Restoring Eden Holistic Health and Wellness Center

clients4restoringeden@gmail.com restoringeden4naturalhealth.com 603-338-8797

Name:_____ Date:_____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work #: _____Cell #:_____

Occupation:_____ Hours of work per week: _____

Age: ___ Birth Date: _____ Current weight: _____ Weight one year ago: _____

Email address: _____ Relationship status: _____

Children: _____ Ages: _____

Pets:_____ How did you hear about us? _____

Present Complaints: List your main health problems:

1._____When did it start?_____

2._____When did it start_____

3._____When did it start?_____

4._____When did it start?_____

5._____When did it start?_____

Medication list:

_____

_____

_____

At what point in your life did you feel best?

_____

_____

_____

What are your health goals?

1._____

2._____

3._____

Level of commitment? _____

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Key: 0=no, symptom does not occur 2=Moderate symptom, occurs weekly

1=Yes, mild symptom, rarely occurs 3=Severe symptom, occurs daily

Section 1– Read each symptom and circle the number that applies

1. 0 1 2 3 Heartburn or Acid Reflux
2. 0 1 2 3 Burping or Gas after eating
3. 0 1 2 3 Bloating after eating
4. 0 1 2 3 Bad breath
5. 0 1 2 3 Sweat has a strong odor
6. 0 1 2 3 Feel better if I don't eat
7. 0 1 2 3 Sleepy after meals
8. 0 1 2 3 Burning pain in stomach
9. 0 1 2 3 Fingernails chip, break, peel
10. 0 1 2 3 Anemia unresponsive to iron
11. 0 1 2 3 Stomach pain or cramps
12. 0 1 2 3 Diarrhea, chronic
13. 0 1 2 3 Diarrhea after meals
14. 0 1 2 3 Black or dark stool
15. 0 1 2 3 Undigested food in stool

Section 2– Read each symptom and circle the number that applies.

16. 0 1 2 3 Skip days between stools
17. 0 1 2 3 Stools hard or difficult to pass
18. 0 1 2 3 Cramping on lower abdomen
19. 0 1 2 3 Blood in stool
20. 0 1 2 3 Mucus in stool
21. 0 1 2 3 IBS or colitis
22. 0 1 2 3 Yeast Infections
23. 0 1 2 3 Nail fungus or athletes foot
24. 0 1 2 3 Dark circles under eyes
25. 0 1 2 3 History of parasites
26. 0 1 2 3 Coated tongue
27. 0 1 2 3 Anus itches
28. 0 1 2 3 Constipation
29. 0 1 2 3 Stools are loose
30. 0 1 2 3 Bad smelling gas

Section 3– Read each symptom and circle the number that applies.

31. 0 1 2 3 Food allergies
32. 0 1 2 3 Bloating after eating
33. 0 1 2 3 Airborne allergies
34. 0 1 2 3 Wheat or gluten sensitivity
35. 0 1 2 3 Dairy sensitivity
36. 0 1 2 3 Sinus congestion
37. 0 1 2 3 Craves bread and pasta
38. 0 1 2 3 Pulse speeds after eating
39. 0 1 2 3 Nightmares
40. 0 1 2 3 Feel spacy or unreal
41. 0 1 2 3 Alternating diarrhea/ constipation
42. 0 1 2 3 Hives

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Section 4– Read each symptom and circle the number that applies.

43. 0 1 2 3 Nausea
44. 0 1 2 3 Pain between shoulder blades
45. 0 1 2 3 Skin rashes, acne, eczema, etc.
46. 0 1 2 3 Age or "Liver" spots
47. 0 1 2 3 Greasy foods upset stomach
48. 0 1 2 3 Gallbladder attacks or stones
49. 0 1 2 3 Motion sickness
50. 0 1 2 3 Headache over eyes
51. 0 1 2 3 Easily intoxicated
52. 0 1 2 3 Hemorrhoids or varicose veins
53. 0 1 2 3 Sensitivity to perfumes or chemicals
54. 0 1 2 3 Pain under right rib cage
55. 0 1 2 3 Insomnia

Section 5– Read each symptom and circle the number that applies.

56. 0 1 2 3 Carpal Tunnel Syndrome
57. 0 1 2 3 Osteoporosis or Osteopenia
58. 0 1 2 3 Legs or foot cramps at rest
59. 0 1 2 3 Pain or swelling in joints
60. 0 1 2 3 Bursitis or tendonitis
61. 0 1 2 3 Joints pop or crack
62. 0 1 2 3 White spots on fingernails
63. 0 1 2 3 Decreased taste or smell

Section 6- Read each symptom and circle the number that applies.

64. 0 1 2 3 Intense Fatigue
65. 0 1 2 3 Brain Fog
66. 0 1 2 3 Memory loss short/long term
67. 0 1 2 3 Pain or swelling in joints
68. 0 1 2 3 Stiff joints in morning
69. 0 1 2 3 Muscle twitching
70. 0 1 2 3 Unexplained fevers
71. 0 1 2 3 Headaches/Migraines
72. 0 1 2 3 Poor concentration
73. 0 1 2 3 Sore soles of feet in morning

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Section 7– Read each symptom and circle the number that applies

74. 0 1 2 3 Body jerks as falling asleep
75. 0 1 2 3 Restless leg syndrome
76. 0 1 2 3 Small bumps on back of arms
77. 0 1 2 3 Heart races
78. 0 1 2 3 Worrier, anxious
79. 0 1 2 3 Nosebleeds
80. 0 1 2 3 Bruise easily
81. 0 1 2 3 Gums bleed easily
82. 0 1 2 3 Depressed regularly
83. 0 1 2 3 Numbness or tingling in body
84. 0 1 2 3 Loss of muscle tone

Section 8– Read each symptom and circle the number that applies.

85. 0 1 2 3 Difficulty falling asleep
86. 0 1 2 3 Slow starter in the morning
87. 0 1 2 3 Suddenly dizzy when standing
88. 0 1 2 3 Difficulty holding chiropractic adjust.
89. 0 1 2 3 Arthritis
90. 0 1 2 3 Crave salty food
91. 0 1 2 3 Headache after exercise
92. 0 1 2 3 Chronic low back pain
93. 0 1 2 3 Clench or grind teeth
94. 0 1 2 3 Perspire too easily
95. 0 1 2 3 Hives
96. 0 1 2 3 Bright light hurts eyes
97. 0 1 2 3 Slow recovery from stress

Section 9– Read each symptom and circle the number that applies.

98. 0 1 2 3 Difficulty losing weight
99. 0 1 2 3 Loss of outer 1/3 eyebrows
100. 0 1 2 3 Mentally sluggish
101. 0 1 2 3 Cold hands and feet
102. 0 1 2 3 Hair loss
103. 0 1 2 3 Easily fatigued
104. 0 1 2 3 Seasonal sadness
105. 0 1 2 3 Low body temperature
106. 0 1 2 3 Sensitive to iodine
107. 0 1 2 3 Fast pulse at rest
108. 0 1 2 3 Nervousness
109. 0 1 2 3 Sensitivity to cold
110. 0 1 2 3 Intolerant to heat
111. 0 1 2 3 Flush easily
112. 0 1 2 3 Heart palpitations

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Section 10- Read each symptom and circle the number that applies.

113. 0 1 2 3 Crave sweets
114. 0 1 2 3 Awaken in night, can't get back sleep
115. 0 1 2 3 Excessive appetite
116. 0 1 2 3 Crave coffee or sugar in afternoon
117. 0 1 2 3 Headache if meals are delayed
118. 0 1 2 3 Get shaky or weak if hungry
119. 0 1 2 3 Sleepy in afternoon
120. 0 1 2 3 Fatigue relieved by eating
121. 0 1 2 3 Afternoon headaches
122. 0 1 2 3 Irritable before meals

Section 11– *Men Only* - Read each symptom and circle the number that applies.

138. 0 1 2 3 Prostate problems
139. 0 1 2 3 Decreased libido
140. 0 1 2 3 Urination difficult
141. 0 1 2 3 Pain or burning with urination
142. 0 1 2 3 Fatigue
143. 0 1 2 3 Pain on inside of legs or heels
144. 0 1 2 3 Feeling of incomplete bowel elimination

Section 12- *Women Only* – Read each symptom and circle the number that applies.

123. 0 1 2 3 Painful menstrual cycle
124. 0 1 2 3 Mood swings around cycle
125. 0 1 2 3 Painful breasts at cycle
126. 0 1 2 3 Irregular cycles
127. 0 1 2 3 Heavy menstrual flow
128. 0 1 2 3 Acne at menstrual cycle
129. 0 1 2 3 Yeast Infections
130. 0 1 2 3 Endometriosis
131. 0 1 2 3 Uterine fibroids
132. 0 1 2 3 Fibrocystic breasts
133. 0 1 2 3 Hot flashes
134. 0 1 2 3 Vaginal itchiness
135. 0 1 2 3 Vaginal discharge
136. 0 1 2 3 Night sweats
137. 0 1 2 3 Menopausal symptoms

Section 13– Read each symptom and circle the number that applies.

145. 0 1 2 3 Shortness of breath with moderate exertion
146. 0 1 2 3 Opens windows in closed room
147. 0 1 2 3 Sigh frequently
148. 0 1 2 3 Bruise easily
149. 0 1 2 3 Muscle cramps during exercise
150. 0 1 2 3 Hands and feet go to sleep
151. 0 1 2 3 Dull pain in chest, worse on exertion

Section 14- Read each symptom and circle the number that applies.

152. 0 1 2 3 Pain upon urination
153. 0 1 2 3 Frequent bladder infections
154. 0 1 2 3 Cloudy, bloody, or dark urine
155. 0 1 2 3 Urine has strong odor
156. 0 1 2 3 History of kidney stones
157. 0 1 2 3 Pain in low back
158. 0 1 2 3 Puffy eyes or dark circles under eyes regularly

Section 15– Read each symptom and circle the number that applies.

159. 0 1 2 3 Catch colds/flu easily
160. 0 1 2 3 Runny or drippy nose
161. 0 1 2 3 Swollen lymph nodes
162. 0 1 2 3 Gets boils, cysts, styes
163. 0 1 2 3 Poor wound healing
164. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles or Chronic Fatigue

Section 16– Read each symptom and circle the number that applies.

165. 0 1 2 3 Use of pesticides in home
166. 0 1 2 3 Use of strong chemicals (bleach, polish, floor wax, window cleaner,etc)
167. 0 1 2 3 Exposed to tobacco, moth balls, incense, varnish, or dust.
168. 0 1 2 3 Treat home for insects
169. 0 1 2 3 Use of perfumes, hairspray, cosmetics, nail polish, etc.
170. 0 1 2 3 Exposed to diesel fumes, exhaust fumes, or gasoline fumes.

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Rate your overall stress level on a scale of 1 to 10. (10= high, 1= low)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is affecting your stress level the most?

What do you enjoy most in your life?

What do you worry about most in your life?

When it comes to FULLY committing to your desire to be healthy, what is getting in the way?

Who will sincerely support you consistently with the beneficial lifestyle changes you will be making?

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List any emotional or personal conflicts that you are exposed to repeatedly:

_____

_____

_____

_____

_____

How is your diet:

☐ Coffee:	_____ cups per:	☐ Day	☐ Week	☐ Month
☐ Soft drinks:	_____ cans per:	☐ Day	☐ Week	☐ Month
☐ Diet soda:	_____ cans per:	☐ Day	☐ Week	☐ Month
☐ Candy:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Chocolate:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Alcohol:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Fast Food:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Milk/cheese:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Fried foods:	_____ times per:	☐ Day	☐ Week	☐ Month

Current Diet Information: Give examples of what foods you typically eat daily:

Breakfast:

_____

Lunch:

_____

Snacks:_____

Dinner:

_____

Liquids:

_____

How many meals do you eat per day? _____ What meals do you skip?

_____

Do you cook? _____

What percentage of your meals are home-cooked? _____

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Family Health History:

☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Other: _____

Please list any surgeries, operations, traumas, car accidents, etc…

_____

_____

_____

What are your hobbies:

_____

_____

List any and all medications and current supplements or herbs you are taking:

_____

_____

_____

_____

_____

_____

_____

Anything else I should know?

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H.N.U.S. Analysis

Test will determine energetic imbalances indicating possible:

- Vitamin and Mineral Deficiencies
- Absorption/Digestive Disorders
- Enzyme Deficiencies
- Heavy Metal/Environmental Toxicity
- Pathogens
- Oxidative Stress Levels
- PH Issues
- Blood Sugar Imbalances
- Kidney and Liver Function
- Hormonal Imbalances

HNUS Instructions:

The first time you go to the restroom after 3:00 am, put urine on a Q-tip and place in a Ziploc bag. In the morning, before you brush your teeth, swab your mouth with a Q-tip and place in a Ziploc bag. Next, cut a lock of hair from around the neck area and place in a Ziploc bag. Last, cut some fingernails / toenails or both and place in a Ziploc bag. Please make sure you have your name and birthdate on the bag.

Please expect a 7-10 days for this test to be run. Along with analysis, a comprehensive health history will be collected, and results will be shared. A holistic and comprehensive plan will be co-created at an office visit.

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 I understand that the Qest4 survey does not provide medical diagnosis and that Restoring Eden Staff may recommend further medical testing. If I suspect that I need further medical intervention, I understand that I should consult MY physician. I give my permission for Restoring Eden Staff to evaluate me on the Qest4. I understand in doing so Restoring Eden Staff is NOT becoming my primary care physician. I understand that Restoring Eden Staff will give me information about myself and make recommendations based on the screening. I understand that Restoring Eden Staff will not pass judgements on prescribed medications and it is the responsibility of my primary care physician to make any changes to my prescribed medications. Any decision to follow through with the recommended program is my own decision and I hold Restoring Eden Staff harmless.

 I understand that the Qest4 screening does not diagnose diseases in the body. I understand that the role of Restoring Eden is not to prescribe, to diagnose, treat, or cure any disease, condition or other physical or mental ailment of the human body. Rather, Restoring Eden is a mentor and guide who has been trained in Holistic and Naturopathic health to help clients reach their own health goals by helping clients implement positive lifestyle changes. I understand that Restoring Eden is not acting in the capacity of a doctor, licensed dietician-nutritionist, psychologist, and that any advice given by Restoring Eden is not meant to take the place of advice by these professionals.

 I understand that I am here to learn about natural health and better lifestyle practices, and I will be offered information about food, supplements, and herbs as a guide to general health. I take full responsibility for my life and well-being, as well as the lives and well-being of my family and children (where applicable) and all decisions made while working with Restoring Eden. I assume risks of trying new foods or supplements, and the risks inherent in making lifestyle changes. I release Restoring Eden from any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in law or equity, which I ever had, now has, or will have in the future against Restoring Eden, arising from my past or future participation in programs and services.

 CONFIDENTIALITY: Restoring Eden will keep the client's information private and will not share the client's information to any third party unless compelled by law.

 ARBITRATION, CHOICE OF LAW AND LIMITED REMEDIES In the event that there ever arises a dispute be-tween Restoring Eden and the Client with respect to the services provided pursuant to this agreement or otherwise pertaining to the relationship between the parties, the parties agree to submit to binding arbitration before the American Arbitration Association. Any judgement on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall be conducted by a single arbitrator. The sole remedy that can be awarded to the Client in the event that an award is granted in arbitration is refund of fees. Without limiting the generality of the foregoing, no award of consequential or other damages, unless specifically set forth herein, may be granted to the Client.
 This agreement shall be construed according to the laws of the State of New Hampshire. If any provision of this agreement is deemed unenforceable, the remaining portions of the agreement shall be severed and remain in full force.

 If the terms of this agreement are acceptable, please sign the acceptance below. By doing so, the Client acknowledges that: he/she has received a copy of this letter agreement; he/she has had an opportunity to discuss the contents with Restoring Eden and, if desired, to have it reviewed by an attorney; and the Client understands, accepts, and agrees to abide by the terms hereof.

Client name: _____

Signature _____ Date:_____