

ACACIA WHOLE HEALTH  
CLIENT INTAKE FORM

Name \_\_\_\_\_

Street \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (cell) \_\_\_\_\_

Marital Status \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Employer name \_\_\_\_\_

Employer address \_\_\_\_\_

Physician \_\_\_\_\_ Date of last physical \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

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

I understand that the health programs and methods recommended at Acacia Whole Health are non-invasive programs designed to suggest a more healthful lifestyle through natural methods. The methods include, but are not limited to homeopathy, naturopathy, diet, herbs, and exercise.

I understand that I should *always consult my physician* for any serious conditions and get at least two medical opinions. This is my right and responsibility for my own body.

I understand that during the treatment there may be side effects such as aggravation of present symptoms, headache, nausea, fatigue, and others.

**Cancellation Notice:** I understand that Acacia Whole Health has a 24-hour advance cancellation policy. Clients canceling with less than 24 hours notice will be charged the following cancellation fees:

90 minute appointment.....\$100.00  
60 minute appointment.....\$ 65.00  
30 minute appointment.....\$ 45.00

Please sign that you have read, fully understand, and agree to the above terms.

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

## CONTRACT FOR AUTHORIZATION OF THE HEALTH ANALYSIS PROCEDURE FOR ENERGY EVALUATION

I hereby authorize Dr. Tyteeka Reye, a licensed and certified traditional naturopath, or her associates, to act in my behalf concerning the HEALTH ANALYSIS PROCEDURE FOR ENERGY EVALUATION and develop a suggested health program. I warrant that all information presented for analysis and evaluation was submitted by me and is true to the best of my knowledge.

I recognize that the HEALTH ANALYSIS PROCEDURE is an established method that is not yet approved - nor rejected - by the medical profession or the Food and Drug Administration.

I acknowledge that the HEALTH ANALYSIS PROCEDURE, the evaluation, and the suggested health program are not for the diagnosis, treatment, alleviation, mitigation, prevention or care of any disease in any way. With this in mind, I reserve the right to use the knowledge I gain regarding my own body in any legal manner I may choose, including the suggested health program.

I agree to be evaluated under the direction of Dr. Reye acting as a holistic practitioner utilizing the Electro-acupuncture of Voll (EAV), the Frequency Generator or the B.E.F.E. machine.

Fees are as follows:

Initial EAV visit\*: \$240.00 – Tyteeka Reye; \$175 – Darla Buell

All follow up visits\*:

30 minutes \$70.00

45 minutes \$95.00

60 minutes \$135.00

Other services (cost/session):

Frequency Generator \$48.00

Ion cleanse \$25.00

Migun bed \$15.00

\*Above rates do not include generator sessions, ion cleanse sessions, or supplements

Payment is due in full at the time of service unless other arrangements have been made and approved *in advance* of appointment. Acacia Whole Health does not bill health insurance companies.

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

**PERSONAL MEDICAL HISTORY (Your medical history)**

MAJOR SURGERIES, ILLNESSES, DISEASES, ACCIDENTS

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**FAMILY MEDICAL HISTORY (This does not refer to you but your family)**

*CIRCLE ALL THAT APPLY*

CANCER	DIABETES	HIGH/LOW BLOOD PRESSURE
HEART TROUBLE	TB	ALLERGIES
KIDNEY DISEASE	EPILEPSY	ASTHMA
LIVER DISEASE	ULCERS	SINUS PROBLEMS
LYME DISEASE	ARTHRITIS	ALCOHOLISM
SPINAL PROBLEMS	MENTAL DISORDERS	DRUG ADDICTIONS
OTHER		

IF DECEASED, AGE PARENTS DIED: MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

**ALLERGIES (DRUGS, CHEMICALS, FOOD, ANIMALS, SEASONAL, ETC.)**

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ARE YOU ALLERGIC TO SULFUR, SULFIDES, SULFATES , ETC? \_\_\_\_ YES \_\_\_\_ NO

**CURRENT HEALTH CONDITIONS**

ARE YOU EXPERIENCING ANY CONDITION THAT YOU THINK MAY BE ADVERSELY AFFECTED BY EXPOSURE TO 10 OR LESS VOLTS OF ELECTRICITY? (e.g. Are or could you be pregnant, have heart disorders/pacemaker, subject to seizures, etc) \_\_\_\_ YES \_\_\_\_ NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

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MEDICATIONS ( INCLUDE VITAMINS, HERBS, PRESCRIPTIONS, HOMEOPATHICS AND ALL OVER THE COUNTER PREPARATIONS)

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MAJOR COMPLAINT

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DATE BEGAN \_\_\_\_\_ HAS IT GOTTEN: WORSE SAME BETTER

DESCRIBE HOW IT STARTED

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HAVE YOU EVER HAD THIS CONDITION BEFORE? \_\_\_\_\_

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? \_\_\_\_\_

IF YES, WHEN? \_\_\_\_\_ BY WHOM? \_\_\_\_\_

WHAT WERE THE RESULTS? \_\_\_\_\_

WHAT MAKES IT BETTER? \_\_\_\_\_ WORSE? \_\_\_\_\_

**RESPIRATORY**

SHORT OF BREATH	DIFFICULT INHALE	SIGH A LOT
CHEST PAIN	DIFFICULT EXHALE	DRY COUGH
ASTHMA	COUGH/PHLEGM	BRONCHITIS
TIGHTNESS IN CHEST	COUGH/BLOOD	HARD TO BREATH LYING DOWN
NORMAL	OTHER	

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**CARDIOVASCULAR**

DIAGNOSED HEART PROBLEMS	PALPITATIONS	CHEST PAIN
LOW BLOOD PRESSURE	BLEED EASILY	ANKLE SWELLING
HIGH BLOOD PRESSURE	VARICOSE VEINS	FACIAL SWELLING
SLOW HEART BEAT	MURMUR	BRUISE EASILY
IRREGULAR HEARTBEAT	HAND SWELLING	HISTORY OF ANEMIA
PURPLE PALMS/FINGERS	BROKEN BLOOD VESSELS	
NUMBNESS IN EXTREMITIES	NORMAL	
OTHER		

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**PAIN**

LOW BACK	SHOULDER	MUSCLE WEAKNESS
SCIATICA	HANDS/WRIST	MUSCLE CRAMPS
UPPER BACK	HIPS	MUSCLE SPASM/TWITCH
MID BACK	KNEES	BOTHERED BY DAMP WEATHER
NECK	SPINE	FOOT/ANKLE
NERVE PAIN	ARTHRITIS	FLANK AREA
OTHER		

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**HAIR**

DRY    OILY    DANDRUFF    FALLING OUT    EARLY GREY    NORMAL

**NAILS**

SOFT	BREAK EASILY	PALE	GROW SLOWLY
SPOTTY	RIDGES/LINES	PURPLE	GROW FAST
NORMAL	OTHER		

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**EARS**

POOR HEARING	RINGING (HIGH PITCH)	DISCHARGES
EARACHES	RINGING (LOW PITCH)	NORMAL
OTHER		

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**NOSE**

STUFFY NOSE	HAYFEVER	SNEEZE A LOT	MUCOUS
BLEEDING	LOSS OF SMELL	TMJ	RHINITIS
BLOW A LOT	ENVIRONMENTAL SENSITIVITY		NORMAL
OTHER			

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**EYES**

WEAR GLASSES/CONTACTS  
SPOTS/LINES IN VISION  
PALE UNDER EYELIDS  
POOR NIGHT VISION  
SENSITIVE TO LIGHT  
COLOR BLINDNESS  
RED DRY  
OTHER\_\_\_\_\_

EYELIDS SWOLLEN  
INFLAMMATION  
YELLOW SCLERA  
FAILING VISION  
HISTORY OF STIES  
BLURRY VISION  
ITCH PAIN

CATARACTS  
GLAUCOMA  
BLINK OFTEN  
TWITCHING  
STRAIN  
TEAR EASILY  
NORMAL

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**MOUTH/THROAT**

DRY  
FREQUENT COLDS  
SORES IN MOUTH  
THYROID PROBLEMS  
DROOLING  
LUMP IN THROAT  
OTHER\_\_\_\_\_

GUM PROBLEMS  
TMJ  
SORES ON TONGUE  
HICCUPS  
GRIND TEETH  
TEETH PROBLEMS

HOARSENESS  
SORE THROAT(OFTEN)  
DIFFICULT SWALLOWING  
DRY/CRACKED LIPS  
SWOLLEN GLANDS  
NORMAL

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**SKIN**

DRY  
OILY  
RASHES  
WARTS  
NORMAL

HIVES  
PIMPLES  
MOLES  
YELLOW SKIN  
OTHER\_\_\_\_\_

CLAMMY  
BRUISE EASILY  
CUTS HEAL SLOWLY  
ECZEMA

ULCERS  
BODY ODOR  
ITCHING  
BOILS

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**URINATION** ( 3-4 TIMES A DAY IS NORMAL)

FREQUENT  
NIGHTTIME  
PROFUSE  
SCANTY  
OTHER\_\_\_\_\_

BURNING  
BLOOD  
PUS  
PAINFUL

URGENCY  
INCONTINENCE  
STRONG SMELL  
UNUSUAL COLOR

BLADDER INFECTIONS  
KIDNEY STONES  
CLOUDY  
NORMAL

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**THIRST**

LESS THAN NORMAL  
THIRSTY BUT DO NOT DRINK  
OTHER\_\_\_\_\_

PREFER COLD DRINKS  
PREFER HOT DRINKS

EXCESSIVE  
NORMAL

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**SLEEP**

HARD TO FALL ASLEEP  
HARD TO GO BACK TO SLEEP  
TIRED IN THE MORNING  
OTHER\_\_\_\_\_

AWAKE EASILY  
LOTS OF DREAMS  
SLEEP TOO MUCH

RESTLESS  
NIGHTMARES  
NORMAL

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**HEADACHES/DIZZINESS**

HEADACHES	VERTIGO	DIZZINESS	MOTION SICKNESS
POOR BALANCE	MIGRAINES	FAINT EASILY	POOR MEMORY
DIZZY IF STANDING/BENDING	NORMAL	OTHER _____	

**DIGESTION**

INDIGESTION	NERVOUS STOMACH	FULL FEELING	HEARTBURN
NAUSEA/VOMITING	STOMACH NOISES	BELCH	BLOAT
PAIN/CRAMPS	GAS	BAD BREATH	GALLSTONES
BITTER TASTE	WEIGHT PROBLEMS	DIFFICULTY DIGESTING	GREASY FOOD
NORMAL	OTHER _____		

**BOWELS**

LOOSE STOOL	BLOOD IN STOOL	UNDIGESTED FOOD IN BOWEL	DIARRHEA
HEMORRHOIDS	CONSTIPATION	STOOL W/ BAD SMELL	ANUS ITCH
BURNING ANUS	MUCOUS IN STOOL	COLON PROBLEMS	BLACK STOOL
HARD STOOL	INTESTINAL WORMS	SMALL AMOUNT OF STOOL	PAIN/CRAMPS
USE LAXATIVES	NORMAL	OTHER _____	

**PERSPIRATION**

VERY LITTLE	PROFUSE	EASILY	NIGHTSWEATS
PALMS	BAD SMELL	FEET	WITHOUT EXERTION
NORMAL	OTHER _____		

**BODY TEMPERATURE**

WARM NATURED	FLUSHED FACE	WARMER IN PM	WARM PALMS
COLD NATURED	CHILLS/FEVER	WARM SOLES	COLD HANDS/FEET
NORMAL	OTHER _____		

**ENERGY**

UP & DOWN	LOW	LOW AFTER EATING	TIRED IN AFTERNOON
EXCESSIVE	NORMAL	OTHER _____	

**HABITS**

CIGARETTES	SOFT DRINKS	SALT	COFFEE	ALCOHOL
BLACK TEA	SUGAR	RECREATIONAL DRUGS		

**EXERCISE**

NEVER	LITTLE	MODERATE	HEAVY
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**APPETITE**

UP & DOWN	POOR	GOOD	HUNGRY	LOSS OF TASTE
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**WEIGHT**

NORMAL      UNDERWEIGHT      OVERWEIGHT      RECENT GAIN/LOSS

**DIET**

BEEF	POULTRY	CHEESE	GRAINS	TOFU	YOGURT
PORK	BREAD	MARGARINE	SWEETS	EGGS	HEALTH FOODS
FISH	BUTTER	ICE CREAM	SALADS	PASTA	HOT/SPICY FOOD
CHIPS	VEGETABLES	CRAVINGS	OTHER_____		

HOW DO YOU MANAGE STRESS? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY OTHER CONCERNS YOU WOULD LIKE TO DISCUSS \_\_\_\_\_  
\_\_\_\_\_

**FOR MALES:**

ARE YOU EXPERIENCING:	REDUCED SEX DRIVE	PREMATURE EJACULATION
SEMINAL EMISSION	IMPOTENCE	DISCHARGES
GENITAL PAIN	PROSTATE PROBLEMS	PAINFUL URINATION
DRIBBLE OF URINE	OTHER_____	

PLEASE EXPLAIN ANY OR ALL OF THE ABOVE \_\_\_\_\_

**FOR FEMALES:**

ARE YOU OR COULD YOU BE PREGNANT? \_\_\_\_\_  
IF YES, APPROXIMATE DATE OF CONCEPTION \_\_\_\_\_  
ARE YOU EXPERIENCING REDUCED SEX DRIVE? \_\_\_\_\_  
OTHER DIFFICULTIES? (PLEASE EXPLAIN) \_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE REGULAR PAP TESTS? \_\_\_\_\_ HOW REGULAR? \_\_\_\_\_  
DO YOU HAVE EXCESS FACIAL/BODY HAIR? \_\_\_\_\_

**MENSTRUAL CYCLE**

AGE BEGAN \_\_\_\_\_ DAYS OF FLOW \_\_\_\_\_ AGE STOPPED \_\_\_\_\_  
HOW MANY DAYS BETWEEN PERIODS? \_\_\_\_\_

ARE YOUR PERIODS:			
IRREGULAR	PAINFUL	HEAVY FLOW	CLOTTING
SCANTY FLOW	LIGHT COLOR	DARK COLOR	RETAIN WATER
BREAST PAIN	BREAST LUMPS	SPOT BETWEEN	BLOAT
EMOTIONAL	SIGH A LOT	CONSTIPATION	DIARRHEA
TIGHT CHEST	HORMONAL PROBLEMS	LUMP IN THROAT	NORMAL
EXPLAIN ANY OR ALL OF THE ABOVE _____			

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_