First Visit Lifestyle Information

name: _____ date:_____

ph #_____ email_____

address:_____

occupation:_____ date of birth_____

sex:_____ single_____ married _____ widowed_____ divorced_____

do you have a health advocate_____

I Hearby Attest To The Following Statement;

I am here on this and any subsequent visit, solely on my own behalf, and not as an agent or formant for any Federal, State or Local agencies. I am not now nor hae I ever beeen a member of any Police Dept or any other State or Federal Investigation or enforement agency, including but not limited to the Massachusetts State Highway Patrol or Police Department, The Bristol County Sheriffs Department, The Federal Marshals Office, The American Medical Association, The Food and Drug Administration, The Drug Enforcement Agency or The Bureau of Alcohol, Tobacco and Firearms.

I am not here on this visit or any subsequent visit, on a mission of investigation, Entrapment or for any other reason that might bring legal charges against Loraine Walsh.

I also fully release and relinquish my right and /or the right of anyone on my behalf, to prosecute or sue Loraine Walsh, and any apprentices, shop owners or volunteers of any of the people or organizations for any reason, including health consltations and nutritional herbal products.

I also release and relinquish my rights to prosecute and sue any of the above people and/or organizations for any and all reasons but especially in regards to their assistance,, health consultations, emotional guidance, nutritional and herbal products, custom formulations and herbs.

I hereby indemnify and hold harmlesss Loraine Walsh, and all persons listed or not listed above, including the companies that the above mentioned persons do business with, from any and all reasons inclusive but not limited to; my voluntary usage of any herbs and herbal formulas or health and nutritional products, whether leagal or not, and for any other possible damage and/or losses resulting from any act regarding my health program and consultations.

I fully understand that Loraine Walsh is not a Medical Doctor and that she is not diagnosing, treating or curing any disease.

I also fully understand that I am hereby advised to continue my current medical treatment and/or to seek the assistance, advice and professional help of a licensed Medical Doctor and/or Hospital for any diagnosis and/or treatment of disease, illness or health problem that I have.

I am also advised to continue any current medical program I am currently on including but not limited to Surgery, Chemotherapy, Radiation, Any Drug Therapy and any other treatment for disease.

I understand that this release is valid for this visit and all subsequent visits.

Signature_____-

date_____

witness or referred by_____

date_____

Hobbies & Leisure Activities_____

_____

Typical Meals: Breakfast time_____ content_____

Lunch time_____ content_____

Dinner time_____ content_____

Nutritional supplements (vitamins, minerals, herbs, etc)_____

_____

How often do you have a bowel movement_____

Do you use any Tobacco_____ Coffee_____ Alcohol_____ Soda_____
Energy drinks_____ Sugar_____ Salt_____ Prescription drugs_____
Street drugs____

Do you drink water_____ if yes, what is your daily intake_____
tap, bottled or other_____

Medical Treatment History_____

Major Illness, Accident & Injuries_____

Surgery and/or Organs missing_____

Allergies, food or drug_____

Describe present physical condition - _____

Describe present emotional condition_____

Any major life changes in the past 7 years_____

Check off the ones you are experiencing:

○ Acne ○ Agitation ○ Muscular Pain ○ Dizziness ○ Cold hands and feet ○ Low energy ○ Joint pains that travel ○ Food allergies ○ Chemical sensitivities to odor, gas heat ○ Hyperactivity ○ Pre-menstrual and menstrual cramping ○ Pre-menstrual anxiety and depression	○ Panic attackes ○ Lack of sex drive ○ Bloating ○ Heartburn ○ Diarrhea ○ Constipation ○ Hot urine ○ Strong smelling urine ○ Mild headaches ○ Rapid panting breath ○ Rapid heartbeat ○ White coated tongue ○ Hard to get up in morning ○ Excess head mucous (stuffiness) ○ Metallic taste in mouth
○ Cold sores (herpes 1 & 2) ○ Depression ○ Loss of memory ○ Loss of concentration ○ Migraine headaches ○ Insomnia ○ Disturbance in smell, taste, vision, hearing ○ Asthma ○ Bronchitis ○ Hay fever ○ Hives ○ Sweating ○ Ear aches	○ Bacterial infections (staph, strep) ○ Fungal infections (candida, vaginal) ○ Impotence ○ Urethristis ○ Cystitis ○ Urinary infection ○ Gastritis ○ Colitis ○ Excessive falling hair ○ Psoriasis ○ Endometriosis ○ Stuttering

○ Viral infections (cold, flu)	○ Numbness and tingling ○ Sinusitis
○ Chrohn's disease ○ Schizophrenia ○ Learning disabled ○ Hodgkin's disease ○ Systemic Lupus Erythematosis ○ Multiple Sclerosis ○ Sarcoidosis	○ Rheumatoid Arthritis ○ Myasthenia Gravis ○ Scleroderma ○ Leukemia ○ Tuberculosis ○ All other forms of Cancer

Do you follow a regular exercise routine___ if yes, what_____

What are 3 things you most struggle with?

What 3 things would you like to overcome?

At the end of your life, what is it that you would like to have achieved?

Topics to discuss·

How to live your best life suggested protocol:

1· self love & care
   ~ understanding your personality (color code)
   ~ habits to let go
2· nutritional food & water choices
3· daily activity

Check your email for your Moving Forward packet, to a Fulfilling Life!

TFW

ThymeForWellness·com

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