4155 E. Jewell Ave, Suite 801
Denver, CO 80222
(303) 504-0772

Name_____

Street_____Apt. #_____

City_____State_____Zip_____

Phone: (H)_____(W)_____(Cell)_____

Email_____Birthdate_____

Age _____Marital Status_____Children (Y/N)?_____

Employer Name _____

Employer Address_____

Physician_____Date of last physical_____

Emergency Contact _____Phone #_____

Relationship _____

Referred by _____

Payment is Due In Full at the time of service. Acacia Whole Health does not bill Health Insurance Companies or write letters for Health Flex Plans.

INITIAL CONSULTATION*:
Rennetta Nikolic - $395.00 Traditional Naturopath

ALL FOLLOW-UP VISITS*:

30 Minutes - $115.00
45 Minutes - $165.00
60 Minutes - $195.00

**Above rates do not include Supplements.*

Please Note: To respect the time of our other clients, product scans are limited to three (3) products per 30 minute appointment. Any amount higher than three (3) requires an appointment time of no less than 60 minutes.

Cancellation Notice: I understand that Acacia Whole Health has a 24-hour Advance Cancellation Policy. Clients canceling with less than 24 hours notice will be charged the following cancellation fees:

90 minute appointment - $100.00
60 minute appointment - $65.00
30 minute appointment - $45.00

The Practitioners at Acacia Whole Health provide holistic complementary health services in the form of dietary and nutritional guidance, nutritional supplements, homeopathic remedies and use of frequency generators.

As complementary health service providers, Practitioners at Acacia Whole Health are not required to be licensed, certified or registered by the state of Colorado as a health care professional.

Degrees, certifications and affiliations:

- Clayton College of Natural Health; Bachelor of Natural Health Studies; Doctor of Naturopathy
- American Association of Acupuncture and Bio-Energetic Medicine; Level II Certification; Electro-Dermal Screening and Measurement
- Institute of Quantum Medicine, Computronix Electro Medical Systems, National College of Oriental Medicine; Level III Certification; Electro-Dermal Screening and Measurement
- American Naturopathic Medical Association

Colorado SB 13-215 requires that we recommend you consult with your primary care physician, obstetrician, gynecologist, oncologist, cardiologist, pediatrician, or other board-certified physician regarding the recommendations made by the Practitioners at Acacia Whole Health.

Practitioners at Acacia Whole Health are covered by liability insurance for the services provided.

I hereby authorize the Practitioners at Acacia Whole Health to act on my behalf concerning the health analysis procedure for energy evaluation, and develop a suggested health program. I warrant that all information presented for analysis and evaluation was submitted by me and is true to the best of my knowledge.

I recognize that the health analysis procedure is an established method that is approved by the Food and Drug Administration to measure galvanic skin response, and is not yet approved by the American Medical Association.

I acknowledge that the health analysis procedure, the evaluation and the suggested health program are not for the diagnosis, treatment, alleviation, mitigation, prevention or care of any disease. With this in mind, I reserve the right to use the knowledge I gain regarding my own body in any legal manner I may choose, including the suggested health program.

I understand that my records are kept strictly confidential, and will only be released upon my written consent.

Please sign that you have read, fully understand and agree to the above terms:

Signature _____ Date _____

FAMILY MEDICAL HISTORY (This does not refer to you but your family)

HEART TROUBLE

IF DECEASED, AGE PARENTS DIED: MOTHER_____ FATHER_____

PERSONAL MEDICAL HISTORY (Your medical history)
You may email us a current document, or fill out the information below.

ALLERGIES (Drugs, chemicals, foods, animals, seasonal, etc.)

HAVE YOU EVER RECEIVED VACCINATIONS? ◯ YES ◯ NO

CURRENT VACCINATIONS? ◯ YES ◯ NO

CURRENT MEDICATIONS, SUPPLEMENTS, HOMEOPATHICS, ETC

MAJOR COMPLAINTS

DATE IT BEGAN ◯ BETTER ◯ WORSE ◯ SAME

HAVE YOU EVER HAD THIS CONDITION BEFORE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS?

IF YES, WHEN? BY WHOM?

WHAT WERE THE RESULTS?

WHAT MAKES IT BETTER?

WHAT MAKES IT WORSE?

RESPIRATORY

NORMAL

CARDIOVASCULAR

NORMAL

PAIN

NORMAL

HAIR

NORMAL

NAILS

NORMAL

EARS

NORMAL

NOSE

NORMAL

EYES

NORMAL

MOUTH/THROAT

NORMAL

SKIN

NORMAL

URINATION (4-6 TIMES PER DAY IS NORMAL)

NORMAL

THIRST

NORMAL

SLEEP

NORMAL

HEADACHES/DIZZINESS

NORMAL

DIGESTION

NORMAL

BOWELS/STOOL

NORMAL

PERSPIRATION

NORMAL

BODY TEMPERATURE

NORMAL

ENERGY

NORMAL

HABITS

SMOKING (AMOUNT): _____ (cigarettes per day / week)
ALCOHOL: (amount) _____ (drinks per day / week)
RECREATIONAL DRUGS: (type) _____ (amount) _____ (per day / week)

EXERCISE

HEAVY

APPETITE

NORMAL

WEIGHT

NORMAL

FOR MALES - ARE YOU EXPERIENCING

NORMAL

FOR FEMALES:

ARE YOU OR COULD YOU BE PREGNANT: ◯ YES ◯ NO

IF YES, APPROXIMATE DATE OF CONCEPTION:

ARE YOU EXPERIENCING: REDUCED SEX DRIVE

DO YOU HAVE REGULAR PAP TESTS? ◯ YES ◯ NO

DATE OF LAST PAP:

MENSTRUAL CYCLE

NONE

EXPLAIN ANY OF THE ABOVE:

MENOPAUSAL FEMALES ONLY:

MENOPAUSAL SYMPTOMS

NONE

STRESS:

PLEASE LIST ANY PHYSICAL OR EMOTIONAL STRESSORS IN YOUR LIFE:

LIST ANY SIGNIFICANT TRAUMAS (PHYSICAL OR EMOTIONAL) INCLUDING APPROXIMATE DATE:

PLEASE DESCRIBE EMOTIONAL OR BEHAVIORAL PATTERNS ABOUT YOURSELF THAT YOU WOULD LIKE TO CHANGE:

HOW DO YOU COPE WITH STRESS?

DO YOU HAVE A DAILY PRACTICE OF SELF CARE? (I.E. JOURNALING, MEDITATION, PRAYER, DEEP BREATHING, STRETCHING) PLEASE DESCRIBE:

PLEASE RATE YOUR HEALTH ON A SCALE OF 1-10 (10 = BEST, 1=WORST)
PHYSICAL.....MENTAL/EMOTIONAL.....SPIRITUAL

PLEASE LIST HOW MUCH OF THE FOLLOWING YOU GET PER DAY:

SLEEP (IN HOURS)? _____

WATER (IN OUNCES)? _____

EXERCISE (IN MINUTES)? _____

REST/RELAXATION/RECREATION (IN MINUTES/HOURS)? _____

SUNLIGHT/FRESH AIR/TIME IN NATURE (IN MINUTES/HOURS)? _____

NUTRITION:

PLEASE LIST HOW OFTEN YOU CONSUME THE FOLLOWING FOODS:

	DAILY	WEEKLY	1-2X MONTHLY	NEVER
VEGETABLES				
FRUITS				
WHOLE GRAINS				
BEANS/SEEDS/NUTS				
CHICKEN/TURKEY				
FISH/SEAFOOD				
EGGS				
DAIRY (YOGURT/KEFIR)				
DAIRY (CHEESE/MILK)				
ORGANIC FOODS				
PORK/HAM				
RED MEAT				
SWEETENED JUICE				
CAFFEINE				
GLUTEN/BREAD				
SODA (INCLUDING DIET)				
SUGARY FOODS				
SOY				
CORN				
ALCOHOL				
FRIED FOODS				