Naturally Unbridled Wellness Client Application Today's Date ____/___/____

Name: _____ __ Male __ Female

Birthdate: _____ Age: _____ Email:_____

FULL Address: _____City:_____State:____Zip:_____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Emergency Contact Phone: _____

Referred by: _____

Are you currently nursing or pregnant? Y or N

What are you trying to accomplish with our services?

___Less Pain
___More Energy
___Digestive Balancing
___Emotional Balance
___Fertility Support
___Autoimmune Disease
___Recovery from Illness or Injury
___Allergy Support
___Urinary Issues (kidney/bladder)
___Neurological Support
___Other:_____

___Better Sleep
___Improved Mood
___Weight Optimization
___Clearer thinking
___Lyme Disease or Other Infection
___Female Hormone Support
___Skin Issues (rash, acne, etc.)
___Healthy Diet & Lifestyle Support
___Circulatory Issues (Blood pressure, etc.)
___Cancer Support

_____

_____

_____

Who is your Chiropractor: _____

How many OUNCES of WATER do you drink in an average day? _____

Pharmaceuticals (prescription or over-the-counter) including birth control taken in last two months:

_____

_____

_____

Vitamins/ Supplements taken in last two months:

_____

_____

_____

Vaccines taken in the last 2 years:

_____

_____

_____

Check All That Apply

Digestive

___Constipation with or without straining
___Diarrhea once a month or more
___Bloating with or without passing gas
___Heartburn, Reflux, GERD, EOE, Barret's Esophagus
___Very stinky gas/stool
___Formed, smooth bowel movements most days
___Belching
___Undigested food in stool
___Greasy food goes right through you
___IBS or inconsistent bowels
___Pain under the right rib cage
___Diagnosed with digestive condition

Details: _____
_____
_____

Sleep

___Fall asleep easily
___Wake frequently in the night
___Pets or family disturbs sleep
___Medication, supplements, or alcohol needed
___CPAP recommended but not used
___Sleep 7-9 hours and wake rested
___Work requires altered sleep schedule
___Bladder wakes 1 or more times/night
___Can't shut off mind
___Tired upon waking
___Wake and cannot fall back asleep
___CPAP used
___Inconsistent sleep
___Pain disturbs sleep

Details: _____
_____
_____

Energy

___Energy is good all day
___Afternoon crash
___Energy drinks or supplements used
___Naps needed
___Second wind late afternoon/evening
___Depression impacts energy level
___Cold hands/feet/generally
___Pain depletes energy
___Tired after eating
___Energy best in the morning
___More than 12 ounces of coffee/day
___Always fatigued
___Night owl
___Not enough energy to exercise
___Exertion wipes me out
___Lightheaded upon standing
___I never stop thinking/working/doing

Details: _____
_____
_____

Emotional

___Grief
___Anxiety
___Depression
___OCD
___Panic Attacks
___Worry
___Phobia
___History of trauma/abuse
___Brain fog
___Can't focus
___Embarrassed
___Puts others first constantly
___Angry
___Lack of joy in life
___Lack of support
___Prescription for emotional balance or sleep

Details: _____
_____
_____

Metabolic

___Hormone challenges
___Weight gain
___Panic Attacks
___Belly fat
___Neck fat
___Cholesterol
___Blood sugar balance
___Weight-loss resistance
___Can't gain weight
___Lack of endurance
___Prescription for hormones or blood sugar
___Diabetic or Prediabetic

Details: _____
_____
_____

Describe your **exercise** routine: _____
_____
_____

Are you looking for natural symptom support or do you want to get to the root cause of the issue?

Fertility Clients: Were you vaccinated for HPV (Gardasil vaccine) or COVID-19: _____

How long do you think it will take to reach your wellness goals? _____

Do you have: ____< Seizure Disorder ____ <Pacemaker ____ <Alcoholism

How willing are you to make lifestyle changes to improve your situation?
Not Willing Slightly Willing Willing Very Willing

I understand that Patti Bartsch, Ph.D. and the staff at Naturally Unbridled Wellness LLC are not medical professionals; therefore, they do not diagnose, treat, cure, or prescribe for any disease or condition. Their comments are not a replacement for qualified medical care. I have stated any medical conditions that apply to me and I take it upon myself to keep the practitioners and my healthcare providers up to date on health changes. It is my responsibility to evaluate all supplements and remedies for allergies and contraindications.

If you are under 18 years old a guardian must sign this form. Thank You.

_____ _____
signature date

Checking in on Facebook allows others to know that we are here to help! Thank you!

You may include any other information that you feel may be helpful to us below:

_____
_____
_____
_____
_____
_____
_____
_____