Vibrant WELLCARE
Melissa Olson, Traditional Naturopath

Name_____ Preferred Phone _____

Address _____ DOB _____

City _____ State/Zip _____ Email _____

Relief from top 3 symptoms? _____

* What are your current life goals?_____

* Why is this goal important to you? _____

* What methods have you tried before this? _____

Blood Type? O. A. B. AB. Unknown. Have you worked with a Naturopath before? Yes No

How much weekly exercise? _____ What type of exercise? _____

How many ounces of water do you drink daily? _____ What type? RO Tap Spring Distilled

How many Bowel Movements per day? _____ Do you take digestive enzymes Yes No

Do you currently or have you had any metal fillings in your teeth? Yes No

What OTC medications or vitamins do you take? _____

_____

How would you characterize your current diet? _____

How would you characterize your current mood? _____

How would you characterize your memory? _____

How would you characterize your family/friend support system? _____

Other health professionals with whom you are working? _____

Previous/Current Medical Diagnosis _____

_____

Do you have current medical bloodwork? Yes No. What did it show?_____

How much daily energy do you have? (1=Lowest, 10=Highest) _____ Is this enough? Yes No

How many hours of sleep do you get per night? _____ Is this enough? Yes No

What surgeries have you had and when? _____

_____

What prescription medications do you take? _____

_____

Who referred you for your appointment today? _____

I understand that I am here to learn about nutrition and better natural health practices and that I will be offered information about food, supplements, and herbs as a guide to general good health and it is my choice wether to take advantage of this information.

I fully understand that Melissa Olson is a Board Certified Traditional Naturopath, not a medical doctor and I am not here tor medical diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health and do not involve diagnosis, treatment, or prescribing medications for disease.

Signature _____ Date _____

(Check all that apply)

_____ Acne
_____ADD/ADHD
_____Adrenal Glands
_____Allergies
_____Alzheimer's Disease
_____Anemia
_____Anger
_____Anxiety
_____Appetite
_____Arteriosclerosis
_____Arthritis
_____Asthma
_____Attention/Focus
_____AutoImmune issues
_____Back Pain
_____Bad Breath
_____Bed Wetting
_____Bell's Palsy
_____Bites or stings
_____Bladder
_____Blood Pressure-High
_____Blood Pressure -Low
_____Blood Sugar - Low
_____Blood Sugar - High
_____Body Odor
_____Boils
_____Bones Concerns
_____Breathing trouble
_____Bronchitis
_____Bruises
_____Burns
_____Cancer
_____Candida
_____Canker Sores
_____Carpal Tunnel
_____Cataracts
_____Chest Congestion
_____Chest Pain
_____Cholesterol
_____Circulation
_____Cold - Common
_____Cold - Temperature
_____Colic
_____Constipation
_____Cough
_____Dandruff
_____Depression
_____Diabetes
_____Diarrhea
_____Difficulty swallowing
_____Digestion
_____Dizzy
_____Ear Infection
_____Ear Ringing
_____Edema
_____Emphysema
_____Epilepsy
_____Eyesight
_____Fainting
_____Fatigue
_____Fever
_____Flu
_____Gallstones
_____Gas
_____Gout
_____Gums
_____Hair Issues
_____Headache
_____Heart Issues
_____Heartburn
_____Hemorrhoids
_____Herpes
_____Hives
_____Hormones
_____Hyperthyroidism
_____Hypothyroidism
_____Hypoglycemia
_____Impotence
_____Incontinence
_____Indigestion
_____Insomnia
_____Kidney Pain
_____Kidney Stones
_____Laryngitis
_____Leukemia
_____Liver
_____Lump in throat
_____Lung Issues
_____Lupus
_____Lymph Glands
_____Memory
_____Menopause
_____Menstrual Cramps
_____Migraines
_____Mononucleosis
_____Motivation
_____Mucous
_____Muscle Aches
_____Nails
_____Nausea
_____Nervousness
_____Nose Bleeds
_____Pain, Muscles
_____Pain, Joints
_____Pain, nerves
_____Pain, organ
_____Pain, unspecified
_____Parasites
_____Parkinson's disease
_____Perspiration
_____PMS
_____Pneumonia
_____Polyps
_____Pregnancy
_____Prostate
_____Psoriasis
_____Rash
_____Reproductive
_____Respiratory
_____Rheumatism
_____Ring Worm
_____Seizures
_____Shingles
_____Shortness of breath
_____Sigh or yawn often
_____Sinus issues
_____Skin Issues
_____Sleep
_____Snoring
_____Sore Throat
_____Stomach
_____Stress
_____Stroke
_____Teething
_____Tonsillitis
_____Tumors
_____Ulcers
_____Urinary Infections
_____Varicose Veins
_____Vertigo
_____Vision
_____Weight -Overweight
_____Weight -Underweight
_____Yeast Infections
____Other please specify:

Acknowledgment and Waiver of Liability

I, _____, hereby certify and agree as follows:

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 services of Melissa Olson and Vibrant Wellcare, LLC for alternative healing suggestions and guidance, which I fully understand are not medical diagnoses or treatments or substitutes for medical diagnoses or treatments.

I certify that with respect to any medical conditions or concerns I may have, I have been advised to consult with my personal care physician, and understand that Melissa Olson, is not a primary care physician, and I do not view her as my physician. Her practice specializes in a natural approach to healing including, but not limited to, nutrition, herbs, homeopathy, and energy. I understand that Melissa Olson does not handle medical conditions or emergencies and does not maintain hospital privileges. I also understand that Melissa Olson is a Board Certified Traditional Naturopath, not a medical doctor.

In seeking to become a client of Melissa Olson and Vibrant Wellcare, 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 (allopathic or otherwise) and which may be considered experimental. These include, but are not limited to Reflex Analysis (kinesiology), Nutrition and Nutraceuticals, Hormone Balancing, Homeopathy, Flower Essences and Energy Balancing techniques.

I also agree that if I am taking psychiatric or other prescription medications while under consultation with Melissa Olson that I will not change those prescriptions without consulting my prescribing physician first. I also understand that email is not confidential, secure or 100 percent reliable. If I have an urgent question I will call her office. If I feel it is an emergency I understand that I need to call 911 or go to the nearest emergency room.

I understand and agree that neither Melissa Olson or Vibrant Wellcare, LLC make any claims whatsoever, expressed or implied, regarding effects or outcomes of the analyses or therapies provided, and shall not be liable for same. I certify that I seek the advice and guidance of Melissa Olson and Vibrant Wellcare, 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.

I understand and agree on behalf of myself, my dependents, heirs, administrators, legal representatives, and assigns, to release and hold harmless Melissa Olson, Vibrant Wellcare, LLC, and any and all associates, employees, agents and representatives thereof, from any and all liability for illness, injuries, or death, and for any losses or damages relating thereto, however occurring, in relation to my consultation with or by Melissa Olson and/or Vibrant Wellcare, LLC. Without limitation, I understand and agree that neither Melissa Olson and/or Vibrant Wellcare, LLC, nor any associates, employees, agents or representatives thereof, is liable for any direct, indirect, consequential, or incidental damage, injury, death, loss, delay, or inconvenience of any kind which may be occasioned by reason of any act or omission, including, without limitation, any willful or negligent act or failure to act, or breach of contract.

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 consultation from Melissa Olson and/or Vibrant Wellcare, LLC and associates, employees, agents and representatives thereof; I have not relied upon any other promises, agreements or representations by Melissa Olson and/or Vibrant Wellcare, LLC, or any associates, employees, agents or representatives thereof concerning the treatment provided or the terms of this Acknowledgment and Waiver of Liability; I have been encouraged by Melissa Olson and/or Vibrant Wellcare, LLC to seek the advice of legal counsel concerning this Acknowledgment and Waiver of Liability; and I execute and deliver this Acknowledgment and Waiver of Liability freely and voluntarily and without duress or coercion and with full knowledge of the representations contained herein and the rights relinquished, surrendered, released and discharged hereunder.

UNDERSTOOD, ACCEPTED AND AGREED

_____

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

Complementary and Alternative Health Care
Client Bill of Rights

Please read this complementary and alternative health care client bill of rights. I am pleased to provide you with this client bill of rights, in accordance with Minnesota laws governing complementary and alternative health care practices.

1) Melissa Olson,
2) Board Certified Traditional Naturopath
BioEnergetic Practitioner
RYT 200 Certified Yoga Teacher
Reiki Master

Vibrant Wellcare, LLC
13959 W Preserve Blvd, Suite 304
Burnsville, MN 55337

In accordance with Minnesota state law, I am providing you with the following notice: "The state of Minnesota has not adopted any educational and training standards for unlicensed complementary and alternative health care practitioners. This statement of credentials is for informational purposes only."

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuation of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer or any other type of heath care provider, the client may seek such services at any time.

3) **Practitioner's supervisor**. - None

4) **Right to file a complaint**. If you have any concerns, you may file a complaint with the following office.
Office of Complementary and Alternative Practice (OCAP)
Minnesota Department of Health
PO Box 64882
Metro Square Building
St. Pail, MN 55164-0882
Phone: 651-201-3721

5) **Fees.** Fees are payable at the time of service. We do not handle insurance claims: however, a receipt will be provided to you should you wish to file a claim with your provider. We do not accept Medicare or Medical Assistance.

6) **Change in service of charges.** You have the right to reasonable notice of changes in services or charges , and I will produce proper notice of any changes.

7) **Brief summary of my wellness approach**. I believe the body has an amazing capacity to heal itself with we live in accordance with the laws of nature. Through proper natural support of the body, it will heal itself.

8) **Assessment and Recommendation.**You have the right to complete and current information concerning my assessment and recommended service, including the expected duration of the services to be provided. If you have any questions, please ask.

9) **Courteous Service.** You may expect courteous treatment and to be free from verbal, physical or sexual abuses by your practitioner.

10) **Confidentiality**. Your records and transactions with this office are confidential. This information will not be released unless you authorize release in writing or unless release is required by law.

11) **Records**. You are allowed access to records and written information from records in accordance with section 144.335 of Minnesota Statues.

12) **Other Community Services.** Other similar services are available in the community. Possible sources of information are Minnesota Wellness Directory, the Edge newspaper directory, or the telephone yellow pages. You may ask your practitioner and she will provide this information to the best of her knowledge.

13) **Selecting and Changing Practitioners**. You have the right to choose freely from available practitioners and to change practitioners at any time. If these services are covered by your health insurance, medical assistance plan or other health program, you should direct all questions about coverage to your health insurance provider.

14) **Coordinated transfer**. If you change practitioners, you have the right to our assistance in coordinating this transfer to another practitioner.

15) **Right to Refuse Service**. You are free to refuse service or treatment unless otherwise provided by law.

16) **No Retaliation**. You may assert your rights described in the Client Bill of Rights at any time without retaliation.

Acknowledgement

I have received a copy of the complementary and alternative Client Bill of Rights. I have read and understand the Client Bill of Rights document and my rights as a client. I understand my rights as a client.

_____

Client or Legal Guardian's Name Printed Date

_____

Client or Legal Guardian's Signature Date

_____

Witness Date

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relieved by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard, dry, or small stool	**0**	**1**	**2**	**3**
Coated tongue or "fuzzy" debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul-smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
Use laxatives frequently	**0**	**1**	**2**	**3**
Category II				
Increasing frequency of food reactions	**0**	**1**	**2**	**3**
Unpredictable food reactions	**0**	**1**	**2**	**3**
Aches, pains, and swelling throughout the body	**0**	**1**	**2**	**3**
Unpredictable abdominal swelling	**0**	**1**	**2**	**3**
Frequent bloating and distention after eating	**0**	**1**	**2**	**3**
Category III				
Intolerance to smells	**0**	**1**	**2**	**3**
Intolerance to jewelry	**0**	**1**	**2**	**3**
Intolerance to shampoo, lotion, detergents, etc	**0**	**1**	**2**	**3**
Multiple smell and chemical sensitivities	**0**	**1**	**2**	**3**
Constant skin outbreaks	**0**	**1**	**2**	**3**
Category IV				
Excessive belching, burping, or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movements	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting proteins and meats; undigested food found in stools	**0**	**1**	**2**	**3**
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	**0**	**1**	**2**	**3**
Use of antacids	**0**	**1**	**2**	**3**
Feel hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief by using antacids, food, milk, or carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	**0**	**1**	**2**	**3**
Category VI				
Difficulty digesting roughage and fiber	**0**	**1**	**2**	**3**
Indigestion and fullness last 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	**0**	**1**	**2**	**3**
Frequent loss of appetite	**0**	**1**	**2**	**3**

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	**0**	**1**	**2**	**3**
Abdominal distention after certain probiotic or natural supplements	**0**	**1**	**2**	**3**
Decreased gastrointestinal motility, constipation	**0**	**1**	**2**	**3**
Increased gastrointestinal motility, diarrhea	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Suspicion of nutritional malabsorption	**0**	**1**	**2**	**3**
Frequent use of antacid medication	**0**	**1**	**2**	**3**
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	**Yes**		**No**	
Category VIII				
Greasy or high-fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and/or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Burpy, fishy taste after consuming fish oils	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates from clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed?	**Yes**		**No**	
Category IX				
Acne and unhealthy skin	**0**	**1**	**2**	**3**
Excessive hair loss	**0**	**1**	**2**	**3**
Overall sense of bloating	**0**	**1**	**2**	**3**
Bodily swelling for no reason	**0**	**1**	**2**	**3**
Hormone imbalances	**0**	**1**	**2**	**3**
Weight gain	**0**	**1**	**2**	**3**
Poor bowel function	**0**	**1**	**2**	**3**
Excessively foul-smelling sweat	**0**	**1**	**2**	**3**
Category X				
Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep going/get started	**0**	**1**	**2**	**3**
Get light-headed if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, or have tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory, forgetful between meals	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**
Category XI				
Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ **years**

Since menopause, do you ever have uterine bleeding?	Yes	No

Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: