Bowtech Health Center

Discover Nature's Healing

Welcome to the Bowtech Health Center! We are excited to begin this new journey alongside you towards fuller health!

Please fill out and return all requested paperwork in its entirety within 2 business days of your appointment. Additionally, the following forms must be filled out over a period of several days and should be begun promptly: The Daily Record of Food Intake (7 days) and the Thyroid Temperature Form (5 days). Please allow enough time to complete all forms as we will need this time to process your paperwork. Incomplete paperwork may result in a 30-45minute wait or the need to reschedule your appointment.

Appointments must be cancelled at least 24 hours in advance. If an appointment is cancelled with less than 24 hours notice, there will be no charge the first time. After that, the normal fee for the service schedule will be charged.

The Bowtech Health Center is a fragrance-free (perfumes/colognes, scented lotions, etc.) environment. Many of our clients are very sensitive to fragrances that invoke headaches, nausea, etc. *Thank you!*

Nutritional Evaluation Form

Name: _____ Date: _____ Email_____

Referred by: _____or how did you hear about us?_____

__Male ___Female Age: _____ years Date of Birth: _____

Born where: City_____ St/Province_____ Country_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Can we call you at this number? ___ Y ___N

Cell Phone: _____ Can we call you at this number? ___ Y ___N

Emergency Contact: _____ Phone: _____

Profession: _____ Employer: _____

Primary Physician: _____Phone:_____

What are your health concerns? (Rank in order of importance)

1. _____
2. _____
3. _____
4. _____

What are your Health Goals for Our Time Together?

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History:

Surgeries: ___ None ___ Yes. If yes, please list them below:

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____

Serious Illnesses: ___None ___Yes. If yes, please list below:

5. _____ Date Diagnosed:_____ Is this illness ongoing? ___no ___yes
6. _____ Date Diagnosed:_____ Is this illness ongoing? ___no ___yes
7. _____ Date Diagnosed:_____ Is this illness ongoing? ___no ___yes
8. _____ Date Diagnosed:_____ Is this illness ongoing? ___no ___yes

Allergies

Allergies to Meds: __ None. Known Allergies: _____

Food Allergies: __ None. Known Allergies: _____

Environmental Allergies: __ None__ Dust__Pollen__Ragweed__Molds__Grass Other: _____

Others not listed:_____

Sleep

How many sleep hours do you get? _____ How many do you think you need? _____

Do you have trouble falling asleep? __ Yes__ No__ Sometimes

If you awaken at night, do you have trouble falling back asleep? __ Yes __ No __ Sometimes

What time do you go to bed? _____ What time do you get up? _____

Are your sleep habits routine? __ Yes __ No Why not? _____

Do you have trouble waking up in the morning? __ Yes __ No __ Sometimes __

Do you get tired during the day? __Yes __ No __Sometimes What times?_____

Do you get a second wind late at night? ____ Yes___ No __ Sometimes How often/ week? _____

Energy

On a scale 1-10 highest what is your present energy level? _____ Energy level 1 year ago _____

What time of day do you have the most energy? From: _____ To: _____

Weight and Exercise

Present Weight _____ 1 year ago _____ 5 years ago _____ Height_____

What do you consider a good weight for yourself now? _____

Exercise: __Yes___ No What type_____ How often:_____

Habits

Smoke____ How Often:_____ Exposed to smoke____ How Often:_____

Chewing Tobacco____ How Often:_____

Food

Food/beverage Cravings: Salt___ Sugar__ Other_____ Always Thirsty___Yes __No Always hungry __Y __N

Emotional Eater? __Yes __ No Diet Often?__Yes __No

Do certain Textures of food bother you? __Y __N

Beverages: Check if use and how much in ounces per day

__Water _____oz __Alcohol ____oz __Diet sodas____ oz ___Sugar drinks _____oz

__Coffee____oz __Tea ___ oz __Energy Drinks ___oz ____ Distilled Water ____oz

For the following Foods: N=Never O= Occasionally W=Weekly D=Daily

___Broccoli
___Brussels Sprouts
___Cauliflower
___Candy
___Carbonated Beverages
___Fast Food Regularly
___Fish (farm raised)
___Fish (wild caught)
___Fried Food
___Kale
___Lunch Meats
___Margarine
___Refined Sugars
___Artificial Sweeteners What type _____
___Salt food without tasting first

Check if you:

___Diet Often Why?_____

___Are under excess stress Explain_____

Stress Level Low_____ Medium _____ High_____

How do you deal with Stress?_____

Bowel Movements

Number per day _____ Number per week_____ Any sign of Blood ____Thin pencil size_____

Well formed? _____ Hard? _____ Small marble size? _____ Runny? _____

*Bowel Movements should come out immediately and be well formed and begin to break apart in the water.

Medications and Treatments

___Antacids
___Antibiotics/Antifungals
___ Diabetic/Insulin
___Aspirin/Tylenol
___Chemotherapy
___Recreational Drugs
___Other
___Cortisone/Anti-Inflammatory
___Heart Medications
___High Blood Pressure
___Hormones
___Ibuprofen
___Laxatives
___Lithium
___Oral Contraceptives
___Radiation
___Relaxants/Sleep Pills
___Inhalers
___Ulcer Medications

List Medications currently taking

_____

_____

_____

_____

_____

Supplements

What supplements and/or vitamins do you take on a daily or regular basis?

_____

_____

_____

_____

Female Only

Is (was) your cycle regular? ___Yes ___ No ___Not always

Is (was) the flow ___ Heavy ___ Medium ___ Light _____

Do you have cramps BEFORE your period? ___Yes ___ No How many days?_____

Do you have cramps DURING period? ___Yes ___ No How many days?_____

Do you experience tender breasts? ___ Yes ___ No If so, when? _____

Age and year of menopause_____

Do you have hot flashes/night sweats? ___Yes ___No # during day ____Mild ___Moderate ___Severe

during night ____ Mild ___ Moderate ___ Severe # per week _____

Ever taken estrogen or hormone replacements (HRT)? ___ Yes ___No

Name:_____Dosage:_____

Do you experience itching or burning of vaginal area? ___Yes ___ No

Do you experience vaginal discharge? ___ Yes ___No

Do you get yeast infections? ___Yes ___ No How often?_____ Date of last one? _____

Any increase of urinary frequency or urgency? ___ Yes ___ No How Long? _____

What is the number of times you get up during the night? _____

Any urinary incontinence? ___ Yes ___ No How Long? _____

Blood in urine___Yes ___ No

Male Only

Any increase of urinary frequency? ___ Yes ___ No How Long? _____

What is the number of times you get up during the night? _____

Is there any dribbling at the end of urination? ___ Yes ___No

Do you have any urgency to urinate? ___ Yes ___ No

Any straining to empty the bladder? ___ Yes ___No

Is there any urinary leakage or blockage? ___ Yes ___No

Is your stream weaker? ___ Yes ___ No

Any difficulty with starting and stopping urine stream? ___Yes ___No

Blood in urine ___ Yes ___ No

Any difficulty in achieving erections or maintaining an erection? ___ Yes ___ No

How long have you had difficulty with erections? _____

Last time PSA checked? _____ ___ Never Results:_____

Have you ever had a sexually transmitted disease? ___Yes ___No If yes, explain _____

REVIEW OF SYSTEMS

System Checklist: Any problems or treatment in the past with your:

Eyes, Nose and Throat: ___None ___Eyes ___Nose ___ Mouth ___Throat ___ Teeth ___ Skin

Explain:_____

Respiratory: ___None ___Cough ___ Sputum ___ Hemoptysis ___ Wheezing ___ Dyspnea

Explain: _____

Cardiovascular: ___None ___Chest Pain ___ Palpitations ___ Swelling ___ Dyspnea (on exertion) ___ Syncope ___

Murmurs ___ Varicosities ___ Anxiety attacks

Explain: _____

Gastrointestinal: ___None ___ Appetite___ Nausea ___ Pain ___ Indigestion ___ Gas___ Acid Reflux

___ Thirst ___ Bleeding ___ Vomiting___ Jaundice ___Hemorrhoids

Explain: _____

Nervous System: ___None ___ Mental state ___ Seizures ___ Vertigo ___ Tremor ___ Weakness

___ Paresthesia's ___ Headache ___ Syncope___ Incoordination ___ Paralysis ___Pain

Explain: _____

Musculoskeletal: ___None ___Pain ___ Stiffness ___ Weakness___ Swelling

Explain: _____

Closing Questions / Comments

1. Is there anything regarding your health or any other questions you have that we have not discussed? _____

2. In the future, if you would to add anything else to the information you have provided, please do not hesitate to let me know immediately.

Form 2: Budget & Expectations

What is your budget for your first visit?

_____

_____

_____

What is your monthly budget for consults and supplements?

_____

_____

_____

Do you currently take supplements?

_____

_____

_____

Are you willing to change your current health routine?

_____

_____

_____

Please briefly describe what results, if any, that you expect to see as a result of using natural medicine.

_____

_____

_____

If you do expect to see results, how long do you expect to wait before you see any results?

_____

_____

_____

Form 3: Contract of Authorization Form

Please Read carefully before submitting:

I hereby authorize Lisa Rhodes and her representatives to act on my behalf concerning the corrective, non-drug programs offered to achieve health. I specifically authorize her to evaluate my health concerns/problems and to recommend the appropriate nutritional and detoxification programs, lifestyle, and environmental modifications. I warrant that all information submitted for analysis and evaluation was submitted by me and is true to the best of my knowledge. I also attest that I am disclosing all medical information, name of my current physician, and my drugs, herbs, supplements, or substances I am currently, or have previously consumed. I understand that Lisa is available to work with my medical doctor or health care provider to implement a program of integrative medicine and therapy. I hereby give permission to release my medical records and information pertaining to my medical records and information pertaining to my medical and alternative therapies, to specific persons, only upon this office receiving authorization from me in writing and dated specified name or names.
I recognize that the approach used will be non-medical. I also recognize that Lisa will evaluate my condition so that she can have the information necessary to approach my problem and its causes, not just its symptoms. I, and my family members, heirs, or any other parties, hereby hold Lisa Rhodes, Et al harmless in any way. I understand that the programs recommended are designed to allow the body to have the necessary natural means to promote health and healing and boost my body's immune system by natural and nutritional programs, alternative therapies, and lifestyle modification.

I, Lisa Rhodes, am neither a medical physician nor a psychologist, and do not hold myself out as one. I have a Bachelors of Science in Home Economics Education* from Abilene Christian University. I am trained as a Certified Traditional Naturopath, a Professional Bowenwork Practitioner, Applied Clinical Nutritionist, and an EPFX/SCIO practitioner. As a client, you will be informed of the natural approaches necessary for a lifestyle of healthy living. The recommendations given are not a substitute for conventional medical treatment; they are natural, non-drug protocols. I do not diagnose, treat or cure, but rather work within holistic, integrative natural protocols to achieve health. It is my goal to assist you in dealing with the underlying causes of your condition, not merely the effects—accomplishing a natural overall approach to your health and quality of life. For any medical problem, it is important that you disclose to my office the name of your physician, and allergies, and any medications you are taking, or have taken within the past 90 days.
At this time, most insurance companies do not pay for nutritional, environmental, or wellness healthcare consulting. Please SAVE ALL YOUR RECIEPTS, we do not bill or deal with insurance companies or year-end summaries. It is your responsibility to submit or deal with your insurance carrier if your policy covers nutritional and wellness services. Payment is due at time of service, no exceptions—we accept Visa, Discover, and Master Card.
If we should have to use legal or collection means to collect on your account, you agree that you will be responsible for all charges/fees incurred by us. A finance charge of 2.5% will be added to all balances beyond 30 days.

Client's Name_____
Client's Signature_____Date_____
If Client is a minor, parent/guardian must acknowledge below:
Name of Minor_____Age_____
Name of Parent/Guardian_____Date_____
Signature of Parent/Guardian_____Date_____

Form 4: Cancellation Policy

Please read carefully before submitting:

Effective: November 1, 2015

Appointments must be cancelled at least 24 hours in advance. If an appointment is cancelled with less than 24 hours notice, there will be no charge the first time. After that, the normal fee for the service scheduled will be charged. If an appointment is forgotten (a patient does not come or call) there will be no charge the first time. After that, the normal fee for the service scheduled will be charged.

I, _____, understand that the Bowtech Health Center will make every attempt to make courtesy reminder calls; however, it is ultimately my responsibility for making it to my appointment.

I, _____, understand the cancellation policy for Lisa Rhodes at the Bowtech health Center and agree that I am responsible for payment under the circumstances specified in the cancellation policy.

Signature: _____Date:_____