New Life Through Balanced Living

www.neoszoe.com

PRIVATE LICENSE, INFORMED CONSENT AND RELEASE

Nutrition and Holistic Health Practitioner

The undersigned hereby grants a **Private License** to Maryann Castello (Nutrition and Holistic Health Practitioner) to engage in nutritional and holistic health modalities with the undersigned.

The undersigned acknowledges that the Practitioner is not a medical doctor and does not diagnose or prescribe for medical or psychological conditions, nor claim to prevent, mitigate or cure such conditions. The Practitioner does not provide diagnosis, care, treatment or rehabilitation of individuals, nor does the Practitioner apply medical, mental health or human development principles.

The Practitioner helps clients achieve good health and peak performance by nutrition and holistic health means, without the use of any drug material remedy or other medical means. **The undersigned gives Informed Consent to the services that will be provided.**

The undersigned hereby releases the Practitioner (and Neos Zoe, LLC), from all claims and liabilities arising from the use or misuse of nutritional or holistic health modalities, indemnifying and holding the Practitioner harmless from all claims and liabilities there from, whatsoever. The Practitioner reserves all rights.

Please Print:

Today's Date: ____

Name: ____

Signature: ____

(Parent's signature, if minor

Maryann Castello, LMT, HHP, CL.N

Phone: 732.713.0123

Fax: 732.381.1985

Nutritional Health & Lifestyle Questionnaire

Email: info@neoszoe.com

Today's Date: ______________ Social Security No: ______________

Name: ______________ Date of Birth: ______________

Street Address: ______________ Apartment Number: ______________

City: ______________ State: ______________ Zip Code: ______________

Home Phone: ______________ Cell Phone: ______________ Fax Number: ______________

Marital Status: ______________ Age: ______________ Height/Weight: ______________

E-mail Address: ______________ Occupation: ______________

Emergency Contact: ______________ Phone: ______________ Relation to you: ______________

What is your chief complaint? What brought you here today? ______________

Are you presently under a Physician's care? (Please Circle:) Yes No

Date of last visit? ______________ For what? ______________

Should a medical consultation be needed, may Maryann Castello, LMT, HHP contact your Physician?

(Please Circle:) Yes No

Physician's Name: ______________

Street Address: ______________

City/State/Zip: ______________

Phone Number: ______________

Are you presently working with Holistic Practitioners? (Please Circle:) Yes No

Date of last visit? ______________ For what? ______________

List any medications you are taking:

Medication Name: ______________ For What? ______________ How Long? ______________

Medication Name: ______________ For What? ______________ How Long? ______________

Medication Name: ______________ For What? ______________ How Long? ______________

Medication Name: ______________ For What? ______________ How Long? ______________

Medication Name: ______________ For What? ______________ How Long? ______________

List any herbal remedies you are taking:

Remedy Name: ______________________ For What? ______________ How Long? ______________

Remedy Name: ______________________ For What? ______________ How Long? ______________

Remedy Name: ______________________ For What? ______________ How Long? ______________

Remedy Name: ______________________ For What? ______________ How Long? ______________

Remedy Name: ______________________ For What? ______________ How Long? ______________

List any vitamins/supplements you are taking:

Vitamin/Supplement: ______________________ For What? ______________ How Long? ______________

Vitamin/Supplement: ______________________ For What? ______________ How Long? ______________

Vitamin/Supplement: ______________________ For What? ______________ How Long? ______________

Vitamin/Supplement: ______________________ For What? ______________ How Long? ______________

Vitamin/Supplement: ______________________ For What? ______________ How Long? ______________

Are you allergic to any medications, herbal remedies, vitamins or supplements?

____

____

____

Have you had any past surgeries/hospitalizations? (Please Circle:) Yes No

For What? ______________________ Date: ______________

For What? ______________________ Date: ______________

For What? ______________________ Date: ______________

What are the present symptoms/problems that you are experiencing? ______________________________

____

Any medical conditions or challenges I should be made aware of? ______________________________

____

Have you traveled outside of the country in the past ten years? ______________________________

____

Any change in weight loss in the past six months? (Please Circle:) Yes No Intentional How much? ________

Have you ever had or been diagnosed as having problems with the following?

Abdominal Pain _____
Acne/Boils _____
Aging Fast _____
AIDS _____
Alzheimer's _____
Anemia _____
Anxiety _____
Arm Problems _____
Arthritis _____
Asthma _____
Back Pain _____
Bad Breath _____
Bedwetting _____
Blackouts _____
Bladder _____
Blood In Urine _____
Blood Pressure _____
Blood Transfusion _____
Bloody Stool _____
Blurred Vision _____
Bone Pain _____
Bowel Movements _____
Bruising _____
Cancer _____
Candida _____
Chest Pains _____
Chicken Pox _____
Circulation _____
Cold Extremities _____
Colds/Flu _____
Colitis _____
Confusion _____
Constipation _____
Cough _____
Cough Blood _____
Cystitis _____
Cysts/Tumors _____
Decreased Sexual Drive _____
Depression _____
Diabetes _____
Diarrhea _____
Difficulty Breathing _____
Digestion _____
Diptheria _____
Dizziness _____
Double Vision _____
Drug Reactions _____
Earaches _____
Ears _____
Eczema _____
Edema _____
Epilepsy _____
Eyes _____
Eyestrain _____
Fainting _____
Fatigue _____
Fevers _____
Flatulence _____
Gallbladder _____
Gas/Bloating _____
Gonorrhea _____
Gum Problems _____
Hay Fever _____
Headaches _____
Heart _____
Heart Attack _____
Heart Disease _____
Heart Palpitation _____
Hemorrhoids _____
Hepatitis _____
High Blood Pressure _____
Hives _____
Hypoglycemia _____
Impotence _____
Increased Sexual Drive _____
Itching _____
Jaundice _____
Joint Pain _____
Joint Swelling _____
Kidney Infection _____
Kidney Stones _____
Kidneys _____
Liver _____
Low Blood Pressure _____
Low Endurance _____
Lungs _____
Measles _____
Memory _____
Mental Breakdown _____
Migraines _____
Mouth Sores _____
Mucous Problems _____
Mumps _____
Muscle Cramps _____
Muscle Tension _____
Nasal Congestion _____
Neck Pains _____
Nerves _____
Nervousness _____
Nightmares _____
Nosebleeds _____
Obesity _____
Osteoporosis _____
Pancreas _____
Parasites _____
Phobias _____
PMS _____
Pneumonia _____
Polio _____
Psoriasis _____
Rashes _____
Rheumatic Fever _____
Ringing In Ears _____
Shortness Of Breath _____
Sinuses _____
Skin Boils _____
Skin Rashes _____
Sore Throats _____
Spine/Back _____
Spleen _____
Swollen Legs _____
Syphilis _____
Teeth Problems _____
Throat _____
Thyroid _____
Tongue Problems _____
Tuberculosis _____
Ulcers _____
Urinary Infections _____
Urinary Problems _____
Varicose Veins _____
Weight Gain _____
Weight Loss _____
Whooping Cough _____
Yeast Infections _____

Have you taken a course of antibiotics in the past five years? ________ Yes _______ No

Have you taken a course of steriods in the past five years? ________ Yes _______ No

Do you use estrogen? ________ Yes _______ No

Do you have: ________ Dandruff _______ Thinning Hair _______ Dry Hair?

Have you patches of rough or dry skin? ________ Yes _______ No

Do you have excess ear wax? ________ Yes ______ No

Do you get nose bleeds? ________ Yes _______ No

Do you have cracks behind your ears or knees? ________ Yes _______ No

Do you have diminshed sense of smell? ________ Yes _______ No

Do you have diminshed sense of taste? ________ Yes _______ No

Do you heal slowly from cuts, scrapes or sores? ________ Yes _______ No

Do you have white spots on your finger nails? ________ Yes _______ No

Are your finger nails brittle and dry? ________ Yes _______ No

Is your night vision: ________ Poor _______ Fair _______ Good _______ Very Good?

Does sunlight hurt your eyes? ________ Yes _______ No

Do your gums bleed when you brush your teeth? ________ Yes _______ No

Are your eyes often red, dry, gritty or burning? ________ Yes _______ No

Is your tongue often sore? ________ Yes _______ No

Do your hands often tingle? ________ Yes ______ No

Do your feet often burn? ________ Yes _______ No

Do you often get leg cramps? ________ Yes _______ No

Are your hands and feet usually cold? ________ Yes _______ No

Do you often feel cold when others feel warm? ________ Yes _______ No

Past/Present History of Alcoholism? (Please Circle:) Yes No
If yes, please explain: ______________________

____

Past/Present History of Drug Addiction? le:)(Please CircYes No
If yes, please explain: ______________________

____

Past/Present History of Smoking? (Please Circle:) Yes No
If yes, please explain: ______________________

____

Past/Present History of Abuse or Neglect? rcle:)(Please Ci Yes No
If yes, please explain: ______________________

____

Do you have any contagious diseases?) (Please CircYes le: No
If yes, please explain: ______________________

____

FAMILY HISTORY:

D Deceased **H** Healthy **C** Chronically Ill

Mother: ________ Father: ________ Sisters: ________ Brothers: ________

Check if there is a history of any of the following in your family:

Asthma	________	Gout	________	Mental Illness	________
Blood Disorders	________	Heart Disease	________	Obesity	________
Cancer	________	Hypertension	________	Thyroid Problems	________
Diabetes	________	Kidney Disease	________	Tuberculosis	________
Epilepsy	________	Lupus	________	Other:	________

EATING HABITS:

How many meals a day do you eat? ________
Do you eat at set times throughout the day? ________

Percentage of your food intake: (Total = 100%)

Chicken	________	Grains	________
Dairy	________	Nut/Bean/Seed	________
Fats	________	Red Meat	________
Fish	________	Sweets	________
Fruits	________	Vegetables	________

Percentage of fruits and vegetables eaten raw? ________
Percentage of food eaten outside the home? ________

Past/Present History of Alcoholism? (Please Circle:) Yes No
If yes, please explain: ______________________________

____

Past/Present History of Drug Addiction? le:)(Please CircYes No
If yes, please explain: ______________________________

____

Past/Present History of Smoking? (Please Circle:) Yes No
If yes, please explain: ______________________________

____

Past/Present History of Abuse or Neglect? rcle:)(Please Ci Yes No
If yes, please explain: ______________________________

____

Do you have any contagious diseases?) (Please Circle: Yes No
If yes, please explain: ______________________________

____

FAMILY HISTORY:

D Deceased **H** Healthy **C** Chronically Ill

Mother: ________ Father: ________ Sisters: ________ Brothers: ________

Check if there is a history of any of the following in your family:

Asthma	________	Gout	________	Mental Illness	________
Blood Disorders	________	Heart Disease	________	Obesity	________
Cancer	________	Hypertension	________	Thyroid Problems	________
Diabetes	________	Kidney Disease	________	Tuberculosis	________
Epilepsy	________	Lupus	________	Other:	________

EATING HABITS:

How many meals a day do you eat? ________
Do you eat at set times throughout the day? ________

Percentage of your food intake: (Total = 100%)

Chicken	________	Grains	________
Dairy	________	Nut/Bean/Seed	________
Fats	________	Red Meat	________
Fish	________	Sweets	________
Fruits	________	Vegetables	________

Percentage of fruits and vegetables eaten raw? ________
Percentage of food eaten outside the home? ________

EXERCISE HABITS:

Do you exercise? (Please Circle:) Yes No

Describe your daily/weekly exercise: ______________________________

____

How much? ______________ How often? ______________

Emotional Observations:

What emotions do you experience the most?

Anger	______	Depression	______	Nervousness	______
Sadness	______	Stress	______	Joy	______
Fear	______	Anxiety	______	Happiness	______
Worry	______	Panic	______	Peace	______

Are you under a lot of stress? (Please Circle:) Yes No

Do you use any stress reduction techniques? (Please Circle:) Yes No

Do you sleep well at night? (Please Circle:) Yes No

How many hours a night? ______________

Is your sleep interrupted? (Please Circle:) Yes No

If yes, please explain? ______________________________

____

Do you dream a lot? (Please Circle:) Yes No

If yes, what are they like? ______________________________

____

What is your favorite…?

Season	______	Weather	______
Color	______	Time Of Day	______

What do you do when you want to celebrate something? ______________________________

____

What do you do when you are very upset? ______________________________

____

In general, how do you feel about yourself? ______________________________

____

In general, how do you feel about life? ______________________________

____

EXERCISE HABITS:

Do you exercise? (Please Circle:) Yes No

Describe your daily/weekly exercise: ______________________________

____

How much? ______________ How often? ______________

Emotional Observations:

What emotions do you experience the most?

Anger	______	Depression	______	Nervousness	______
Sadness	______	Stress	______	Joy	______
Fear	______	Anxiety	______	Happiness	______
Worry	______	Panic	______	Peace	______

Are you under a lot of stress? (Please Circle:) Yes No

Do you use any stress reduction techniques? (Please Circle:) Yes No

Do you sleep well at night? (Please Circle:) Yes No

How many hours a night? ______________

Is your sleep interrupted? (Please Circle:) Yes No

If yes, please explain? ______________________________

____

Do you dream a lot? (Please Circle:) Yes No

If yes, what are they like? ______________________________

____

What is your favorite…?

Season	______	Weather	______
Color	______	Time Of Day	______

What do you do when you want to celebrate something ? ______________________________

____

What do you do when you are very upset? ______________________________

____

In general, how do you feel about yourself? ______________________________

____

In general, how do you feel about life? ______________________________

____

Which modality are you coming for today?

Aromatherapy	________	Jin Shin Jyutsu	________
Consultation	________	Massage	________
Enzyme Therapy	________	Ministerial Counseling	________
Flower Essences	________	Nutrition	________
Herbal Education	________	Reflexology	________
Homeopathy	________	Reiki	________

Would you like to receive more information on any modality? (Please check all that apply)

Aromatherapy	________	Jin Shin Jyutsu	________
Consultation	________	Massage	________
Enzyme Therapy	________	Ministerial Counseling	________
Flower Essences	________	Nutrition	________
Herbal Education	________	Reflexology	________
Homeopathy	________	Reiki	________

Which days of the week are more convenient for you to make an appointment?

Monday	________	Thursday	________
Tuesday	________	Friday	________
Wednesday	________	Saturday	________

Which time of day is most convenient for your appointments?

Mornings	________	Time Preferred:	____________
Afternoons	________	Time Preferred:	____________
Evenings	________	Time Preferred:	____________

How did you learn about our services? ____