check the appropriate box for each question.

Using the diagram below, indicate any areas you are feeling pain by marking a

PPP = Pain NNN= Numbness TTT = Tingling BBB = Burning CCC= Cramping XXX = Other



On a scale of 1-10, with 10 being the worst possible pain, what is your level of pain?

1 2 3 4 5 6 7 8 9 10

Please indicate any other symptoms that you have experienced:

_ Dizziness _ Memory Loss _ Numb Feet/ Toes
_ Irritability _ Ears Ringing _ Back Pain
_ Difficulty Sleeping_ Fatigue _ Jaw Problems _ Chest Pain _ Arm/ Shoulder Pain_ Leg Pain _ Back Stiffness
_ Blurred Vision _Numb Hand/ Fingers _ Tension
_ Low Back Pain _ Neck Stiffness _Shortness of Breath
_ Nausea _ Buzzing in Ear _ Neck Pain _ Upset Stomach_

Circle Quality of Pain:

Stabbing Shooting Dull Constant Intermittent Better /Worse with heat Better/Worse with ice
Better/Worse with movement Better/Worse sitting Better/Worse standing Better/Worse lying down

If yes,
How many days a week do you exercise? _____ how long? _____
What type of exercise (s)? _____
Have you ever seen a pain management specialist? NO__ YES__
If yes, what treatments are you currently receiving on a regular basis? (Adjustments, physical therapy, medication…)_____

_____ _____ _____

Client/Authorized Person Signature **Witness** **Date**

Environmental Profile:

According to the World Health Organization, as much as 65% of all illnesses can be caused or made worse by the indoor environment. Numerous chronic diseases, which were once rare, are becoming commonplace as the levels of toxins present in our environment continue to escalate. Many times medical treatments are rendered ineffective if the environment in which a client lives is not conductive to the healing process. During the course of your consultation program, the consultant will obtain a complete profile of your living environment. This will enable **Amazing Natural Health Practitioners Group** to determine if your illness is probably caused or worsened by your living or working environment and to specifically individualize a suggested program for optimal results.

Please answer the following questions by checking YES or NO:

Question	Yes	No
Are pesticides in your home or office?		
Do you use natural cleaning and laundry products?		
Is the construction of your house less than 15 years old?		
Have you had plumbing leakage, wet carpets or other water damage anywhere in your home?		
Do you have animals live indoors?		
Do you or your neighbors use lawn chemicals?		
Do you have moldy odors, mildew or visible molds anywhere in your home?		
When turning on your heating or air conditioning system(s) do you smell foul or moldy odors?		
Does the dust in your home reappear shortly after dusting?		
Do you have "blown-in" insulation in your attic?		
Are you, or is anyone in your home, experiencing any chronic ailments such as asthma, allergies, sinus infections, respiratory problems, or frequent cold or flu-like symptoms?		
Have you ever had bird, rat, mouse or any rodent infestation in your home?		
Do you have a "crawlspace" or an unfinished basement in your home?		
Do you feel better after you leave your home or office for an extended period?		
Do you use only natural products for your skin?		
Do you have moldy odors or visible molds in your workplace?		
Has there ever been water stains on the ceiling tiles, chemical odors, dirty air vents or excessive dust intrusion in your home or workplace?		
Do you frequently feel tired or run-down at the end of a workday?		
Is smoking permitted in your workplace or home?		
Do you have carpeting in your home or office?		
Do you use a filter for all drinking, cooking and shower/bath water?		
Do you have an air filter in your home or work place?		

What is your current occupation? _____
If less than one year, what was your prior occupation? _____

_____ _____ _____
Client/Authorized Person Signature **Witness** **Date**