Stephanie Harper Iridology LLC
CERTIFIED IRIDOLOGIST PRACTITIONER
& INTEGRATIVE WELLNESS CONSULTANT

New Patient Health Intake & Liability Waiver Form

Name_____
DOB_____ Age_____
Occupation_____
Address_____
City_____ State_____ Zip Code_____
Telephone_____ Cell Phone_____ Email_____
Preferred Method of Contact_____

1) What are your goals for this visit?

_____
_____
_____

2) Please prioritize your most important health concern/s today:

Concern	**Onset**	**Frequency**	**Severity**
Ie. headache	*June 2020*	*2x a week*	*mild/mod/severe*

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

3) Describe your typical diet. (Paleo, Keto, Gluten-Free, Dairy-Free, Fast Food, Healthy, Not Always Healthy, etc.)

_____
_____
_____

4) Do you have any allergies or intolerances that you are aware of? List/describe.

_____
_____
_____

5) Are there self care or wellness therapies that you receive or practice on a routine basis? (massage, acupuncture, reiki, yoga, meditation, etc.) If so, how often?

6) List current medications and doses, including over the counter:

7) List supplements and doses:

8) Have you experienced any recent traumatic event? *(job loss, divorce, death of loved one, relocation, harm)*

9) Are any of your current health issues affecting your daily life? If so, how?

10) What are the major stressors in your life?

11) How do you relieve your stress?

12) Whom do you live with? List names & ages.

_____

_____

13) What are your interests/hobbies?

_____

_____

_____

14) Do you exercise? If so, what type & how often?

_____

_____

15) Would you describe yourself as experiencing any of the following on a recurrent basis? Please check all that apply.

- ❑ Headaches/Migraines/Dizziness
- ❑ Fatigue/Trouble Sleeping
- ❑ Brain Fog/Poor Memory
- ❑ Itchy/Puffy/Irritated Eyes
- ❑ Stuffy/Runny Nose
- ❑ Chronic Cough/Sore Throat
- ❑ Chest Congestion/Shortness of Breath/Pain
- ❑ Fast/Irregular Heart Rate
- ❑ Acne/Hives/Rash/Dry Skin
- ❑ Hot Flashes/Night Sweats
- ❑ Under/Over Weight
- ❑ Irritability/Moodiness/Depression
- ❑ Anxiety/Nervousness
- ❑ Digestion Issues (Constipation/Diarrhea/Bloating/Gas/Pain/Cramps)
- ❑ Muscle Pain & Stiffness
- ❑ Joint Pain & Stiffness
- ❑ Other: _____

16) Is there any additional information that you would like me to know?

_____

_____

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17) I give permission for Stephanie Harper to use my iris photos for educational and/or promotional purposes.

Please circle: YES or NO

Acknowledgement and Waiver of Liability

I accept full responsibility for my health and voluntarily complete this Acknowledgment and Waiver of Liability. I certify that I am seeking the consultation and treatment services from Stephanie Harper Iridology LLC for holistic healing suggestions and therapies, which I fully understand are not medical diagnoses or treatments or substitutes for medical diagnoses or treatments. In seeking to become a client of Stephanie Harper Iridology LLC, I understand I am seeking analyses and/or therapies that may not be FDA registered or approved and may not be offered by practicing physicians. These include, but are not limited to Iridology, Reiki, Kinesiology, and Herbalism. I acknowledge that Stephanie Harper is not a medical physician and that she specializes in a holistic approach to healing. I certify that I should always consult my personal physician before starting any new health program as well as inform them of any and all changes that I make to my lifestyle. I seek the advice and treatment of Stephanie Harper Iridology LLC solely in my personal capacity, and do not represent any governmental agency, law firm, attorney, or investigator. I am not involved in a lawsuit nor am I gathering information for a potential lawsuit. My signature below indicates that I have carefully read and reviewed this Acknowledgment and Waiver of Liability, and I fully understand all of its terms and conditions; I recognize and accept all risks and limitations involved in seeking advice and treatment therapies from Stephanie Harper Iridology LLC.

_____	_____	_____
Client's Name (printed)	Client's Signature	Date