HEALTH ALKEMY

Craig Lane, BS Nutrition, CMT, Certified Herbalist, Nutritional Doctor

Welcome to Health Alkemy!

You are here because you realize something is missing in your current health paradigm. Like many of us, you realize there is more to health than what we have been brought up to understand. Unlike many of us, you are taking steps to do something about it! This program will very likely change your life. You have many choices on how to proceed.

Here are a couple of important things about Health Alkemy, and the way these health programs can be of the most benefit to you:

- If you follow the instructions, YOU WILL GET THE RESULTS YOU WANT. Those who really want to be whole and healthy make the changes, listening both to the advice of this program, and to the natural wisdom of their own body.

- Health is not an 'Easy Fix'. Your ailments did not occur over a period of weeks or months, even though it may seem that way. The human body takes YEARS of abuse before it finally begins showing signs and symptoms of disease. Consequently, it takes time for the body to recuperate from years of not getting the repair, building blocks, and proper orientation. Most of us are starving for minerals, and REAL nutrients.

- You decide how compliant you want to be (results are based on compliance though), and we support you wherever you are at. You'll find us to be a loving and supportive presence in your life with surprising insights into yoga postures, breath work, guided meditations, essential oil therapy, herbs, foods, recipes, and in the subtle areas of consciousness and how it affects one's health on an ongoing basis.

- We use a food-based, raw nutrition, and whole food supplement and herbal program for many. Most people are not aware that most supplements at retail outlets are not from food, nor can be properly used by the body. We have sorted through the many companies that have food based, and do use synthetic supplements with awareness that they are “drug-like” and should be treated as such.

- I do not require a financial contract or commitment. However, it is important to choose a path. Most people require 6-12 months of commitment to ANY program to see long-lasting results. You will likely receive benefit from a change in diet within 4-6 weeks, but serious changes like habits in body, mind and emotions take usually 3-6 months minimum to change. See Explorations Introduction for your choices of programs.

RATES

I charge $200 for the first visit, including a detailed report of findings on your system within a month. The initial consult includes an hour consultation and examination, along with a detailed plan of foods, herbs, and lifestyle options explored over three visits. We also explore recipes, menus, your state of health, and more. Clients may choose longer programs, of nine visits, or pick and choose from the Explorations Introduction.

Ala-carte visits are $25 per 15 minutes, $50 per 30 minutes, or $100 per hour. Sliding scale options can be explored. Internet and phone consults are available. Most people require monthly follow-ups for 6 months, with bi-monthly check-ups following, as your progress through the layers of healing that naturally occur. Questions will undoubtedly arise.

Depending on your condition, the average client spends $20-50 per week in raw, whole food supplements, along with custom Herb/Fiber blends. Each client is different, as each body has taken a different road to arrive here.

We are overjoyed to be a part of your healing, and growth. Welcome!

Craig Lane
Owner/Founder

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Confidential Client Information

☐ Married ☐ Divorced ☐ Single # of Children _____ Blood Type ☐ O ☐ A ☐ B ☐ AB

Name _____ Telephone ( ) _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Sex ☐ M ☐ F DOB ___ / ___ / _____ Age ____ Employment _____

Hobbies & Special Interests _____

How did you hear about us? _____

Medications, Herbs, Supplements, Vitamins & Therapies

Medical Doctors & Other Practitioners _____

_____

Prescription Drugs _____

_____

_____

Over The Counter Drugs _____

_____

Herbs, Supplements, Vitamins & Therapies _____

_____

_____

Medical History I Please list all major past illnesses

Major Illnesses _____

_____

Injuries _____

_____

Operations _____

_____

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Have you moved this past year? ☐ Yes ☐ No Has anyone close to you passed away in the past year? ☐ Yes ☐ No

Medical History of Relatives | Please list all major past illnesses

Grandparents _____

Parents _____

Aunts/Uncles _____

Siblings _____

Children _____

Health Concerns | Describe to the best of your ability

A. Primary Complaint _____

_____

_____

_____

When did you first notice this problem? _____

B. Other Health Issues (List all symptoms whether they seem related to your primary complaint) _____

_____

_____

_____

For Women

What is the length of your menstrual cycle? _____ Days ☐ Excessive or ☐ Light Flow Clotting? ☐ Yes ☐ No

Cramping? ☐ Yes ☐ No Before _____ After _____ Duration _____

PMS: Duration/Severity _____

Other changes during menstrual cycle? ☐ Yes ☐ No Explain _____

_____

_____

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Health & Self-Awareness Inquires

Briefly describe how you feel about your life _____

_____

What are your strengths? _____

Any special ambitions or desires? _____

What are the strongest/predominant emotions in your life? (Check all that apply)

❑ Sadness ❑ Grief ❑ Depression ❑ Moodiness ❑ Irritability ❑ Worry ❑ Anger ❑ Nervousness
❑ Frustration ❑ Anxiety ❑ Panic ❑ Fear ❑ Shame

How would you describe your energy levels? _____

Your sex drive? _____ Were you breast fed? ❑ Yes ❑ No How long? _____

What is your favorite season? _____ Are you sensitive to temperature changes? ❑ Yes ❑ No

Phobias _____

Describe your digestion _____

Bowel Movements/Day _____ What time of day is most frequent? _____

Describe (Consistency, Color, Texture) _____

Do they: ❑ Float or ❑ Sink? Any: ❑ Gas? ❑ Bloating? ❑ Flatulence? Are they smelly? ❑ Yes ❑ No

How soon after meals? _____ Urine Frequency _____ Color/Odor _____

How well do you sleep? _____ How long per night? _____

Do you fall asleep easily? ❑ Yes ❑ No Do you wake easily? ❑ Yes ❑ No

How do you feel when upon waking? _____

Do you use any of the following substances (Specify Type, Frequency & Quantity)
Please note: There are no judgements here. This is about restoring health and balance, not placing blame.

❑ Alcohol _____ ❑ Tobacco _____

❑ Coffee _____ ❑ Soft Drinks _____

❑ Marijuana _____ ❑ Cocaine _____

❑ Methamphetamines _____ ❑ Heroin _____

❑ Other Recreational Drugs _____

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Symptoms Specifics | Please check what applies to you

Headaches
- ❑ Basal
- ❑ Temples
- ❑ Cluster
- ❑ Crown
- ❑ TMJ
- ❑ Frontal
- ❑ Migraine

Ears
- ❑ Ringing
- ❑ Hissing
- ❑ Pounding
- ❑ Plug
- ❑ Pop
- ❑ Ache
- ❑ Drain
- ❑ Itch
- ❑ Dizzy
- ❑ Wax

Tongue
- ❑ Thick
- ❑ Coated
- ❑ Swollen
- ❑ Red
- ❑ Painful

Eyes
- ❑ Burn
- ❑ Tear
- ❑ Ache
- ❑ Red
- ❑ Dry
- ❑ Film
- ❑ Itch
- ❑ Blur
- ❑ Floaters
- ❑ Spots
- ❑ Tired
- ❑ Puffy
- ❑ Twitch
- ❑ Circles

Sinus
- ❑ Dry
- ❑ Drain
- ❑ Plug
- ❑ White
- ❑ Yellow
- ❑ Green
- ❑ Gray
- ❑ Brown
- ❑ Clear
- ❑ Sneezing
- ❑ Smell Loss
- ❑ Taste Loss
- ❑ Thirst

Throat
- ❑ Sore
- ❑ Hoarse
- ❑ Dry Cough
- ❑ Productive Cough
- ❑ Allergies
- ❑ Fever
- ❑ Chills
- ❑ Bad Breath
- ❑ Cankers
- ❑ Blisters
- ❑ Flu

Chest
- ❑ Tension
- ❑ Tight
- ❑ Pressure
- ❑ Heavy
- ❑ Anxiety
- ❑ Congestion
- ❑ Pain
- ❑ Sternal
- ❑ Sharp Heart Pain
- ❑ Palpitations
- ❑ Fast Heart
- ❑ Irregular
- ❑ Murmur
- ❑ Arm Pain

Neck
- ❑ Stiffness
- ❑ Shoulder Tension
- ❑ Cracked Lips
- ❑ Dry Mouth
- ❑ Cold Hands
- ❑ Sweaty Hands
- ❑ Cold Feet
- ❑ Sweaty Feet
- ❑ Gums
- ❑ Teeth
- ❑ Glands
- ❑ Swallow Trouble

Breath
- ❑ Shortness
- ❑ Constant
- ❑ Exertion
- ❑ Asthma
- ❑ Wheeze
- ❑ Air Hunger
- ❑ Yawning
- ❑ Sighing

Heartburn
- ❑ Aches
- ❑ Cramps
- ❑ Nausea
- ❑ Queasy
- ❑ Bloating
- ❑ Gas
- ❑ Belching
- ❑ Ulcer
- ❑ Hiatal Hernia

Bowels
- ❑ Regular
- ❑ Incomplete
- ❑ Sluggish
- ❑ Cramps
- ❑ Laxative
- ❑ Suppositories
- ❑ Enemas
- ❑ Colonics
- ❑ Bulk

Fecal Consistency
- ❑ Soft
- ❑ Ribbons
- ❑ Mucous
- ❑ Normal
- ❑ Hard
- ❑ Pebbles
- ❑ Dry
- ❑ Pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Difficult
- ❑ Fast
- ❑ Slow

Rectum
- ❑ Hemorrhoids
- ❑ Current
- ❑ History
- ❑ Swollen
- ❑ Burn
- ❑ Blood
- ❑ Distend
- ❑ Itch
- ❑ Sting
- ❑ Ache
- ❑ Cramp

Prostate
- ❑ Current
- ❑ History
- ❑ Burn
- ❑ Ache
- ❑ Pain
- ❑ Restrict
- ❑ Dribble
- ❑ Emissions
- ❑ Swell

Vagina
- ❑ Burn
- ❑ Itch
- ❑ Dry
- ❑ Pain
- ❑ Blood
- ❑ Discharge
- ❑ Clear
- ❑ White
- ❑ Yellow
- ❑ Green
- ❑ Brown
- ❑ Odor

Menses
- ❑ Regular
- ❑ Irregular
- ❑ Early
- ❑ Late
- ❑ Skip
- ❑ Birth Control
- ❑ Heavy Flow
- ❑ Moderate Flow
- ❑ Light Flow
- ❑ Long Flow
- ❑ Brief Flow
- ❑ Mild Cramps
- ❑ Medium Cramps
- ❑ Severe Cramps
- ❑ Ab Puffiness
- ❑ Fluid-Face
- ❑ Hands Swell
- ❑ Feet Swell
- ❑ Body Swell
- ❑ Tender Breasts
- ❑ Acne
- ❑ Spotting
- ❑ Clots

PMS
- ❑ Mood Swings
- ❑ Irritable
- ❑ Depression
- ❑ Breast
- ❑ Fluid
- ❑ Tired

Ovulation
- ❑ Pains
- ❑ Cysts
- ❑ Discharge
- ❑ Regular
- ❑ Irregular
- ❑ Fibroids

Urination
- ❑ Nocturnal
- ❑ Frequent
- ❑ Urgent
- ❑ Burn
- ❑ Pain
- ❑ Odor
- ❑ Spasm
- ❑ Leak
- ❑ UTI

Sleep
- ❑ Difficulty Sleeping
- ❑ Insomnia
- ❑ Interrupted Sleep
- ❑ Sleep Craving
- ❑ Jolts

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Symptoms Specifics Continued | Please check what applies to you

Sleep Cont.
☐ Dreams
☐ Nightmares
☐ Night Sweats
☐ Restlessness

Energy
☐ Low
☐ Variable
☐ Up
☐ Slow To Start
☐ Improving
☐ Worsening
☐ AM
☐ PM
☐ Meals Low

Memory
☐ Poor Names
☐ Poor Numbers
☐ Poor Words
☐ Coordination
☐ Concentration
☐ Sexually Flat
☐ Sexually Low
☐ Sexually Normal
☐ Impotent

Healing
☐ Slow
☐ Bruising
☐ Arthralgia
☐ Pain

Skin
☐ Rash
☐ Hives
☐ Psoriasis
☐ Dry
☐ Easy Sweat

Food/Diet

Describe your meal environment (Rushed, Relaxed, Thankful, etc.) _____

_____

What foods and drinks do you strongly like (crave) and strongly dislike? _____

_____

What temperature do you prefer in terms of climate and foods? _____

_____

What diet or nutritional program do you follow? (Vegan, Vegetarian, Meat-Eater, Macrobiotic, The Zone, Blood Type, etc.)

_____

Are you on a special diet? ☐ Yes ☐ No | Please check the appropriate boxes

☐ Atkins
☐ Blood Type Diet
☐ Dairy Restricted
☐ Diabetic
☐ Elimination Diet
☐ Food Combining
☐ Fruitarian
☐ Gerson/Cancer Diet
☐ Gluten Restricted
☐ Jenny Craig
☐ Ketogenic
☐ Kosher
☐ Low Carb
☐ Low Fat
☐ Low Sodium
☐ Macrobiotic
☐ Mediterranean
☐ Paleolithic
☐ Pescetarian
☐ Raw Food
☐ South Beach
☐ Specific Carb
☐ Vegan
☐ Weight-Watchers
☐ Vegetarian
☐ Lacto (Dairy OK)
☐ Ovo (Eggs OK)
☐ Ovo-Lacto (Both OK)
☐ Semi
☐ Other _____

How much water and liquids do you drink per day? _____

Do you cook your food? _____

Where do you shop for food? _____ How often do you eat out? _____

Do you eat when bored, upset, under stress, or angry? _____

What foods do you like at these times? _____

_____

How is your appetite for food? ☐ Good? ☐ Fair? ☐ Poor? Do you leave the meal satisfied? ☐ Yes ☐ No

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Dietary Assessment | Please check the boxes in regards to how often you eat or drink the listed types of foods

	More than Once Daily	Daily	3 Times Weekly	Once Weekly	Twice Monthly	Less or Never
Red Meat	☐	☐	☐	☐	☐	☐
Poultry	☐	☐	☐	☐	☐	☐
Seafood	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Cold Cuts	☐	☐	☐	☐	☐	☐
Soy Foods	☐	☐	☐	☐	☐	☐
Nuts/Seeds	☐	☐	☐	☐	☐	☐
Beans/Legumes	☐	☐	☐	☐	☐	☐
Bread	☐	☐	☐	☐	☐	☐
Pasta	☐	☐	☐	☐	☐	☐
Whole Grains	☐	☐	☐	☐	☐	☐
Rice	☐	☐	☐	☐	☐	☐
Cold Cereals	☐	☐	☐	☐	☐	☐
Muffins	☐	☐	☐	☐	☐	☐
Candy	☐	☐	☐	☐	☐	☐
Cookies	☐	☐	☐	☐	☐	☐
Desserts	☐	☐	☐	☐	☐	☐
Fried Foods	☐	☐	☐	☐	☐	☐
Potato Chips	☐	☐	☐	☐	☐	☐
Soda, Snapple, Sobe	☐	☐	☐	☐	☐	☐
Juice	☐	☐	☐	☐	☐	☐
Butter	☐	☐	☐	☐	☐	☐
Margarine	☐	☐	☐	☐	☐	☐
Salad Dressing	☐	☐	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐	☐	☐
Sandwiches	☐	☐	☐	☐	☐	☐
Cheeses, Soft & Hard	☐	☐	☐	☐	☐	☐
Icy Cold Drinks	☐	☐	☐	☐	☐	☐
Sweet Snacks	☐	☐	☐	☐	☐	☐
Salty Snacks	☐	☐	☐	☐	☐	☐
Frozen Foods	☐	☐	☐	☐	☐	☐
Packaged Foods	☐	☐	☐	☐	☐	☐
Vegetables - Cooked	☐	☐	☐	☐	☐	☐
Vegetables - Raw (incl. Salads)	☐	☐	☐	☐	☐	☐
Nightshade (Potato, Tomato, Eggplant)	☐	☐	☐	☐	☐	☐
Oxalic Veggies (Spinach, Chard, Beets)	☐	☐	☐	☐	☐	☐
Temperate Fruits (apple, berries, tree fruits)	☐	☐	☐	☐	☐	☐
Tropical Fruits (banana, citrus, pineapple)	☐	☐	☐	☐	☐	☐
Fruit Juices	☐	☐	☐	☐	☐	☐