New Client Form **Date**: _____

Name: _____ Address: _____

City: _____ State: ____ Zip Code: _____ Phone Number: _____

DOB:_____ Sex: _____ **Referred By**: _____

Email: _____

Blood Type: ____ Do you exercise regularly? Yes/No Number of bowel movements per day? _____

How long since last antibiotic: _____ Allergies: _____

Current nutritional supplements: _____

_____

Current prescriptions: _____

Surgeries: _____

Please circle the symptoms you feel in the list below. Rate each symptom you circled with an intensity rating from 1 (slight) - 5 (major) concern. Add any details you'd like us to know.

lack of energy	headaches	backaches
weight imbalance	heartburn	respiratory
blood pressure imbalance	frequent infections	joint pain
cold hands/feet	poor circulation	gas/bloating
menstrual problems	water retention	low sex drive
food allergies	diarrhea	inability to concentrate
memory loss	irritability	depression
anger	sinus problems	other

How may we help you today? _____

_____

Nutritional Client Statement, I hereby attest to the following:

I fully understand that staff members of the House of Sunshine are not medical doctors or practitioners. They do not diagnose or treat disease, and I am not here for medical diagnoses or treatment procedures.

The services performed whether in person, by mail, by telephone, virtual, or by e-mail are, at all times, restricted to consultation on the subject matters intended for the best possible state of nutritional health and maintenance; and do not involve the diagnosing, treatment, or prescribing of remedies for the treatment of disease.

I understand that it is my constitutional right to decide how I wish to care for the health of my body. No one at the House of Sunshine has suggested that I cease any current medical care or procedure that my medical doctor has deemed necessary for my health. Should I choose not to follow recommendations made by my medical doctor, I accept responsibility for said decision and I will hold
House of Sunshine harmless for any consequences related to my decision.

I am here on this and any subsequent visits solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation.

Signature: _____ Date: _____

Authorization Form Regarding the Use of Muscle Testing & Cancellation Policy, please initial each blank space:

_____ I authorize the natural health practitioners at the House of Sunshine to perform a Muscle Response health analysis and to develop a natural health improvement program for me. This may include dietary/nutritional supplement changes and are not for the treatment or “cure” of any disease, but rather to identify deficiencies or imbalances in the body that may contribute to various health problems.

_____ I understand that Muscle Response Testing is safe, non-invasive method of analyzing the body’s physical and nutritional needs and is not intended to diagnose, treat, or cure disease.

_____ No one at the House of Sunshine has made any promises or claims that I will be “cured” of any diseases I may have by following the program received at the House of Sunshine.

_____ I understand that should I choose to cancel my appointment with the natural health practitioners, I must do so with a 24-hour notice or I may be subject to a cancellation fee.