					Today's Date:						
Client Information											
irst Name: Last Name:					Sex: □ M □ F	Birth o	Birth date: / /				
Street Address:			City,	State and Zip (State and Zip Code:						
Home Phone: () Mobile Ph			none: ()			How did you find us?					
Email Address:			,								
1)											
List your top 3 health concer											
List your top 3 health concerns: 2) 3)											
Every day I consume: (1 serving = 1 cup) Please check number that applies to you:											
Servings of fresh fruits			more	4	3	2 1 0					
Servings of vegetables, salads and green foods			more	4	3	2	1	□ 0			
Servings of water			more	4	3	2	1	0			
Number of hours of sleep per nigl	ht	□ 8 + 0	or more	D 7	□ 6	5	4	3	2	1	0
Number of bowel movements per		☐ Diar	rhea	4	3	2	1	☐ Constip	ated		
I usually use the following oils when I cook			onut	□ Butter	☐ Olive	☐ Canola		-		☐ Shor	tening
I use the following to balance the flora in my gut			lophilus	□ Probiotics	□ Kefir	☐ Yogurt		How often?		/day	
	□ White sug		•					•		_	
I use the following sweeteners			☐ Brown sugar ☐ Splenda		☐ Honey	☐ SweetNLow		U Stevia	□Stevia □ Xylitol		Οί
I currently have some of the following symptoms (Check all that apply)											
☐ History of ulcers or gastritis ☐ Frequent heartburn or indigesti					· ·			☐ Acid reflux after eating			
☐ Frequent use of antacids	antacids				☐ Freque	ent belching					
☐ Right shoulder pain/pain by scapula ☐ Frequent belch				ching	ing Gallbladder issues						
☐ Pain or tenderness under right rib cage ☐ Pain between				shoulder blades 🔲 Gas							
☐ Suffer from panic attacks				☐ Feel exhausted all the time/ tired for no reason							
☐ Consistently have low blood pressure				☐ Feel worse after exercising, not energized							
☐ Feel dizzy upon standing				☐ Have trouble getting up and out of bed in the morning							
☐ Frequent anxiety				☐ Have dark circles under my eyes ☐ Light sleeper and/or suffer from insomnia							
☐ Often told that I am too serious or intense☐ Often edgy or pessimistic☐				☐ Allergies and/or my nose runs frequently							
☐ Often feel my best before 6 p.m.				☐ Crave chocolate or salty foods (circle which)							
☐ Short term memory loss/brain fog				☐ Often suffer from headaches, migraines and muscle cramps							
□ Low sex drive				☐ Frequently have nightmares							
☐ Trouble staying focused on my job while working				□ Sometimes wake up between 3 and 4 a.m.							
☐ Cold hands or feet ☐ Heart palpit					☐ Feel cold most of the time						
☐ Hard time losing weight ☐ Frequent feeli											
· · · ·				☐ Ringing in my ears, carpal tunnel or canker sores							
☐ Infertility problems			☐ Vertical ridges on my nails or my nails crack and/or peel ☐ History of "yo-yo" dieting								
☐ My hair is falling out or thinning☐ I have an energy drop in the afternoon				☐ I have a voice strain							
☐ I have dry skin				☐ Eyebrows are thinning							
☐ My pulse is < 70 or > 90				☐ Often feel my heart pounding							
☐ I have missing patches of skin pigmentation				☐ Panic of anxiety attacks in the past							
☐ I have muscle aches or cramps often				☐ Dark patches or rough skin on my elbows or heels							
☐ Family history of breast cancer ☐ Frequent headaches				☐ My tongue is wide ☐ Frequently taken birth control pills or Aspirin in the past							
☐ My periods are irregular or very heavy				☐ I have elevated cholesterol							
☐ White spots/transverse lines on nails ☐ Dandruff				☐ Delayed wound healing ☐ Alcoholism					m		
-				a (toxemia) in pregnancy Eczema and/or psoriasis							

☐ Do you have foamy bubbles in your urine when you urinate?				☐ Do you have bleeding gums?					
Do you have increased secretions in mouth/nose/eyes?				Do you have edema (fluid) in your hands or feet?					
☐ I have trigger point pain in the muscles across the upper shoulders				☐ Dry skin, dandruff, hair loss			☐ Asthma		
☐ History of frequent canker sores, cold blisters, or boils				☐ Painful ribs or pain on inhalation			☐ Pain in lower back & buttocks		
☐ Dry, itchy eyes or mouth ☐ Poor memory ☐ Unable to				become relaxed or become serene			☐ Crave sugar ☐ Depression		
☐ Frequent sore or irritated throat, sores on tongue or in the mouth							☐ History of speech impediment		
☐ Foul odor to breath and/or white film on tongue ☐ Unusua				arge appetite		☐ Abdon	☐ Itchy skin		
☐ Intense cravings for sugars, sweets and breads ☐ Frequent stomach pains and digestion problems									
How much bread do you consume daily?									
MALE ONLY SECTION									
☐ Prostate problems (BPH) ☐	Impotence	☐ Frequent (urina	tion 🔲 Bla	dder irritation		Low sex o	lrive	
		FEMALE OF	NLY S	SECTION					
☐ Do you have premenstrual brea	☐ Do you have premenstrual breast tenderness? ☐ Polycystic ovaries ☐ Osteoporosis ☐ Foggy thinking								
☐ Do you have premenstrual fluid	d retention and w	eight gain?			☐ Premenstru	trual headaches			
☐ Migraine headaches		☐ Acceleration of	the a	aging process Severe menstrual cramps					
☐ Do you have heavy periods wh	ile clotting?				☐ Do you have irregular menstrual cycles?				
☐ Are you or have you taken any	estrogen support				☐ Do you have uterine fibroids				
☐ Do you have endometriosis?		☐ Dry eyes		☐ Irritability	☐ Started me	enstruation before age 13			
☐ Decreased libido	☐ Have you had problems with infertil			<i>ı</i> ?	miscarriage				
☐ Anxiety or panic attacks	☐ Do you have p	oremenstrual mood s	wing	s?	☐ Foggy think	inking			
☐ Inability to lose weight	☐ Acne	☐ Mood swings		☐ Headaches	☐ Racing mind		☐ Erectile Dysfunction		
☐ Low blood sugar	☐ I have an inventive mind			☐ Hair loss	☐ Insomnia		☐ ADD and/or ADHD		
☐ Urinary tract infections	□ Nervousness			☐ Tendonitis ☐ Vegetarian		□ Unexplained Nausea			
☐ Excessive sexual desire	☐ I stutter ☐ Vaginal dryness			☐ Chronic yeast or infections			☐ I have a copper IUD		
☐ I crave carbohydrates ☐ High blood pressure ☐ Muscle aches or pains in low back and/legs									
I have had the following health	conditions:								
☐ Seizures		High cholesterol			☐ Frequent	constipa	tion		
☐ Bypass surgery - Date of Surgery:									
□ Stroke - Date of Stroke:									
☐ Heart failure and/or heart atta	ack - Date of Hear	t Attack:							
□ Pace maker - Date Installed:									
☐ Surgeries - Date & Reason:									

Tobacco Use: ☐ Never ☐ Quit years ago ☐ Current user T	ype of tobacco used?						
□ Diabetes Age at onset? □ Type 1 □ Type 2 □ I use insulin Amount of insulin used?							
☐ Excessive thirst & appetite ☐ Increased urination	☐ Cuts/bruises that are slow to heal	☐ Blurred vision					
☐ Tingling/numbness in the hands/feet	☐ Recurring skin, gum or bladder infections						
I drink: ☐ Soda(s)/day ☐ Diet soda(s)/day I drink alcoholic beverages a day							
Color of stools: ☐ Brown ☐ Orange ☐ Yellow ☐ White ☐ Black ☐ Green							
☐ Are you taking any steroid medications?	☐ Have you had an organ transplant?	☐ Do you have gout?					
☐ Are you taking birth control? ☐ Are you pregnant or nursing?	☐ Do you take any diuretics?	☐ Allergy to hCG?					
☐ Do you have cancer and/or are you receiving cancer treatments?							
I take the following medications/vitamins/herbs/over the counter drugs:							
I understand that Mary Theresa Jurnack is not a medical doctor and does not directly dispense medical advice or prescribe the use of herbs or supplements as a form of treatment for any illness, including COVID19. The information provided is for educational purposes only and is not a substitute for professional medical advice. I understand that Mary Theresa Jurnack disclaims any liability if anyone uses or prescribes any remedies, natural or otherwise, for him/herself or another. I understand that I am to consult a licensed medical professional if I am seeking medical advice, diagnosis or treatment. I aim to accurately represent to Mary Theresa Jurnack the information I provide. I acknowledge that I am participating voluntarily in using any information Mary Theresa Jurnack provides to me and that I am solely and personally responsible for my choices, actions, and results, now and in the future. I accept full responsibility for the consequences of my use, or non-use, of any information provided, and I agree to use my own judgement and due diligence before implementing any idea, suggestion or recommendation from Mary Theresa Jurnack to my life. By working with Mary Theresa Jurnack, I agree to absolve Mary Theresa Jurnack of any liability or loss that I or any other person may incur from use of the information Mary Theresa Jurnack provides.							
Printed Name: Si	ignature:						
Guardian of (for those under 18):							
Date:							