

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 | 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
- Variable
- Up
- Slow To Start
- Improving
- Worsening
- AM
- PM
- Meals Low

Energy

- 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

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Atkins | <input type="checkbox"/> Fruitarian | <input type="checkbox"/> Low Carb | <input type="checkbox"/> Pescetarian | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Blood Type Diet | <input type="checkbox"/> Gerson/Cancer Diet | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Raw Food | <input type="checkbox"/> Lacto (Dairy OK) |
| <input type="checkbox"/> Dairy Restricted | <input type="checkbox"/> Gluten Restricted | <input type="checkbox"/> Low Sodium | <input type="checkbox"/> South Beach | <input type="checkbox"/> Ovo (Eggs OK) |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Macrobiotic | <input type="checkbox"/> Specific Carb | <input type="checkbox"/> Ovo-Lacto (Both OK) |
| <input type="checkbox"/> Elimination Diet | <input type="checkbox"/> Ketogenic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Vegan | <input type="checkbox"/> Semi |
| <input type="checkbox"/> Food Combining | <input type="checkbox"/> Kosher | <input type="checkbox"/> Paleolithic | <input type="checkbox"/> Weight-Watchers | <input type="checkbox"/> 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Poultry | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seafood | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eggs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Cuts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Soy Foods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nuts/Seeds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Beans/Legumes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bread | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pasta | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Whole Grains | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Cereals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Muffins | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Candy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cookies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Desserts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fried Foods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Potato Chips | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Soda, Snapple, Sobe | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Juice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Butter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Margarine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Salad Dressing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fast Food | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sandwiches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cheeses, Soft & Hard | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Icy Cold Drinks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweet Snacks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Salty Snacks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Frozen Foods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Packaged Foods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vegetables - Cooked | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vegetables - Raw (incl. Salads) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nightshade (Potato, Tomato, Eggplant) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Oxalic Veggies (Spinach, Chard, Beets) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Temperate Fruits (apple, berries, tree fruits) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tropical Fruits (banana, citrus, pineapple) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fruit Juices | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |