

WELCOME TO ECO CHIC WELLNESS!

Please help us serve you better by completing this client intake form.

Date//			
Month Day Year			
First name			
Last name			
Address Line 1			
Address Line 2			
City	State	Zip	
Phone (
Email Address			
I wish to receive emails from Eco Chic.			
Gender			
Date of Birth / /			

For your comfort and safety, please complete the **health history information** on the following pages.

HEALTH HISTORY

Do you use organic household	and hy	giene pr	oducts?	Yes No		
Have you ever had a reaction t	to perso	onal car	e products	s? Yes No		
If yes, please list						
Are you allergic to any medica	tions?	Yes	s No			
If yes, please list						
Are you taking any medication	s at pro	esent?	Yes	No		
If yes, please list						
Do you smoke?	Yes	No				
Are you pregnant?	Yes	No				
Do you have a history of any o	f these	health	conditions	s?		
High Blood Pressure Bleeding Problems Heart Problems Claustrophobia Skin Condition Nail Fungus Spinal Problems Blood Clots Acute Injury If yes, please elaborate	Y 6 Y 6 Y 6 Y 6 Y 6 Y 6	es No es No es No		Diabetes Seizures Cancer Thyroid Problems Radiating Pain Systemic Disease Varicose Veins Arthritis	Yes Yes Yes Yes Yes Yes	No No No No No No
Have you ever had surgery? If yes, please explain		Yes				
Do you have any other medica					Yes	No
If ves. please list						

HEALTH HISTORY CONTINUED

Do you see a chiropractor? Yes No
Do you see a nutritionist or naturopath? Yes No
Do you work out regularly? Yes No
Do you use fluoride? Yes No
Do you use an air filter/purifier or diffuser in your home? Yes No
Do you bio hack/track your sleep? Yes No
Do you wear blue light blocking glasses? Yes No
Do you have a WiFi box and high exposure to EMFs in your home? Yes No
Do you live near a 5G tower or have a Smart Meter on your home? Yes No
Do you have a gene mutation? Yes No
Have you been exposed to molds? Yes No
Do you have any metal fillings or had a root canal before? Yes No
Is your home/tap water filtered? Yes No
Do you use a sauna, red light therapy, or any other holistic methods? Yes No
If yes, please list
What "diet" do you subscribe to? Paleo Vegan Whole 30 Keto 80/20 SAD
Have you ever done Whole 30, sugar detox, keto, or paleo for beyond 30 days? Yes No
If yes, which one
Have you ever been vaccinated? Yes No If yes, when was the date of your last vaccine.

HEALTH HISTORY CONTINUED

Have you had any of the following tests done?						
Allergy (food)	Yes	No				
Dr. Hilu Blood Test	Yes	No				
Functional or Standard Blood Work	Yes	No				
Genetic Testing (MTHFR, COMT)	Yes	No				
GI-MAP	Yes	No				
Mycotoxin Test	Yes	No				
Dutch Test	Yes	No				
Muscle Testing	Yes	No				
What are your health priorities and o	conce	rns in order fro	m m	ost in	nportant:	
Diet and Nutrition		Skin				
Digestion and Gut Health		Sleep				
Hormones		Stress				
Immune System		Testing				
Have you read any of the following books?						
The Body Keeps the Score by Besse	l van	der Kolk		Yes	No	
Healing Through Wisdom by Chrissy Helmer				Yes	No	
How I Healed Cancer by Andrea Thompson			Yes	No		
Patient Heal Thyself by Dr. Jordan R	•			Yes	No	
, ,			Yes	No		
Addition Nation of Bullion 1. Bobadin and Nyan 1. Bobadin 100 110						
Is there anything else we should know	ow?	Yes	No			
If yes, please explain						