Nutritional Consultation Informed Consent & Evaluation Forms

Synergistic Nutrition is a Private Health Care Membership Association

In order to speak freely without censorship to our conversation and in order to utilize our right to freedom of speech, freedom of association and freedom to choose the type of health care you want to learn about and utilize, we must take our matters out of the public domain and bring them into the private by means of a private agreement format.

By signing this agreement you acknowledge and agree to the following. Stephen Heuer is a Degreed Nutripath not recognized by any State of Federal Agency as a medical practitioner. Stephen is not a medical doctor and does not claim to be able to diagnose, treat or cure disease. He asserts that to every ailment there is a cause or combination of causes that need to be identified and removed. Once the cause(s) are removed and the body is properly nourished physically, mentally and emotionally then the bodies own innate self-healing capacity becomes activated to heal itself of whatever the disease label is.

By signing this document you agree to be a Member of The Private Health Care Association of Synergistic Nutrition. You understand that you have taken your health care needs out of the public domain and chosen to address them in the context of a private association. In a private agreement all disputes are solved between the parties and no governmental agency can be called upon to try to resolve the matter.

For in person consultations you also consent to allowing Stephen to use a finger-pricking device to acquire a few drops of your blood for examination under a microscope. This examination may reveal information about your health that may be of value in determining the course of action you wish to take with regards to your diet and supplementation needs.

O-Ring Muscle Testing that may be used. It is a procedure, which measures the strength or weakness of your body when different stressors are applied. Weaknesses in the body become apparent when different meridian points and or injuries are tested. Once identified we can then proceed at finding out which supplements may strengthen the system being tested and or have no effect at all. While not always 100% accurate, it can be a very useful and valuable to proceed.

I agree that the information being sought is of a nutritional nature and is not for medical diagnosis, or treatment of any disease. I understand that this facility accepts specimens for research purposes only. I hereby certify that I am not an employee, agent, or otherwise affiliated with the Food and Drug Administration, CLEA, or other regulatory agencies. I understand that urine and saliva specimens are screenings for research purposes only and that the researcher conducting these sessions is not a Medical Doctor. I understand that any dietary guidelines or nutritional supplements I take, I do so under my own free will choice. I

understand that detoxification or reactions to said food and supplements are my responsibility. If detoxification or allergic response occurs I will consult with Stephen or other health care professional if I feel the need to for further guidance.

I understand some ailments are of a mental/emotional/spiritual nature and as such may go unaffected by nutritional intervention. As such they can only be addressed at the mental/emotional/spiritual level.

The cost for a consultation with Nutripath, Stephen Heuer is $150 per hour or every ten-minute increment thereof. A full consultation typically lasts from 1 to 1&1/2 hours. If your consultation is by phone then you will not be doing the muscle testing and consultation time is usually only 1 hour. Please scan and email your health evaluation forms to ttsfree@gmail.com.

If applicable I agree to use my typed name on the signature line in lieu of an actual signature as proof that I've agreed to the terms and conditions of this document.

Signature _____

Printed Name

_____

Witness _____

Date _____

FIRST TIME EVALUATION

Please complete the following questions carefully. This information will help us to build a specialized Nutritional Program personally designed for you.

Today's Date: _____ Referred by:_____

Name: _____ _____ M___ F☐ Birth date_____ Age_____

Mailing Address: _____

City:_____ State: _____ Zip: _____ Occupation: _____

Height: _____ Weight: _____ Marital Status: S☐ M☐ D☐ W☐ No. of children: _____

Daytime phone: (_____)_____ Email _____

For in person Consultations do not take any supplements for 2 meals before evaluation

1. Complaints - Please rank your current complaints and rate their severity (on a scale of 1 to 10, 10 being the most severe):

_____

_____

2. Other Information - Please tell us any additional information or concerns about your health:

_____

_____

3. Medications - Please list any medications you are currently taking and how long you have taken them (*including birth control pills, aspirin, pain medications, etc*):

_____

_____

4. Smoking - Do you currently smoke? _____ If yes, how much?_____ How long have you smoked? _____

5. Surgeries - What surgeries, operations, traumas, car accidents, etc. have you had?

_____

_____

a.) Do you have breast implants?_____ Other surgical implants or prostheses? _____
b.) Have you had elective surgery (tummy tuck, face-lift, burned off moles, etc.)? _____
c.) Do you have any metal or plastic inside your body (such as pins, clamps, plates, etc.)? _____
d.) Do you have pierced ears or other body piercings? _____

6. Scars - Describe any scars on your body (*major and minor ones*):_____

_____

7. Drugs -*This is strictly confidential information*. Do you currently use recreational drugs? _____ [circle] (marijuana, cocaine, heroin, uppers, downers) Others: _____ How often? _____
Have you used recreational drugs in the past?_____ If yes, for how long?_____

8. Stress - Please rate your current stress level (on a scale off to 10, 10 being the highest stress):
What is the main reason(s) for your stress? If over level 5, what step(s) are you taking to reduce your stress level?

9. Dental Work - Indicate how many of the following you have:
Silver fillings in your life_____Composites (tooth-colored) _____Extractions _____Bridgework _____
Partial or full dentures _____Gold crowns or inlays _____Stainless steel crowns or inlays _____
Porcelain crowns or inlays _____DeGussa Porcelain crowns or inlays _____Veneers _____Root canals _____
Root canals with BioCalex _____Posts _____Implants _____Temporaries _____Braces _____Bleeding Gums _____Sensitive teeth _____Bad Bite _____New cavities _____

10. Clothing - How often do you wear 100% natural clothing (*cotton, ramie, wool, silk, or linen*)? _____
Synthetic clothing *(polyester, acrylic, nylon, rayon, etc)?*_____ Blends (natural fabric combined with synthetic)? _____

11. Personal Care Products - List the brand names that you use: (*Please take time to complete this list*.)

Shampoo? _____
Deodorant? _____
Toothpaste? _____
Soap? _____
Hand/Body Lotion? _____
Facial Cleanser/Moisturizer? _____
Hair Spray/Gel? _____
Personal (sexual) Lubricant? _____
Contraceptive jelly/spermacide? _____
Hair Dye? _____
Fingernail/Toenail Polish? _____

Shave Cream? _____
Dish Washing Soap? _____
Laundry Soap? _____
Tub/Tile Cleaner? _____
Glass Cleaner? _____
All Purpose Cleaner? _____
Perfume/Cologne? _____
Roach/Ant Spray? _____
Toilet Freshener? _____
Hair Permanent? _____
Face make-up/Eye make-up? _____

Other chemical exposure (from yard, workplace, art chemicals, etc.)? _____

12. Appliances - Circle which of the following you use:
Gas stove Electric stove Electric heater Electric blanket Water bed VitaMix Microwave Oven
Air Purifier (Brand: _____) Water Purifier (Brand: _____)

13. Cookware - What type of cookware do you use? ***[Circle:*** *stainless steel, aluminum, iron, teflon-coated, glass,Ultrex.]*
Other types: _____

14. Shower Filter - What brand of shower filter do you use (for chlorine protection)? _____
When was your filter last changed? _____

15. Pets - Do you have a pet(s)? _____ If so, what kind/how many?_____
Is it allowed in the house? _____ On your bed? _____What do you feed your pet(s)? _____

Food Choices

Circle each type of food you eat often:

1. Pre-made foods: a) canned food b) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food
2. Red meat *(beef, pork, lamb):* a) commercially grown b) naturally raised (*Brand*: _____)
3. Chicken: a) commercially grown b) naturally raised (*Brand*: _____)
4. Turkey: a) commercially grown b) naturally raised (*Brand*: _____)
5. Fish: a) canned tuna b) fresh fish c) frozen fish d) at restaurants
6. Fresh vegetables: a) commercially grown (store-bought) b) organically grown (store-bought) c) organically grown *(direct from farmer)* d) from natural growers at a farmer's market
7. Fresh fruit: a) commercially grown (store-bought) c) organically grown (store-bought) c) organically grown *(direct from farmer)* d) from natural growers at a farmer's market
8. Whole grains: a) commercially grown (store-bought) b) organic (store-bought) c) biogenic *(from PR Labs)*
9. Whole beans: a) commercially grown (store-bought) b) organic (store-bought) c) biogenic *(from PR Labs)*
10. Eggs/Butter: a) commercial eggs (store-bought) b) naturally grown eggs c) commercial butter d) natural butter
11. Milk: a) commercial milk b) Alta Dena milk c) goat's milk d) Claravale raw milk e) Organic Pastures
12. Cheese: a) commercial cheese b) organic cheese (store-bought) c) recommended cheeses by Dr. Marshall
13. Condiments: a) commercial salt and/or pepper b) pink sea salt (*PRL*) c) artificial sweeteners *(Equal, Sweet 'NLow, Coffeemate, etc.)* d) commercial ketchup or mustard e) vinegar f) commercial olive oil g) PRL Moroccan Olive Oil

Food Stressors

Circle which of the following you have every week. In the column, indicate how many times per week you have each item.

Stimulants		**Toxic Oils**		**Commercial Dairy**		**Highly Heated Foods**	
Coffee *(including decaf)*		Fried foods		Cow's Milk		Bread *(store-bought)*	
Black tea, caffeine drinks		Fast food		Yogurt		Crackers *(store-bought)*	
Soft drinks *(colas, etc.)*		Potato or corn chins		Ice cream		Bagels *(store-bought)*	
Drinks with NutraSweet		Roasted nuts		Cottage cheese		Buns *(store-bought)*	
Alcohol *(wine beer, etc.)*		Mayonnaise		Sour cream		Pasta *(store-bought)*	
Chocolate		Margarine		Cheese *(commercial)*		Muffins *(store-bought)*	
Candy pastries sweets		Peanut butter *(commercial)*				Cookies *(store-bought)*	

Do you need further dental work? _____ If so, what? _____

Health Overview *For the following questions, circle the phrases that apply to you.*

1. Sleep - How is your sleep? [**Circle:** restful, restless, hard to get to sleep, wake up often, get up during the night, bad dreams.]
Other complaints?
_____
What time do you usually go to sleep? _____Number of hours of sleep per night?
_____ Type of mattress? _____ Type of pillow, sheets, covers, bedding?
_____

2. Digestion - How is your digestion? [**Circle:** adequate, poor, acid reflux, burp often, bloating, burning/pain in stomach.]
Other complaints?
_____

3. Urination - How are your daily urinations? [**Circle:** every 2 to 3 hours, too frequent, sense of urgency, too small amount, too large amount, burning, dribbling, up at night several times.]
Other complaints?
_____

4. Bowels - How are your bowel eliminations? [**How often?** 3 times daily, once per day, skip days **Amount:** normal, too little, too large
Consistency: normal, too hard, very soft, diarrhea **Color:** brown, black, whitish **Other:** lots of mucus, lots of gas, foul smell]
Other complaints?
_____

5. Women Only: Are you pregnant? _____ Are you breast-feeding? _____ Do you have monthly periods? _____
Date of last menstrual period? _____ Are you going through menopause? _____ Have your periods stopped? _____
Had a hysterectomy? _____ (If so, when? _____)

Are your monthly periods regular (28 day cycles)? _____
Number of days of your menstrual flow? _____
Circle any of the following symptoms you experience associated with your period: cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark dotty blood.
Other menstrual complaints?
_____

6. Exercise - What kind of exercise do you do?
_____
How often? _____ For how long at a time?
_____

7. Sunlight - Amount of natural sunlight you receive daily outside? _____ Amount of sunlight you receive daily through windows? _____ Hours spent daily under fluorescent lights? _____ Do you use Chromalux light bulbs at
home? _____ At work? _____

8. Eyewear - Do you wear contact lenses? _____ Glasses? _____ If so, how many hours per day?
_____
Do your lenses have tints? _____ An anti-glare coating? _____ A scratch-resistant coating? _____

9. Electromagnetic Exposure - ***How many hours do you spend daily:***
Watching TV? _____ Working on a computer? _____ Talking on a phone? _____ Talking on a cellular phone? _____
Wearing a pager? _____ Wearing a headset? _____ Wearing a wrist-watch (with battery)? _____
Riding in a car/truck/vehicle? _____ Near electrical equipment for long periods of time *(such as copy machines, high power lines, computers, etc.)*? _____ When you sleep, is your head within 10 feet of a plug-in clock (such as on a night stand)? _____

Food Habits

1. Eating Out - Do you eat out at restaurants?_____ If yes, how often? _____Where? _____
What type of food do you eat at restaurants? _____

2. Home Meals - Do you prepare meals at home? _____ If so, how often? _____
If yes, what type of food do you prepare?_____
_____

3. Meal Habits - ***Do You: [circle]*** a) skip meals often b) have irregular eating times c) eat food past 7 PM

4. MSG - Do you avoid food/drinks that list "natural flavors" (which means hidden MSG) on the label? _____

5. Water - Do you drink tap water? _____ What brand of drinking water do you use?_____
If you have a home water purifier, when was the cartridge last changed? _____

Typical Diet

Please fill out your typical diet for the last few weeks. Please be as detailed as possible. (For example, instead of writing "chicken," identify what brand and how it was made such as "baked Foster Farms chicken. "Instead of writing "salad," identify what it made of such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Moroccan Olive Oil.) PLEASE, BE HONEST!

BREAKFAST: (Time eaten:_____) _____
_____
_____
_____

LUNCH (Time eaten:_____) _____
_____
_____
_____
_____

DINNER (Time eaten:_____) _____
_____
_____
_____
_____

SNACKS (Time eaten:_____) _____
_____
_____
_____
_____

The Three Body Types

Identifying Your Constitution - To learn your basic Ayurvedic constitution type (called a "dosha"), please rate the following traits as they have pertained to you in the last 2 to 3 years. Answer each number and be sure to put a number in all 3 blanks per line, even if it is "0".

0 = Doesn't describe me at all
1 = Describes me a little
2 = Describes me quite well
3 = Describes me almost perfectly

	VATA	PITTA	KAPHA
1. My hair texture tends to be:	___ Dry, curly, wavy, shiny	___ Straight or fine	___ Thick or full bodied
2. My hair color is:	___ Medium or light brown	___ Blond or reddish tone or early gray	___ Dark brown or black
3. My skin tends to be:	___ On the dry side	___ Delicate or sensitive	___ Oily or smooth
4. My complexion (when compared to others of my race) is:	___ Darker	___ More reddish or freckled	___ Lighter
5. Compared to others of my height, I have:	___ Smaller bones	___ Average bones	___ Larger bones
6. My weight is:	___ Thin; I don't gain weight easily	___ Average	___ Heavy; I gain weight easily
7. My energy level:	___ Tends to fluctuate, may be high or low	___ Is moderate to high; I can push myself too hard	___ Is steady
SUBTOTALS:	**VATA = _____**	**PITTA = _____**	**KAPHA = _____**
8. Regarding temperature, I:	___ Dislike cold. Comfortable in heat	___ Dislike heat, perspire easily, like cold temperatures	___ Dislike damp and cold, can tolerate extremes well
9. My typical hunger level:	___ Can vary from excessive to no interest in food	___ Is intense; I need regular meals.	___ Is usually low but can be emotionally driven
10. I prefer my food/drinks:	___ Warm or moist or oily	___ Cold	___ Warm or dry
11. I generally eat:	___ Quickly	___ Moderately fast	___ Slowly
12. My sleep is most often:	___ Interrupted, light	___ Sound, moderate	___Deep, long
13. My sexual interest is:	___ Strong when romantically involved; low to moderate otherwise	___ Moderate to strong	___ Slow to awaken but then is sustained
14. My emotional moods:	___Change easily; I'm very responsive	___ Are intense; I'm quick tempered	___ Are even; I'm slow to anger
15. My general reaction to stress is:	___ Anxious, fearful	___ Irritated	___ Mostly calm
16. With regard to money I:	___Am easy and impulsive	___ I am careful, but I spend	___ Tend to save, accumulate
17. My way of learning is:	___ To learn quickly, enjoy more than one thing at a time	___ To focus sharply, discriminate	___ To take my time
SUBTOTALS:	**VATA = _____**	**PITTA = _____**	**KAPHA = _____**
18. With regard to tasks, I may:	___ Start a task, but not finish it	___ Finish what I start	___ Tend to be methodical
19. My memory is:	___ Best in the short term	___ Overall good	___ Best in the long term
20. My way off speaking is:	___ Quick, often imaginative or excessive	___ Clear, precise, detailed, well organized	___ Soothing, clam
21. If there was one trait to best describe me, it would be:	___ Vivacious	___ Determined	___ Easy going
22. Regarding my relationships, I:	___ Easily adapt to different kinds of people	___ Often choose friends on the basis of their values	___ Am slow to make new friends but then I am loyal
23. My family and friends might prefer me to be more:	___ Settled	___ Tolerant	___ Enthusiastic
TOTALS:	**VATA = _____**	**PITTA = _____**	**KAPHA = _____**

Add each of the subtotals together for each dosha, and then enter in the grand total for each.

GRAND TOTALS:	**VATA = _____**	**PITTA = _____**	**KAPHA = _____**

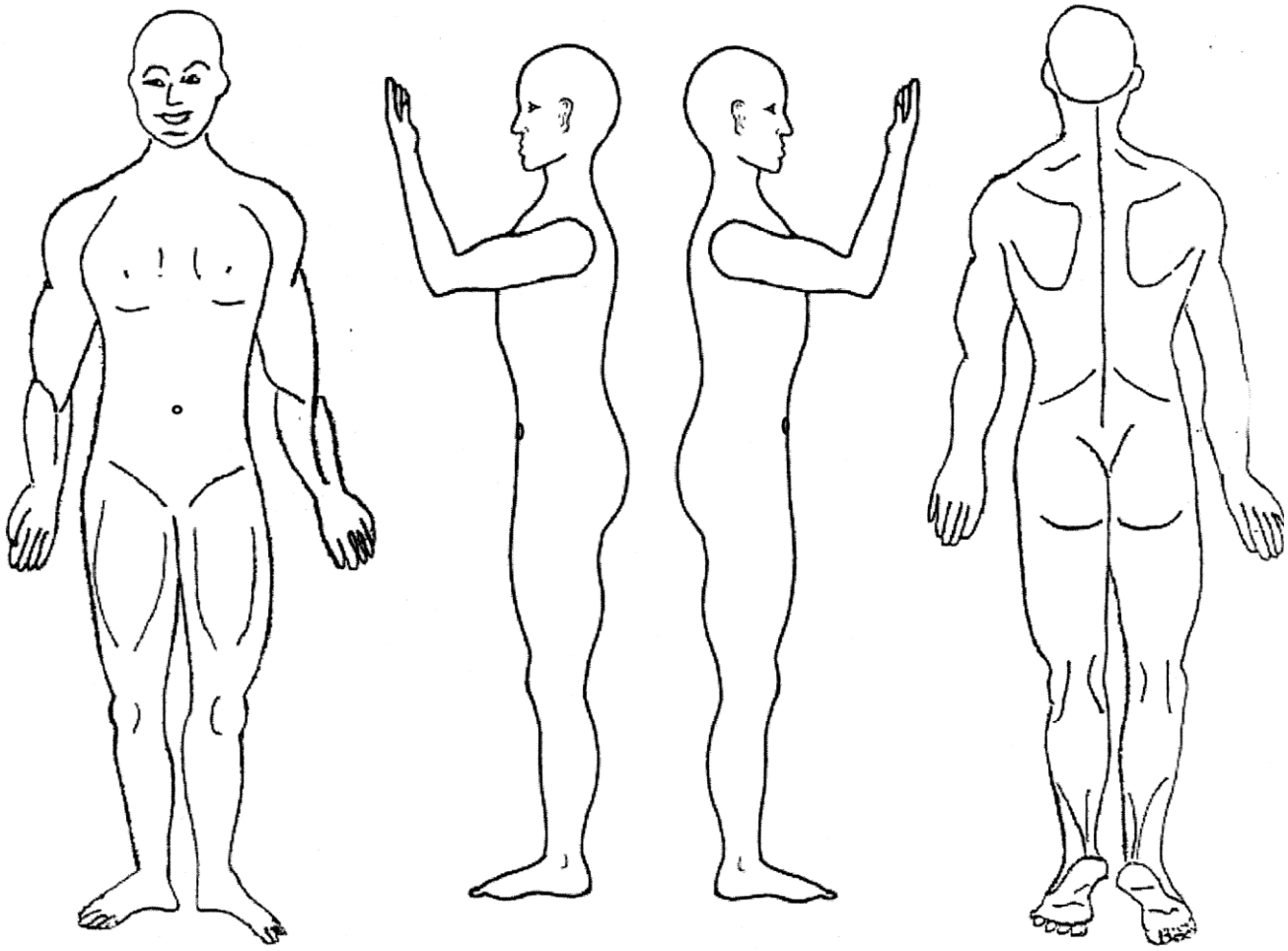
Assessing Your Score

If one column total is 15 or more points higher than the other two column totals, this is clearly your dominant constitutional type – vata, pitta or kapha. If two of the column totals are 0 to 15 points apart, you are dual-dosha constitution type – vata-pita, (or pitta-vata), pitta-kapha (or kapha-pita) or vata-kapha (or kapha-vata). If all three column totals are with in 0 to 10 points of each other, you are a tri-dosha type.

Birth Dosha: To determine your original constitutional type, take this test again; only answer the questions as they would have pertained to you as a child. Compare your present (acquired dosha) with your birth dosha.

Scar / Trauma Chart

Name: _____
Date: _____



Directions

All Scars Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, etc.
All Trauma Areas Please put a red "X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.
Internal Metal Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.
Date of injury and type of injury Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")

Client's Name _____ Date _____

Evaluator_____

Wellness Checklist

Write the date before each item when it was completed or when begun.

1. Teeth

_____ Silver fillings: All replaced
_____ Composites: All replaced
_____ All other metals replaced
_____ All teeth: Dry ice tested
_____ All toxic root canals replaced

2. TMJ/Bite

_____ TMJ Test ok
_____ Bite Test ok

3. Drugs

_____ No medical drugs used
_____ No street drugs used
_____ No OTC drugs used

4. Diet

_____ Food Sources
_____ Organic vegetables used
_____ Red meat stopped
_____ Organic cheese
_____ Restaurant eating reduced/stopped
_____ Homemade meals daily

5. Water

_____ Drinking water: purified
_____ Shower: shower filter used
_____ Swimming pool: ozonated only

6. Body Care

_____ Nontoxic skincare used
_____ Nontoxic hair care used
_____ Nontoxic soap used

7. Home Cleaning Agents

_____ Nontoxic dish soap used
_____ Nontoxic household cleaners used