Vintage Roots
Holistic Family Wellness Inc.

Name: _____

Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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? _____ Would you like to receive our newsletter? _____

Present Complaints: List the 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? _____

At what point in your life did you feel best?

_____

_____

What are your health goals:

_____

_____

Medications or nutritional supplements you are currently taking: List them:

_____

_____

_____

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

Key: 0=no, symptom does not occur 1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly 3=Severe symptom, occurs daily

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

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

16. 0 1 2 3 Skip days between bowel movements.
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

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, etc...
54. 0 1 2 3 Pain under right rib cage
55. 0 1 2 3 Insomnia

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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

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 Become dizzy when standing suddenly
88. 0 1 2 3 Difficulty holding chiropractic adjustments
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

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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

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

113. 0 1 2 3 Crave sweets
114. 0 1 2 3 Awaken during night, hard to fall back asleep
115. 0 1 2 3 Excessive appetite
116. 0 1 2 3 Crave coffee or sugar in after noon
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– Women only:

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

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Section 12– Men only section:

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

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

How is your Diet:

☐ Coffee: _____ cups per: ☐Day ☐Week ☐Month

☐ Soft drinks: ____ can per: ☐Day ☐Week ☐Month

☐ Diet soda: _____ can per: ☐Day ☐Week ☐Month

☐ Candy: _____ times per: ☐Day ☐Week ☐Month

☐ Chocolate: ____times per: ☐Day ☐Week ☐Month

☐ Alcohol: _____ times per: ☐Day ☐Week ☐Month

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☐ Fast food: _____ times per: ☐Day ☐Week ☐Month

☐ Milk/cheese: ____ times per: ☐Day ☐Week ☐Month

☐ Fried food: _____ times per: ☐Day ☐Week ☐Month

☐ Margarine or tub spreads ☐Day ☐Week ☐Month

Current Diet Information: Give some examples of foods you typically eat:

Breakfast: _____

Lunch: _____

Snacks: _____

Dinner: _____

Liquids: _____

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

Do you cook? _____ What percentage of meals are home-cooked? _____

Health History:

List any major illnesses with approximate dates: Illness: Date: Recovered?

_____ _____ _____

_____ _____ _____

_____ _____ _____

Any family history of serious illnesses? ☐ Cancer ☐ Heart Disease ☐ Diabetes

☐ Other: _____

Please list any surgeries, operations, traumas, car accidents, etc...:

_____

_____

What are your Hobbies: _____

What would you like to do once you get healthier that you can't do now? _____

_____

Commitment Level:

How serious are you about improving your health?

☐ Very serious ☐ Serious ☐ Other: _____

What are you willing to do to improve your health?

☐ Take supplements only ☐ Exercise only ☐ Whatever it takes!!

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Disclaimer The computerized Electro-Dermal Screening device (Qest4 Asyra) provides a completely noninvasive method for gaining valuable information about how your body functions. The primary objective is to find patterns of stress and provide feedback that will assist in developing a program to restore areas of the body to balance.

☐ I understand that the Qest4 Asyra survey does not provide medical diagnosis and that my testing technician 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 the testing technician to evaluate me on the Qest4 Asyra. I understand in doing so my testing technician is NOT becoming my primary care physician. I understand that the testing technician will give me information about myself and make recommendations based on the screening. I understand that the testing technician 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 the testing technician harmless. ☐ I understand that the Qest4 Asyra screening does not diagnose diseases in the body. I understand that the role of Vintage Roots Holistic Family Wellness Inc. is not to prescribe, to diagnose, treat, or cure any disease, condition or other physical or mental ailment of the human body. Rather, Vintage Roots Holistic Family Wellness Inc. 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 Vintage Roots Holistic Family Wellness Inc. is not acting in the capacity of a doctor, licensed dietician-nutritionist, psychologist, or other licensed or registered professional, and that any advice given by Vintage Roots Holistic Family Wellness Inc. 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 Vintage Roots Holistic Family Wellness Inc.. I assume risks of trying new foods or supplements, and the risks inherent in making lifestyle changes. I release Vintage Roots Holistic Family Wellness Inc. 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 Vintage Roots Holistic Family Wellness Inc., arising from my past or future participation in programs and services, unless arising from the gross negligence of Vintage Roots Family Wellness Inc.. ☐ CONFIDENTIALITY: Vintage Roots Holistic Family Wellness Inc. 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 between Vintage Roots 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 Canadian 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 Province of Alberta. In the event that 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 Vintage Roots Holistic Family Wellness Inc. 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:_____

Guardian Signature (if under 18 years of age):_____ Relationship: _____