About Your Health, LLC

Connecting Your Dots… To Better Health

DISCLAIMER

I am not a physician and the relationship between you and I is not of a prescriber and patient, but as an educator and resource provider sharing healthy information. The material content provided and taught by About Your Health, LLC is educational and informational in nature and is provided only as general information and does not constitute medical or psychological practice, advice, opinion, diagnosis, treatment, or guarantee. The content does not create any doctor-patient, therapist-patient or any other professional relationship and is not a substitute for medical diagnosis, advice, or treatment, or other professional health care. For the avoidance of doubt, About Your Health, LLC cannot and does not provide specific treatment advice to anyone. If you have questions about this, please contact About Your Health, LLC.

You are responsible for your own health care decision-making and should obtain necessary consultations with appropriate healthcare professionals.

It is fully your responsibility and choice as to whether or not you take advantage of the healthy information presented to you which can be found as public knowledge. Information about Homeopathy may be discussed during your consult. Homeopathy does not treat an illness. It stimulates the body's natural ability to correct conditions that are out balance. It considers the wholeness of a person. Diagnosis from a holistic physician can be pivotal in addressing any condition and is encouraged.

Any information shared between you and About Your Health, LLC will remain private and protected. Information will only be shared with your written consent to appropriate medical providers in order to better serve you.

Patient Signature:

Print: _____

Sign: _____ Date: _____

About Your Health, LLC
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Rebecca Bryant

PRACTICAL HOMEOPATH

&

ALTERNATIVE HEALTH CONSULTANT

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Health Intake and History

Name: _____ Date: _____

Age: _____ DOB: _____

Email: _____ Phone #: _____

Check your preferred method of contact: ☐ Email ☐ Text ☐ Phone Call

Address: _____

Top 3 Primary Complaints:

1. _____
2. _____
3. _____

List any Definitive Diagnosis you have been Given:

_____

List your issues in order from Worst to Least:

Indicate a pain or aggravation scale for each issue issue:	Scale 1-10	Approximate Onset of issue Date:

Check any of the following that you would like to discuss:

- ☐ Alcohol/Drug Addiction
- ☐ Allergies
- ☐ Anemia
- ☐ Eating Disorders
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bladder Infections
- ☐ Depression
- ☐ Pneumonia
- ☐ Migraines
- ☐ Bronchitis
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Heavy menstrual bleeding
- ☐ Painful Menses
- ☐ Pre-Menopausal
- ☐ Menopausal
- ☐ Hot Flashes
- ☐ Gout
- ☐ Previous Miscarriages
- ☐ Food Allergies
- ☐ Gallbladder
- ☐ Insomnia
- ☐ Panic Attacks
- ☐ Overweight
- ☐ Anaphylactic Reaction
- ☐ Stroke
- ☐ Eczema
- ☐ Low Blood Pressure
- ☐ Kidney Stones
- ☐ IBS
- ☐ Dry Skin
- ☐ Psoriasis
- ☐ Thyroid Diagnosis
- ☐ Warts
- ☐ High Blood Sugar
- ☐ HB Pressure
- ☐ ADHD
- ☐ Low Blood Sugar
- ☐ Colitis
- ☐ Acne
- ☐ UTI's
- ☐ Chronic Fatigue
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Epilepsy
- ☐ Sinusitis
- ☐ Ear Infections
- ☐ Hives
- ☐ Shingles
- ☐ Diabetes
- ☐ Dementia
- ☐ Heat Stroke
- ☐ Sleep Apnea
- ☐ Brain Fog
- ☐ Adrenal Fatigue
- ☐ Kidney Disease
- ☐ Fatigue
- ☐ Seizures
- ☐ Cravings
- ☐ Heart Burn
- ☐ Nausea
- ☐ Bells Palsy
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Acid Reflux
- ☐ Weakness
- ☐ Other:

List all Supplements and Medications you are currently taking, reason for taking and how long you have been on them: If the list is lengthy and you already have them typed up, you may send an attachment and note "See Medication Attachment" or add them to the bottom of the last page of this document.

Lifestyle:

Do you have any allergies? ☐ Yes ☐ No Please list them here:

How many hours a day do a sleep?

How many glasses of water do you drink daily?

The type of water you drink daily

Number of alcoholic drinks Daily?

Number of Cigarettes Daily?

Type of Caffeine daily and amount? Coffee: ☐ Tea: ☐ Energy Drinks: ☐ Soda: ☐ Chocolate: ☐

Number of times you eat Fast Food Weekly?

Do you eat fruits and vegetables Daily? ☐ Yes ☐ No How many servings of each?

Do you grind or clench your teeth? ☐ Yes ☐ No

How Many Bowel Movements do you have daily? ☐ 1-2 ☐ 3-4 ☐ 1-2 a week Other:

Are your bowel movements…? ☐ Hard like popcorn balls ☐ Soft and easy to pass ☐ Long like a snake ☐ Liquid ☐ Diarrhea ☐ Contain undigested Food ☐ Mucus in stool

Check your average level of daily stress: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you think you need to lose weight? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No How Often: ☐ Daily ☐ 2-3 x Weekly ☐ 4-7 x weekly

When was the last time you were prescribed an antibiotic?

Did you have to take more than one round of antibiotics?

What is your idea of living a “Healthy Life?”

How committed are you to making new food choices, lifestyle changes or adding nutrients where gaps exist in your diet on a scale of 1-10?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

1-not committed at all, 5-somewhat committed, but money and time are obstacles, 10 highly committed “ I’m ready to achieve my best health!”

Additional supplements and medications can be listed here. Be sure to include how long you have been taking each one

Name	Reason Why Taking	How long been taking

About Your Health, LLC

Services and Pricing

Consultations Packages:

*First 15 min are complimentary to see if we are a good match for a working relationship.

A 3 – (1) Hour Consults = $420.00

B Ask About The Pricing For Broadcasting Services

Pay as you go

A $185.00 per hour

B $95.00 per 30 min.