

Information and Release of Liability

Print name: _____ Age _____
First M. I. Last
 Shipping Address _____
 City _____ State _____ Zip code _____
 Day phone (_____) _____ Evening phone (_____) _____
 Mobile phone (_____) _____ E-mail _____
 Occupation _____ Employer _____
 Emergency contact _____ Phone (_____) _____
 Referred by or how did you hear about me? _____

I understand that I am here to learn how to improve my health through nutrition, purification, and dietary supplements. I understand that Bill Yeary is not a medical doctor and services provided do not involve diagnosing, treatment or prescribing of remedies or cure for any disease or medical condition. I understand that I should continue to see any medical doctors that I am under the care of, and that any prescription or medication should not be altered without consulting with my medical doctor. I am not on this visit or any subsequent visit as an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

I knowingly waive and release all claims for damages to myself or any person or property arising out of or in any way related to the services received. I further agree to indemnify, have and hold harmless Bill Yeary and Getting Well Naturally™ from any and all claims and damages of every kind to myself or any person or property arising out of or attributed to the services performed or received and at any point after the date of this release. It is further understood and agreed that this waiver and release constitutes an admission and acknowledgment by the undersigned that they have received no warranty, guarantee, or promise of any particular temporal or permanent result either expressed or implied. This release contains the entire agreement between the parties.

The undersigned further states they have carefully read the foregoing declaration, disclaimer, and release, know the contents thereof, are fully competent, fully agree with it, and sign the same as their own free act and deed.

Signature: _____ Date: _____

Circle all that you think you may be having problems with.					
Anemia	Diarrhea	Heart	Prostate	Nerves	Thyroid
Skin / Acne	Gall Bladder	Spleen	Arthritis	Kidneys	Blood Sugar
Ovaries	Yeast Candida	Bladder	Pancreas	Digestion	Lungs
Edema	Indigestion	Colon	Spine/Back	Bleeding	PMS
Constipation	Anxiety	Liver	Circulation	Stomach/Ulcer	Blood Pressure
Hormones	Depression	Parasites	Adrenal Glands	Memory	Mood Swings

Are you pregnant? _____ What conditions are you presently under the care of a physician for? _____

List past surgeries _____

List biggest health concerns _____

If you could resolve one thing today, what would it be? _____

Name: _____ Date: _____

Name of medications?	Purpose or reason for taking it?	Amount?	How long?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Food allergies		Glasses of water/day	
Blood pressure		Bowel movements/week	
Number of silver fillings		Sugar intake - times/wk	
Stress level		Blood type	
Past emotional trauma		Are you sleeping well	

<p>PARA</p> <p><input type="checkbox"/> Alternating consistency of stools and bowel habits</p> <p><input type="checkbox"/> Itching around the anus, especially at night</p> <p><input type="checkbox"/> Stomach aches or bowel cramping</p> <p><input type="checkbox"/> Grinding teeth at night</p> <p>CANA</p> <p><input type="checkbox"/> Taken a broad-spectrum antibiotic for any reason?</p> <p><input type="checkbox"/> Chronic fungous infections of the skin or nails?</p> <p><input type="checkbox"/> Crave sugar/sweets/breads?</p> <p><input type="checkbox"/> Tingling or numbness in the hands, feet, or face?</p> <p><input type="checkbox"/> (female) Had vaginal yeast infections?</p> <p>LOWGA</p> <p><input type="checkbox"/> Gas, belching, or burping immediately after meals</p> <p><input type="checkbox"/> Abdominal bloating or distension</p> <p>LIVGAL</p> <p><input type="checkbox"/> Fats / greasy foods cause nausea or headaches</p> <p><input type="checkbox"/> Skin rashes</p> <p><input type="checkbox"/> History of gallstones</p> <p><input type="checkbox"/> Dandruff or itchy scalp</p>	<p>ADR</p> <p><input type="checkbox"/> Eyes overly sensitive to sunshine or bright light</p> <p><input type="checkbox"/> Episodes of dizziness upon standing</p> <p><input type="checkbox"/> Wake too early in the morning, such as 3 or 4 am</p> <p><input type="checkbox"/> Low blood pressure</p> <p>THY</p> <p><input type="checkbox"/> Cold hands and feet</p> <p><input type="checkbox"/> Depressed</p> <p><input type="checkbox"/> Gain weight easily or hard time losing it</p> <p>O-3</p> <p><input type="checkbox"/> Dandruff or dry flaky skin or eczema or psoriasis?</p> <p><input type="checkbox"/> Depression?</p> <p><input type="checkbox"/> Dry eyes or chapped lips?</p> <p>O-6</p> <p><input type="checkbox"/> Ancestry that is ¼ or more Celtic Irish, Scandinavian, Native American, Welsh, or Scottish?</p> <p><input type="checkbox"/> Family history of alcoholism, depression, suicide, schizophrenia, or other mental illness?</p> <p><input type="checkbox"/> Winter depression that lifts or lightens in the sunny springtime?</p>
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Women's Hormonal – check all that apply			
Progesterone Deficiency		Estrogen Deficiency	
Miscarriage (s)		Night sweats	
PMS		Vaginal dryness	
Painful or lumpy breasts		Hot flashes	
Infertility		Testosterone Excess	
Estrogen Excess and Progesterone Deficiency		Loss of scalp hair	
Mood swings or crying spells		Oily skin, acne	
Heavy Menstruation		Increased facial hair	
Decreased desire for sex		Testosterone and / or DHEA Deficiency	
Tender breasts		Low sex drive	
Water retention or puffiness		Vaginal dryness	