Welcome to Vibrant Living Wellness Center

Where You Begin Healing With a Nourishing Lifestyle

Holistic nutrition evaluates health concerns by considering your body as a total system, unique to you. I, Leona Harter am here to assess all of your body systems, discover the origins of your health concerns, make recommendations, educate you, and guide you through your healing journey. Although I am here to help you, ultimately, the power of healing resides in you.

By assessing your family history, nutritional status, lifestyle, digestive function, food and environmental allergies, amino acid balance, metabolic function, and hormone levels, we can start to see patterns unique to your biochemical individuality and work to alleviate symptoms, balance body systems, and rejuvenate your health. I will evaluate the information you provide and make dietary and lifestyle suggestions that will help you feel better. It is up to you to follow the recommendations and be aware of the effects these changes have on your body and your mind. You may begin to feel relief within a couple of days, but more substantial changes will occur over time. Please remember to be patient and stay positive: it may have taken you years to develop your health concerns so expecting immediate results is impractical.

I am here to provide nutritional support and lifestyle management. To provide the best support, I need to know about your symptoms, health concerns, digestive wellness, and family history. Please complete the following questionnaires, being as honest and as detailed as possible.

In regards to the food intake journals, keep a detailed record of your food and liquid consumption for three days. Include preparation method (boiled, fried, sautéed, grilled) and portions. Please be detailed and specific. If a food you eat is not a part of your normal diet, note that as well. Note the fluctuations in your energy levels and mood throughout the day. Record any other observations you may have and supplements or medications you take.

Note that the information and recommendations I propose for you are not intended to diagnose, treat, or cure disease.

New Client Intake Form

Date____________________

Last name________________________First_____________________Middle____________

Date of Birth_________________________ Age___________ Gender_____________

Height__________ Weight____________ Desired Weight____________Blood Type:___________

Address____ City__________________

State_______ Zip__________ Home phone #____________________ Cell #___________________

Work #_____________________ Email___________________________________

Please denote how you prefer to be reached: (home/ cell/ work/ email) _______________________

Primary Care Physician______________________________________ Phone__________________

Other health care professionals with whom you are working:

Name _________________________________ Phone _____________________________________

Name _________________________________ Phone _____________________________________

Name _________________________________ Phone _____________________________________

Referred by/How did you hear about me?:

What are your health concerns? Please include history of symptoms, severity, frequency, blood tests, duration of medication, and previous types of care.

What are your health-related goals? On a scale of 1-10, how motivated are you to change? ______

What are your current medications (please provide dosage and length of time you've been taking each medication)?

What supplements, vitamins, or herbs do you take (please provide brand, dosage, and duration)?

What is your relationship status? Do you have children and/or pets?

Do you have a history of serious surgeries or hospitalizations? If yes please explain, especially if it is related to your health concerns.

How often do you take over the counter pain medication (Aspirin, Advil, Tylenol)?

Do you have any known allergies (food, medication, environmental)?

What is your occupation? How would you describe your work environment? On a scale of 1-10, how stressful is your job?

How well do you sleep at night? How long? Do you have trouble falling asleep? Staying asleep? How is your energy level when you wake up? During the day?

How often do you eat at home? How often do you eat out?

In the past 6 months, have you had any diet or lifestyle changes, including weight gain or loss?

Please describe your current exercise routine:

Do you smoke cigarettes? If yes, how frequently?

FOR WOMEN:
Do you have regular periods?________ How many days do they last?________How often?________

Are your periods painful or symptomatic? Please explain, including what you find alleviates or aggravates your symptoms.

Are you taking birth control pills? If yes, for how long?

Do you experience frequent yeast infections or urinary tract infections? If yes, please explain.

Your Health History

1 = past; **2** = current; **3** = both

Abscesses		Bad breath (halitosis)		Goiter		PMS	
Acne		Benign tumors		Herpes/cold sores		Pneumonia	
Alopecia/hair loss		Bipolar disorder		Hot Flashes		Seizures	
Amenorrhea		Bronchitis		Heavy metal toxicity		Pain during sex/ impotence	
Anemia		Teeth grinding		Insomnia		Shingles	
Appetite (excess/reduced)		Dry skin		Lactose Intolerance		Sinusitis	
Arrhythmia		Endometriosis		Low blood pressure		Tendonitis	
Autism		Epstein-Barr Virus		Lyme disease		Other	
Back Problems/Sciatica		Fainting/dizzy spells		Nervousness		Other	
Bacterial Infection		Fibrocystic breast disease		Night blindness		Other	

Family History

Mark **1** for you, and **2** for a family member):

AIDS		Candida		Heart Failure		Metabolic Syndrome	
ADD/ADHD		Chronic Fatigue		Heart Murmur		Migraines	
Alcoholism		Depression		Hypertension		Obesity	
Allergies		Diabetes Type 1 or 2		Immune Disease		Osteoporosis	
Alzheimer's		Eczema		Kidney Disease		Prostate Disease	
Anxiety		Epilepsy		Kidney Stones		Stroke	
Arthritis (Rheumatoid or Osteo)		Fibromyalgia		Lactose Intolerance		Hypo/ Hyperthyroidism	
Asthma		Gallbladder Issues		Liver Disease		Tuberculosis	
Bowel Problems		Glaucoma		Lung Disease		Ulcer	
Bronchitis		Gout		Lupus		Other	
Cancer		Heart Attack		Menopause Problems		Other	

Health Appraisal Questionnaire

In this section, you will complete a series of surveys that will address your gastrointestinal system, detoxification processes, metabolism, adrenal health, and your musculoskeletal system. Please answer all questions in terms of how you are feeling now, not how you used to be or how you think you should be. Some questions are asked multiple times as one symptom can have several different origins. Please be thoughtful and honest when answering the questions in order for the results to accurately reflect your health. These tests can be repeated after making dietary and lifestyle changes as a means of tracking progress and identifying areas of the body that need support.

The questions are designed to be answered on a scale of 0 to 3:

0: I do not experience this symptom
1: Mild (twice a week or less)
2: Moderate (three to 6 times a week)
3: Severe (daily, or several times a day)

Hyperacidity of the Stomach

Stomach pains	
Dependency on antacids for heartburn/acid reflux relief	
Chronic abdominal pain	
Butterfly sensations in stomach	
Burping or bloating	
Stomach pains when emotionally upset	
Sudden, acute indigestion	
Relief by drinking a carbonated drink	
Relief of pain by drinking milk	
History or family history of ulcer or gastritis	
Current ulcer	
Black stool (not from iron supplement)	
Use or previous use of pain medications (aspirin, advil)	
Total:	

Hypoacidity of the Stomach

Bloating, burping, gas immediately after eating	
Indigestion, diarrhea, constipation	
Sense of fullness during meals	
Known food allergies	
Nausea after taking supplements	
Rectal itch	
Weak, pealing, cracked fingernails	
Dilated blood vessels in cheeks and nose	
Acne	
Iron deficiency	
Undigested food in stool	
Chronic candida infections	
Difficulty swallowing	
Partial loss of taste or smell	
Total:	

Yes or No? (these questions only)
Have you ever had a diagnosis of:

Asthma ______
Eczema ______
Hepatitis ______
Chronic hives ______
Osteoporosis ______
Psoriasis ______
Rheumatoid arthritis ______
Rosacea ______
Vitiligo ______

Small Intestines/Pancreas

Abdominal cramps	
Indigestion and fullness 1-3 hours after eating	
Fatigue after eating	

Lower bowel gas	
Alternating constipation and diarrhea	
Specific foods aggravate indigestion	
Diarrhea	
Constipation	
Mucus in stools	
Stool poorly formed	
Shiny stools	
3 or more large bowel movements *daily*	
Dry flaky skin/hair	
Pain in left side under rib cage	
Chronic stomach pain	
Acne	
Food allergies	
Difficulty gaining weight	
Gallstones/history of gallbladder disease	
Undigested food in stool	
Nausea	
Acid reflux/heartburn	
Connective tissue disease: lupus, rheumatoid arthritis, Sjogrens	
Alcoholism, diabetes, osteoporosis	
Total:	

Colon/Large Intestine

Seasonal or recurring diarrhea	
Frequent and recurring illness	
Bladder and kidney infections	
Vaginal yeast infections	
Abdominal cramps	
Ab pain relieved by bowel movement or gas	
Toe and fingernail fungus	
Alternating diarrhea and constipation	
Constipation	
More than 3 bowel movements daily	
Narrow stools	
History of antibiotic use	
Meat eater	
Rapidly failing vision	
Recurrent stomach pain	
Blood or pus (mucus) in stool	
Rectal itching	
Family history of IBD	
Total:	

Liver/Gallbladder

Intolerance to greasy foods (indigestion)	
Headaches after eating	
Burping, heart burn, gas after meal	
Light-colored stool	
Foul-smelling stool	
Less than one bowel movement per day	
Hard stools	
Sour taste in mouth	
Gray-colored skin	
Yellow in whites of eyes	
Bad breath	
Body odor	
Fatigue and sleepiness after eating	
Pain in right side under rib cage	
Abdominal pain worsens with deep breathing	
Painful to pass stool	
Water retention	
Feel restless and agitated, fatigue, weak, irritable	
Big toe painful	
Pain radiates along outside of leg	
Dry or red skin /hair	
Red blood in stool	
Jaundice or hepatitis	
High blood cholesterol and low HDL	
Cholesterol above 200	
Triglyceride level above 115	
Total:	

Intestinal Integrity/Dysbiosis

Constipation and/or diarrhea	
Abdominal pain or bloating	
Mucus or blood in stool	
Joint pain, arthritis or swelling	
Chronic fatigue or frequent tiredness	
Food allergies, sensitivities, intolerances	

Sinus or nasal congestion	
Chronic or frequent inflammation anywhere in body	
Eczema, skin rashes, hives	
Asthma, hayfever, or airborne allergies	
Confusion, poor memory, mood swings	
Use of nonsteroidal anti-inflammatory drugs	
History of antibiotic use	
Alcohol consumption makes you feel sick	
Ulcerative colitis, Chrone's disease, celiac disease	
Headaches or migraines	
Total:	

Gastric Reflux

Sour taste in mouth	
Regurgitate undigested food in mouth	
Frequent nocturnal coughing	
Burning sensation from citrus in esophagus	
Heartburn	
Burping	
Difficulty swallowing solids or liquids	
Total:	

Thyroid Health

Fatigue, sluggish	
Cold hands and feet, general cold feeing	
Difficult, infrequent bowel movements	
Dryness of skin or hair	
Thick, brittle nails	
Outer third of eyebrow thins	
Puffy face, hands, feet	
Swollen upper eyelids	
Eyeballs move involuntarily	
Muscles are weak, they cramp and tremble	
Slow mental processes, forgetfulness	
Slow heart beat	
Loss of appetite	
Abdominal swelling	
Unsteady gait, movements	
Lack of interest in sex	
Premenstrual tension	
Infertility	
Heavy menstrual bleeding	
Gain weight easily	
Swelling of the neck	
Thinning hair on scalp, face, and genitals	
Total:	

Adrenal Health

Progressive, mild fatigue after exertion or stress	
General weakness	
Blurred vision, dizzy when rising	
Depression	
Rapid mood swings	
Irritable, nervous	
Dark circles under eyes	
Disinterest in food	
Abdominal pain	
Indigestion	
Blotchy skin (white patches)	
Tan skin, no sun	
Black freckles on upper forehead, face, neck	
Craving for salty foods	
Gradual loss of body hair	
Sensitive to subtle changes in surroundings, weather	
Total:	

Bone Integrity

Generalized bone tenderness and achiness	
Localized bone pain	
Bone deformity or swelling	
Shins hurt during or after exercises	
Low back or hip pain	
Limp, walking difficulties	
Crunching or creaking sounds when	

joints move	
Hands, feet, throat spasms, feel numb	
Joint pain and stiffness in hips, knees, spine	
Hearing loss, headaches, ringing in ears	
Established bone loss	
Calcium deposits	
Spinal curvature	
Recent loss of height	
Bowed legs	
Stooped posture	
Hump at base of neck	
Unexplained bone fracture	
Tooth loss, gum disease	
Total:	

Muscle Health

General muscle aches and pains	
Localized muscle stiffness, tension, pain	
Specific points on body feel sore when pressed	
Headaches	
Fatigue, tired, sluggish	
Difficulty sleeping	
Do not feel refreshed upon awakening	
Muscle weakness or loss	
Difficulty speaking or swallowing	
Muscle cramps or spasms	
Muscle twitch or tremble, eyelids, thumb, calf	
Irresistible urge to move legs	
Legs move during sleep	
Numb, tingling sensation	
Excessive joint mobility	
Unable to fully straighten or extend legs/arms	
Upper or lower back pain	
Total	

Connective Tissue/Joints

Joint stiffness, soreness	
Red, swollen painful joints	
Joint stiffness worsens with rest, improves with movement	
Cracking joints	
Shooting, aching, tingling pain in back of leg	
Join pain in multiple joints	
Joints hurt when moving or carrying weight	
Limited range of motion	
Difficulty standing up from sitting position	
Headache	
Difficulty chewing food or opening mouth	
Numbness, prickling, tingling sensation in neck, shoulders, or arms	
Involuntary muscle spasms	
Deliberate movement with hands is difficult	
Injure, strain, sprain easily	
Discomfort or pain in neck, shoulder, arm	
Total:	

Yes or no?
One leg shorter than the other? __________
Double jointed? __________
Knobby overgrowths on joints close to fingertips? __________

Are there any other symptoms or comments you have in regards to your health?

Name:_________________________________ Date:____________________

Foods and beverages eaten together should be clustered together (leave an empty line in between meals).

Food & Liquids (include portion)	Time	Mood/EnergyObservations	Supplements/Medication

Physical Activity (type and duration):

Name:___________________________________ Date:___________________

Foods and beverages eaten together should be clustered together (leave an empty line in between meals).

Food & Liquids (include portion)	Time	Mood/EnergyObservations	Supplements/Medication

Physical Activity (type and duration):

Name:_________________________________ Date:____________________

Foods and beverages eaten together should be clustered together (leave an empty line in between meals).

Food & Liquids (include portion)	Time	Mood/EnergyObservations	Supplements/Medication

Physical Activity (type and duration):

Informed Consent

I understand that the evaluation and recommendations of Vibrant Living Wellness Center, specifically Leona Harter may include but are not limited to:

- Medical history
- Physical examination
- Laboratory tests of blood, urine, stool, and saliva
- Dietary advice
- Therapeutic foods/supplements

Providing all known allergens, prescriptions, and health conditions will reduce your risk of potential allergic reactions to prescribed herbs and supplements. Please note that some conditions will be exacerbated during healing before they are alleviated (i.e. detoxification).

Policies:

- Payment is expected at time of service or before. Phone, Skype, and Email consults will be charged 48 hours prior to their appointment.
- There are no refunds on supplements or pre-paid packages. Packages expire 6 months after purchase date unless otherwise specified.
- Discounts cannot be combined with any other offer.
- Programs and pricing are subject to change, depending on the needs and goals of the client.
- There is a 24 hour cancellation policy. No-shows charged at full price. Studio etiquette applies.

By signing below I________________________________, agree to actively participate in making dietary and lifestyle changes to support a nourishing lifestyle. I agree to pay for all services rendered and supplements given according to the personalized payment plan. I acknowledge that no guarantees have been given to me concerning the results intended from the treatment plan created for my unique health conditions and biochemical individuality. I understand that Leona Harter cannot diagnose, treat, or cure disease, but can provide support and guidance through my healing journey.

____________________________________   ______________________

Please Sign Here   Today's Date

Credit Card # __________________________________

Expiration Date ____________ Security Code ________

Billing address, if different than physical address:

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