Lifestyle Intake Form

1 General

Name_____ Date_____ Age_____ Sex M/F

How did you hear about my service? _____

What are your health goals/concerns? _____

What is your occupation? _____

Do you enjoy you work? ❑ yes ❑ no ❑ sometimes What hours do you work?

_____

Do you presently use any of the following services:

❑ chiropractor ❑ acupuncture ❑ homeopath ❑ relaxation techniques (Yoga, massage etc) ❑ naturopath

❑ osteopath ❑ therapist or emotional consultant ❑ physiotherapist ❑ herbalist ❑ personal trainer

2 Habits

How many hours do you sleep? _____ Do you use sleep aids regularly? ❑ yes ❑ no

What time do you go to sleep? _____ What time do you wake? _____

Do you have trouble falling asleep? ❑ Staying asleep? ❑ Do you awaken rested? ❑ Do you snore? ❑

Do you feel energetic right now? ❑ yes ❑ no Do you feel energetic most of the time? ❑ yes ❑ no

Do you have any energy lulls during the day? ❑ yes ❑ no Times: _____

Do you smoke? ❑ yes ❑ no How long? _____ Does anyone in your house smoke? ❑ yes ❑ no

What do you do for exercise? (indicate type/frequency/and time)

_____

How many hours a day on average do your spend:

alone _____ driving_____ watching television_____ reading_____ computer?_____

Do you use natural toothpaste? ❑ yes ❑ no Do you use natural deodorant? ❑ yes ❑ no

3 Stress

What level of stress do you feel you are experiencing at this time? 1-10 (10 is most) _____

Can you relate the stress to anything? ❑ financial ❑ career ❑ personal ❑ marriage ❑ health ❑ family ❑ other (please elaborate)_____

How does your stress manifest itself?_____

Do you use any coping mechanisms?_____

Do you feel anxious? ❑ yes ❑ no ❑ Sometimes Are you a worrier? ❑ yes ❑ no ❑ Sometimes

Do you feel depressed? ❑ yes ❑ no ❑ Sometimes Related to?

_____

4 Medical Information

When did you last visit your medical doctor? _____

What did he/she find? _____

Have you ever been diagnosed with an ailment related to your main health goal/concern? Explain.

_____

Were you hospitalized? _____

Have you had surgery? ❑ gallbladder ❑ tonsils ❑ appendix ❑ other

_____

Have you ever had a serious accident? _____

Have you experienced any other major trauma or loss in the past 5 years? Specify.

_____

Are you currently taking medication? ❑ yes ❑ no

List/reason_____

Do you have allergies? Please list: _____

Have you had many antibiotics? _____ Did you have ear infections as a child? ❑ yes ❑ no

Heredity diseases (indicate M (mother), F (father), S (sibling), G (grandparent), O (other)):

____Allergies ____Autoimmune Disease ____Gall Bladder ____Kidney dysfunction

____Alcoholism ____Cancer (type) ____Heart disease ____Mental illness

____Arthritis ____Diabetes ____Hypertension ____Osteoporosis

____Asthma ____Drug Abuse ____Intestinal disease ____Skin conditions _____Ulcers

Do you have many dental amalgams? ❑ yes ❑ no Have you had any root canals? ❑ yes ❑ no

Females

Did you ever take birth control? For how long and when? _____

Are you or could you be pregnant? ❑ yes ❑ no Are you peri-menopausal or menopausal? ❑ yes ❑ no

Do you experience PMS? ❑ yes ❑ no Bone density test? ❑ yes ❑ no Result? _____

Are you experiencing any menopausal symptoms? ❑ yes ❑ no _____

Males

Have you experienced any prostate issues (frequent urination, discomfort urinating) ❑ yes ❑ no

Have you experienced fungal infection? (eg. jock itch, athlete's foot) ❑ yes ❑ no

Are you irritable? ❑ yes ❑ no Lost sexual interest? ❑ yes ❑ no

5 Digestion Habits

Do you regularly eat ❑ breakfast ❑ lunch ❑ dinner? Do you snack during the day? ❑ yes ❑ no

Are you a: ❑ meat eater ❑ vegetarian ❑ vegan?

How often do you eat meat? _____ cow dairy? _____ soy products? _____ candy? _____ fruit? _____

chocolate? _____ fried foods? _____ margarine? _____ vegetable oils? _____ vegetables? _____

Which vegetables do you eat regularly? _____

What is a typical: Breakfast_____

Lunch_____

Dinner_____

Snacks _____

What are your favourite foods?_____

Do you avoid certain foods? Why?_____

Do you crave certain foods? _____

Do you experience any symptoms if meals are missed? _____

Do you experience any symptoms after meals? Explain? _____

Please indicate how many cups of the following you drink per day:

_____ beer _____ wine _____ other alcoholic beverage

_____ coffee _____ tea _____ bottled/spring water

_____ tap water _____ herbal tea _____ fresh fruit juices

_____ diet soft drink _____ regular soft drink

_____ whole milk _____ 1% or 2% milk _____ other. Specify _____

Do you eat or use: Indicate 1 rarely 2 regularly 3 often

aluminum pans ____ microwave ____ refined foods ____ luncheon meats ____ fast foods ____

Nutra-Sweet/Aspartame/Splenda ____

List any vitamins/minerals/herbal or homeopathic remedies you are currently taking and the amounts/dosage?

_____

_____

Do you move your bowels regularly? ❑ yes ❑ no How frequently?

_____

Do you **strain** to have a bowel movement? ❑ yes ❑ no ❑ Occasionally Use laxatives often? ❑ yes ❑ no

Related to a particular food/circumstance? _____

Do you have **loose** bowel movements? ❑ yes ❑ no ❑ Occasionally

Related to a particular food/circumstance? _____

Ionic Foot Detox Consent Form

Date:_____ Birthdate:_____

Full Name:_____

Mailing address:_____

Ph # _____ email:_____

Cell # _____ check the box to receive monthly newsletter ☐

General Information

Have you ever had an Ionic Foot Detox? Y/N

What are your reasons for having a session today? _____

Current Medications you are taking: _____

Any Allergies? _____

Any Supplements? _____

Diet information: Do you consume coffee/ tea/soda/dairy/ meat/grains/ sugar/ fried food/ fast food/ alcohol/ tobacco/ drugs

Are you currently being treated by a Physician? _____

Contradictions to using the Ionic Foot Bath: Any of the following you would not be a candidate for the Ionic Foot Bath. If you have questions about this, please ask.

Do you where a pacemaker, metal or electromagnetic device? Y/N

Have you had a heart transplant? Y/N Another organ transplant Y/N

Do you have very high Blood Pressure? Y/N

Any open wounds on the feet? Y/N (if yes, may we soak you hands instead?)

I take medications to regulate epilepsy or psychotic episodes Y/N

Certain Diseases would but a contradiction/ please name any you may have _____

Are you Pregnant? Y/N Breastfeeding? Y/N

Are you a blood cancer patient? Y/N currently receiving chemo or radiation treatment Y/N

Is there any else that you feel you should let me know? _____

I, the undersigned, consent to the Ionic Detox therapy Foot bath treatment. I understand that this procedure is used for the purpose of detoxification and is not intended to take the place of medical care or medications. I clearly confirm that I do not have any contradictions to the Ionic Foot Detox therapy foot bath (as noted above) I understand that I take full responsibility for my own health and well being. I will place everything I have brought with me in the basket provided, including watches, credit cards, all jewelry, hairpins, hearing aids, cell phones, kindles, I-pads and any other electronic devices I have with me, failure to do so will be at my own personal expense.

Client Signature: _____ Date: _____

Therapists Signature: _____ Date: _____

Although not dangerous it is recommended for those with low blood sugar eat before the treatment.

Some more information:

Those taking Medications should take them 4 hours prior or after treatment

Because the Ionic Detox is designed to aid the body in eliminating toxins that the liver and kidneys can not eliminate on there own, and as a rule can be used by those on dialysis or diagnosed with diabetes or with congestive heart failure. However, persons with these conditions should consult their physician prior to using the Ionic Foot Detox system

Please understand that although safe to use with metal implants you may experience a warm feeling in the area of the implant.

Some side affects can include fatigue and headache. These will lesson with subsequent visits.

Reiki/Reflexology/Massage Client Consent Form

Client name: _____ Date of birth: _____

Address: _____

Phone: _____ Alt Phone: _____

Emergency name & ph.# _____

Client signature: _____ todays date: _____

Receive monthly newsletter? Yes/no email: _____

Reiki- A gentle holistic therapy using universal energy to assist the body's natural ability to heal. Using gentle hands on or above the client energy passes through practitioner to client. Reiki seeks out the root of stress and imbalances, promoting relaxation and restore your innate sense of wellbeing

Reflexology- By applying pressure to the reflex points of the feet, all organs, glands and structures of the body can be stimulated and encouraged to heal. Soothe away stresses and strains of everyday life

Holistic Massage- Holistic massage is a broad term that can include relaxational and deep tissue methods. Your holistic massage is designed for optimal relaxation to allow muscle release and a time for you to destress.

These therapies are not a diagnosis and shouldn't take the place of medical advice but can be used in addition to and to compliment treatments or diagnosis. If you experience any side effects, please discontinue use. For any serious side effects please your doctor.

Benefits of these therapies include:

~Relaxation and sense of peace

~Feeling of wellbeing

~manage and alleviate stress

~Improved Circulation

~ reduction of inflammation

~ Accelerates one's own healing system

Please indicate any of the following that apply to you:

- ○ Breastfeeding yes/no
- ○ Neuropathy
- ○ Use a pacemaker
- ○ Any metal implants
- ○ Fibromyalgia
- ○ Recently hospitalized
- ○ Joint replacement(s)
- ○ Arthritis
- ○ Have you had surgery
- ○ High/low blood pressure
- ○ Blood Clots?
- ○ Heart issues
- ○ Kidney Dysfunction
- ○ Numbness
- ○ Circulatory problem
- ○ Stroke
- ○ Heart Attack
- ○ Diabetes? Yes/No
- ○ Sprains/Strains
- ○ Cancer

Reiki/Reflexology/Massage Client Consent Form

○ Epilepsy? Yes/No ○ Headaches/migraines

Are you Pregnant? Yes/No How far along?_____ Any risk factors? _____

_____

○Do you wear prostheses? Artificial limb, hearing aid?

○Do you smoke?

○Do you have Allergies? Sensitivities? Yes/No Explain? _____

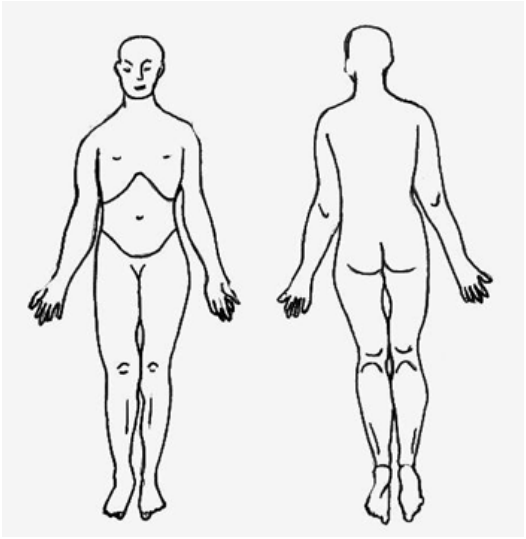
Health Concerns: _____

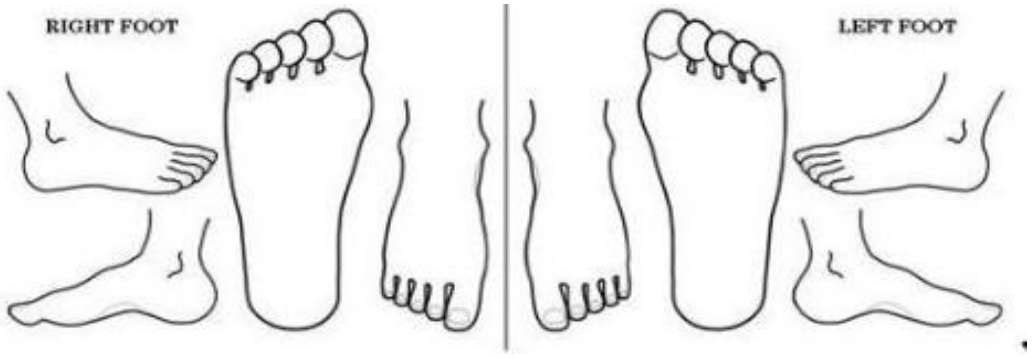
_____

Areas of the body experiencing pain: _____

Why are you seeking Reiki/Reflexology/ massage?_____

Please circle areas of the body experiencing pain





Becky Dixon CNC, NNCP

Reiki/Reflexology/Massage Client Consent Form

Client Statement

I understand and acknowledge that Becky Dixon is dedicated to protecting and advancing the general well-being of clients in a natural way and is not operating as a centre for the treatment of disease or illness.

The services performed by Becky Dixon is at all times restricted to consultation on the subject of health matters intended for general well-being and do not involve the diagnosing, prognosticating, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine in this province. I understand that he/she is not a medical practitioner, naturopath or dietician.

I am aware that all activities, programs and services offered are educational, recreational or self-directed in nature. I assume full responsibility during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health (physical, mental or emotional) and the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, program or service of Nutrition Counseling brings with it the assumption by me of those risks or results stemming from these choices and the fitness, health, awareness, care and skill that I possess and use. I understand that I am free to withdraw from, reduce or modify my involvement in any program/activity and I realize that I should do so upon recognition of any signs of transient light-headedness, fainting, chest discomfort, cramps, nausea, allergic reaction etc.

I also acknowledge that I have inquired about the nature of any activity, program or service that I am not completely familiar with and I have been informed of any inherent risks.

I understand that all the information which I provide is purely for the purpose of assessment and that no information will be disclosed to others or used in any other manner without my written permission.

This statement is being signed voluntarily.

Date: _____ Signature: _____

Name: _____

Address:_____

City: _____Province _____ Postal Code _____

Phone:_____ Email: _____