



## Immunitrition Confidential Health Questionnaire

Fax: (480) 393-5410

E-mail: [consultations@immunitrition.com](mailto:consultations@immunitrition.com)

Consultation Date: \_\_\_\_\_

Consultation Time: \_\_\_\_\_

**\*\* All of your personal information will remain strictly confidential! \*\***

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Name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Would you like your weight to be different? \_\_\_\_\_ If so, what? \_\_\_\_\_

Occupation: \_\_\_\_\_ How many hours do you work per week? \_\_\_\_\_

Relationship Status: \_\_\_\_\_ Children? \_\_\_\_\_

Blood Type (if known): \_\_\_\_\_

Referred by: \_\_\_\_\_

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Describe the symptoms you are currently experiencing: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What would you like to accomplish/gain from this consultation? \_\_\_\_\_

\_\_\_\_\_

Do you sleep well? \_\_\_\_\_

Do wake up during the night? \_\_\_\_\_ If so, what time(s)? \_\_\_\_\_

What time do you go to bed? \_\_\_\_\_ What time do you generally wake-up? \_\_\_\_\_

How do you feel when you wake up? \_\_\_\_\_

Do you drink caffeinated drinks? \_\_\_\_\_ How much & how often? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much & how often? \_\_\_\_\_

If no, why, how and when did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much & how often? \_\_\_\_\_

Do you drink soda (diet or regular)? \_\_\_\_\_ How much & how often? \_\_\_\_\_

What role does exercise play in your life? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any known allergies to medications or herbs? Please list all - \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently under a practitioner's care for a specific health issue? If so, what treatments are you undergoing? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries, accidents, injuries or childhood diseases you have had along with the type and date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are your eating/drinking habits these days?**

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

What were your eating habits like as a child? (List types of foods) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What percentage of your food is home cooked? \_\_\_\_\_

How often do you eat out? \_\_\_\_\_

What are the three worst foods you eat each week? \_\_\_\_\_  
\_\_\_\_\_

What are the three healthiest foods you eat each week? \_\_\_\_\_  
\_\_\_\_\_

Do you crave sugar? \_\_\_\_\_ Do you crave salt? \_\_\_\_\_

Do you feel tired, bloated, and/or gassy after meals? \_\_\_\_\_

Do you experience constipation or diarrhea often? \_\_\_\_\_ When & how often? \_\_\_\_\_  
\_\_\_\_\_

Do you feel excessively hungry? \_\_\_\_\_ Do you have a poor appetite? \_\_\_\_\_

Please list any known food allergies and/or intolerances: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Within the last two years, have you been tested for any of the following hormones?

- 1) DHEA \_\_\_\_\_
- 2) Cortisol \_\_\_\_\_
- 3) Testosterone \_\_\_\_\_
- 4) Estrogen \_\_\_\_\_
- 5) Progesterone \_\_\_\_\_

Were your hormone levels normal? \_\_\_\_\_ If not, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any previous colon cleansing sessions with a certified colon therapist? \_\_\_\_\_  
When? \_\_\_\_\_ How many? \_\_\_\_\_

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### Family Health History

Diabetes? \_\_\_\_\_ Kidney disease? \_\_\_\_\_  
Heart Disease? \_\_\_\_\_ Arthritis? \_\_\_\_\_  
Asthma? \_\_\_\_\_ Gallbladder disease? \_\_\_\_\_  
Cancer? \_\_\_\_\_ Type of cancer? \_\_\_\_\_  
Stomach/Intestinal disorders? \_\_\_\_\_ Other: \_\_\_\_\_

Mother: Age: \_\_\_\_\_ Died from? \_\_\_\_\_  
Father: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

Maternal Grandmother: Age: \_\_\_\_\_ Died from? \_\_\_\_\_  
Paternal Grandmother: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

Maternal Grandfather: Age: \_\_\_\_\_ Died from? \_\_\_\_\_  
Paternal Grandfather: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

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### WOMEN ONLY:

Age of your first period: \_\_\_\_\_ Are your periods regular? \_\_\_\_\_  
How frequent? \_\_\_\_\_ # of pregnancies \_\_\_\_\_  
How many days is your flow? \_\_\_\_\_  
Do you experience PMS? \_\_\_\_\_ Is it mild or severe? \_\_\_\_\_

Are you peri-menopausal? \_\_\_\_\_ When did this change first occur? \_\_\_\_\_  
Are you menopausal? \_\_\_\_\_ When was your last period? \_\_\_\_\_  
List your symptoms of peri/menopause: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many children have you delivered and how were they born (vaginally or by cesarean)?  
\_\_\_\_\_  
\_\_\_\_\_

Were there complications associated with these births? \_\_\_\_\_ Please explain: \_\_\_\_\_  
\_\_\_\_\_

Did you receive antibiotics during labor? \_\_\_\_\_  
Have you ever had a miscarriage or an abortion? \_\_\_\_\_ How many? \_\_\_\_\_

**Health Check list** - Please answer “Y” or “N”. Leave blank if symptom does not apply

<p><b><u>General Symptoms:</u></b></p> <p>Allergies - Colds- Depression - Fatigue - Fainting spells - Insomnia - Frequent illness -</p>	<p><b><u>Ears:</u></b></p> <p>Itchy ears - Earaches - Ear Infections - Ringing in Ears - Ear Drainage - Hearing Loss -</p>	<p><b><u>Eyes:</u></b></p> <p>Watery Eyes - Itchy or red eyes - Blurred Vision - Tunnel Vision -</p>
<p><b><u>Nose:</u></b></p> <p>Stuffy nose - Sinus problems - Hay Fever - Sneezing - Excess Mucus - Nose Bleeds -</p>	<p><b><u>Emotions:</u></b></p> <p>Mood Swings - Anxiety - Nervousness - Anger - Irritability - Depression -</p>	<p><b><u>Heart/Cardiovascular:</u></b></p> <p>Irregular heartbeat - Rapid heartbeat - Chest pains - Swelling of ankles - Poor Circulation - High/Low blood pressure -</p>
<p><b><u>Joint/Muscle:</u></b></p> <p>Joint pain - Arthritis - Muscle pain - Varicose veins - Back pain -</p>	<p><b><u>Head:</u></b></p> <p>Dizziness - Headaches -</p>	<p><b><u>Lungs/Respiratory:</u></b></p> <p>Chest congestion - Asthma - Shortness of breath - Bronchitis - Chronic Cough -</p>
<p><b><u>Mind:</u></b></p> <p>Poor memory - Confusion - Learning -</p>	<p><b><u>Disabilities:</u></b></p> <p>Stuttering - Poor concentration -</p>	<p><b><u>Mouth/Throat:</u></b></p> <p>Chronic Sore throat - Swollen gums - Canker sores - Sensitive teeth-nerves -</p>
<p><b><u>Energy:</u></b></p> <p>Fatigue - Apathy -</p> <p><b><u>Lethargy:</u></b></p> <p>Hyperactivity - Restlessness -</p>	<p><b><u>Digestive Tract:</u></b></p> <p>Nausea - Diarrhea - Constipation - Bloating - Belching - Excess Gas - Heartburn/Reflux -</p>	<p><b><u>Urinary Tract</u></b></p> <p>Bladder trouble - Kidney failure - Kidney infection - Kidney stones - Prostate trouble - Chronic UTI's - Burning urination -</p>
<p><b><u>Skin:</u></b></p> <p>Acne - Boils - Hives or rashes - Hair loss - Excess sweating - Dryness - Eczema or psoriasis - Sensitive skin - Bruising easily -</p>	<p><b><u>Weight:</u></b></p> <p>Binge eating - Cravings - Excessive weight - Compulsive eating - Water retention - Under weight - Eating disorders -</p>	<p><b><u>Women:</u></b></p> <p>Genital itch/discharge- Fibrocystic breasts - Hysterectomy - Irregular pap tests - Yeast infections - Vaginitis – Endometriosis - Absence of period - Infertility -</p>

## **DISCLAIMER**

The health and nutritional information you receive from any Immunitrition practitioner during a consultation, whether given by phone, in person at your home, in the office, through lectures, workshops, brochures, or newsletters is not intended to diagnose or prescribe. It consists of combined information from many educational sources and points of view to help you make informed decisions regarding your desired level of health. The sources behind this information include: modern medicine, ancient Chinese medicine, naturopathic medicine and the therapist's personal research, study, and life observation as well as client results and experiences. Anyone deciding to act upon any information mentioned during a consultation shall assume full responsibility for any effects of their actions. There are risks and unforeseen results associated with any change of diet and lifestyle. It is not recommended that you apply these changes unless you are willing to assume full responsibility for the risks you choose to take. If you choose to implement dietary and lifestyle changes without consulting your physician, which is your constitutional right, you are, in effect, prescribing for yourself. When in doubt of the appropriateness of any treatment, whether recommended to you by a practitioner or by your own intuition, please consult a physician. Consultation information should not be used as a substitute for a physician's advice. It is our hope that you do choose a physician who realizes the importance of a healthy diet and lifestyle choices in correcting imbalances in the body and who has experience in treating immune disorders and other health imbalances. Please be aware that you have the right to make your own health decisions based on any information made available to you. **YOU are the driving force in guiding yourself on a path to radiant health!**

## **ACKNOWLEDGEMENT**

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by Immunitrition, LLC and Caroline Barringer is to be used for educational purposes only. I also acknowledge that neither Immunitrition, LLC, nor Caroline Barringer claim to be medical doctors and will not prescribe for or diagnose any disease or condition. Immunitrition, LLC and its nutritional consultants have been thoroughly trained and certified by the Nutritional Therapy Association, Clayton College of Natural Health, Body Ecology, and the Medtexx Medical Corporation.

The preceding answers are true and correct to the best of my knowledge. If I experience any changes in my health or current medications, I will immediately communicate this information to Immunitrition, LLC and Caroline Barringer. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Immunitrition, LLC or Caroline Barringer liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

Client Name (print): \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **CONSULTATION DURATIONS AND FEES**

Initial Consultation (90 minutes) - \$195.00  
Initial Consultation (120 minutes) - \$240.00  
Initial Consultation (For every ½ hour over) - \$45.00  
Follow-up Consultation (1 hour) - \$135.00  
1/2 Hour Follow-up Consultation - \$95.00

We accept Visa, MasterCard, Amex and Discover. To pay for your consultation, call (877) 773-9229 or send a check or money order to the address below along with your completed questionnaire. Payment is due upon the completion of your consultation. For frequently asked questions about our services, please visit [www.immunitrition.com](http://www.immunitrition.com) and navigate to our "FAQS" Web page. If you are interested in purchasing our Organic Cultured Vegetables, visit our ONLINE STORE at: [www.culturednutrition.com](http://www.culturednutrition.com).

If paying by check or money order, please make payable to:

Immunitrition, LLC  
P.O. Box 430  
Franklin Square, NY 11010 - 0430