

						Today's Date:			
Client Information									
First Name:		Last Name:			Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Birth date: / /		
Street Address:				City, State and Zip Code:					
Home Phone: ()		Mobile Phone: ()			How did you find us?				
Email Address:									
<i>List your top 3 health concerns:</i>				1)					
				2)					
				3)					
Every day I consume: (1 serving = 1 cup) Please check number that applies to you:									
Servings of fresh fruits		<input type="checkbox"/> 5 or more	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		
Servings of vegetables, salads and green foods		<input type="checkbox"/> 5 or more	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		
Servings of water		<input type="checkbox"/> 5 or more	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		
Number of hours of sleep per night		<input type="checkbox"/> 8 + or more	<input type="checkbox"/> 7	<input type="checkbox"/> 6	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 0
Number of bowel movements per day		<input type="checkbox"/> Diarrhea	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> Constipated		
I usually use the following oils when I cook		<input type="checkbox"/> Coconut	<input type="checkbox"/> Butter	<input type="checkbox"/> Olive	<input type="checkbox"/> Canola	<input type="checkbox"/> Vegetable		<input type="checkbox"/> Shortening	
I use the following to balance the flora in my gut		<input type="checkbox"/> Acidophilus	<input type="checkbox"/> Probiotics	<input type="checkbox"/> Kefir	<input type="checkbox"/> Yogurt	How often?		/day	
I use the following sweeteners		<input type="checkbox"/> White sugar	<input type="checkbox"/> Brown sugar	<input type="checkbox"/> Splenda	<input type="checkbox"/> Honey	<input type="checkbox"/> SweetNLow	<input type="checkbox"/> Stevia	<input type="checkbox"/> Xylitol	
I currently have some of the following symptoms (Check all that apply)									
<input type="checkbox"/> History of ulcers or gastritis		<input type="checkbox"/> Frequent heartburn or indigestion with nausea and pain				<input type="checkbox"/> Acid reflux after eating			
<input type="checkbox"/> Frequent use of antacids		<input type="checkbox"/> Stomach pain relieved by eating			<input type="checkbox"/> Frequent belching		<input type="checkbox"/> Arm, shoulder or neck pain		
<input type="checkbox"/> Right shoulder pain/pain by scapula			<input type="checkbox"/> Frequent belching			<input type="checkbox"/> Gallbladder issues			
<input type="checkbox"/> Pain or tenderness under right rib cage			<input type="checkbox"/> Pain between shoulder blades			<input type="checkbox"/> Gas			
<input type="checkbox"/> Suffer from panic attacks				<input type="checkbox"/> Feel exhausted all the time/ tired for no reason					
<input type="checkbox"/> Consistently have low blood pressure				<input type="checkbox"/> Feel worse after exercising, not energized					
<input type="checkbox"/> Feel dizzy upon standing				<input type="checkbox"/> Have trouble getting up and out of bed in the morning					
<input type="checkbox"/> Frequent anxiety				<input type="checkbox"/> Have dark circles under my eyes					
<input type="checkbox"/> Often told that I am too serious or intense				<input type="checkbox"/> Light sleeper and/or suffer from insomnia					
<input type="checkbox"/> Often edgy or pessimistic				<input type="checkbox"/> Allergies and/or my nose runs frequently					
<input type="checkbox"/> Often feel my best before 6 p.m.				<input type="checkbox"/> Crave chocolate or salty foods (circle which)					
<input type="checkbox"/> Short term memory loss/brain fog				<input type="checkbox"/> Often suffer from headaches, migraines and muscle cramps					
<input type="checkbox"/> Low sex drive				<input type="checkbox"/> Frequently have nightmares					
<input type="checkbox"/> Trouble staying focused on my job while working				<input type="checkbox"/> Sometimes wake up between 3 and 4 a.m.					
<input type="checkbox"/> Cold hands or feet			<input type="checkbox"/> Heart palpitations			<input type="checkbox"/> Feel cold most of the time			
<input type="checkbox"/> Hard time losing weight			<input type="checkbox"/> Frequent feeling of depression			<input type="checkbox"/> Usually gain weight under my waist			
<input type="checkbox"/> Nod off easily or have sleep apnea				<input type="checkbox"/> Ringing in my ears, carpal tunnel or canker sores					
<input type="checkbox"/> Infertility problems				<input type="checkbox"/> Vertical ridges on my nails or my nails crack and/or peel					
<input type="checkbox"/> My hair is falling out or thinning				<input type="checkbox"/> History of "yo-yo" dieting					
<input type="checkbox"/> I have an energy drop in the afternoon				<input type="checkbox"/> I have a voice strain					
<input type="checkbox"/> I have dry skin				<input type="checkbox"/> Eyebrows are thinning					
<input type="checkbox"/> My pulse is < 70 or > 90				<input type="checkbox"/> Often feel my heart pounding					
<input type="checkbox"/> I have missing patches of skin pigmentation				<input type="checkbox"/> Panic of anxiety attacks in the past					
<input type="checkbox"/> I have muscle aches or cramps often				<input type="checkbox"/> Dark patches or rough skin on my elbows or heels					
<input type="checkbox"/> Family history of breast cancer				<input type="checkbox"/> My tongue is wide					
<input type="checkbox"/> Frequent headaches				<input type="checkbox"/> Frequently taken birth control pills or Aspirin in the past					
<input type="checkbox"/> My periods are irregular or very heavy				<input type="checkbox"/> I have elevated cholesterol					
<input type="checkbox"/> White spots/transverse lines on nails			<input type="checkbox"/> Dandruff		<input type="checkbox"/> Delayed wound healing			<input type="checkbox"/> Alcoholism	
<input type="checkbox"/> Decrease in taste or smell sensation			<input type="checkbox"/> Pre-eclampsia (toxemia) in pregnancy			<input type="checkbox"/> Eczema and/or psoriasis			

Tobacco Use: Never Quit _____ years ago Current user --- Type 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 Journack 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 Journack 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 Journack the information I provide. I acknowledge that I am participating voluntarily in using any information Mary Theresa Journack 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 Journack to my life. By working with Mary Theresa Journack, I agree to absolve Mary Theresa Journack of any liability or loss that I or any other person may incur from use of the information Mary Theresa Journack provides.

Printed Name: _____

Signature: _____

Guardian of (for those under 18): _____

Date: _____