

**Client Release Form**

**Date:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ **Referred By:** \_\_\_\_\_

Blood Type: \_\_\_\_\_ Email: \_\_\_\_\_

Do you exercise regularly? Y/N Number of bowel movements per day? \_\_\_\_\_ How long since last antibiotic: \_\_\_\_\_ Current nutritional supplements: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Current prescriptions: \_\_\_\_\_

**Please circle the symptoms you feel in the list below:**

lack of energy    headaches    backaches    weight imbalance    heartburn    asthma    respiratory  
blood pressure imbalance    frequent infections    joint pain    cold hands/feet    poor circulation  
gas/bloating    menstrual problems    water retention    low sex drive    food allergies    diarrhea  
inability to concentrate    memory loss    irritability    depression    anger    sinus problems

Any complaints not listed: \_\_\_\_\_

How may we help you today? \_\_\_\_\_

**Nutritional Client Statement, I hereby attest to the following:**

I fully understand that staff members of the House of Sunshine are not medical doctors or practitioners. They do not diagnose or treat disease, and I am not here for medical diagnoses or treatment procedures.

The services performed whether in person, by mail, by telephone, or by e-mail are, at all times, restricted to consultation on the subject matters intended for the best possible state of nutritional health and maintenance; and do not involve the diagnosing, treatment, or prescribing of remedies for the treatment of disease.

I understand that it is my constitutional right to decide how I wish to care for the health of my body. No one at the House of Sunshine has suggested that I cease any current medical care or procedure that my medical doctor has deemed necessary for my health. Should I choose not to follow recommendations made by my medical doctor, I accept responsibility for said decision and I will hold House of Sunshine harmless for any consequences related to my decision.

I am here on this and any subsequent visits solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation.

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

## Authorization Form Regarding the Use of Muscle Testing & Cancellation Policy

### **PLEASE INITIAL EACH BLANK SPACE**

\_\_\_\_\_ I authorize the natural health practitioners at the House of Sunshine to perform a Muscle Response health analysis and to develop a natural health improvement program for me. This may include dietary/nutritional supplement changes and are not for the treatment or “cure” of any disease, but rather to identify deficiencies or imbalances in the body that may contribute to various health problems.

\_\_\_\_\_ I understand that Muscle Response Testing is safe, non-invasive method of analyzing the body’s physical and nutritional needs and is not intended to diagnose, treat, or cure disease.

\_\_\_\_\_ No one at the House of Sunshine has made any promises or claims that I will be “cured” of any diseases I may have by following the program received at the House of SUNshine.

\_\_\_\_\_ I understand that should I choose to cancel my appointment with the natural health practitioners, I must do so with a 24-hour notice or I may be subject to a cancellation fee.