

Center for Natural Healing

225-610-3447 or 225-927-9273

Name _____ Date _____
Occupation _____ Birth _____ Height _____ Weight _____

List your top three health concerns that you would like to address naturally

1. _____
2. _____
3. _____

Regarding the health concerns listed above, list major symptoms you are experiencing for each

SYMPTOMS FOR 1

SYMPTOMS FOR 2

SYMPTOMS FOR 3

_____	_____	_____
_____	_____	_____
_____	_____	_____

List the treatments you have tried to improve the health concerns listed above

TREATMENTS FOR 1

TREATMENTS FOR 2

TREATMENTS FOR 3

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use tobacco? _____ alcohol? _____ Caffeine? _____

Although results are often noticed within the first weeks of a program, the body often takes 4 ½ months for comprehensive improvements. Are you willing to follow a program for this length of time? _____

Are you willing to include the following in your nutritional program:

Change your eating patterns? _____	Begin a form of exercise? _____
Add new foods to your diet? _____	Let go of self limiting habits? _____
Let go of self limiting thoughts/attitudes? _____	Read recommended publications? _____

On the back, Please list all medication and dietary supplements that you take.

Client Information

Name _____ Date _____

Address _____

Home Phone _____ Cell Phone _____

Do you accept text messages on your cell phone? _____

Email _____

How did you hear about us? _____

Informed Consent

I acknowledge that Tiffany N. Burton, HHP and staff members of Center for Natural Healing (herein referred to as CNH) are not medical doctors and do not portray themselves to be. I fully understand that they do not offer allopathic drugs or any other conventional treatments. In addition, I understand that they do not diagnose, treat, or prescribe remedies for any condition, illness or disease nor do they practice medicine in any way. I understand that practice of medicine requires a license in the state of Louisiana and that these professionals do not hold such a license and that I must seek attention of a medical doctor for a medical condition illness or disease. **Initial** _____

I fully understand that the training, services, products and information provided are not generally accepted and or recommended by allopathic doctors or other conventional health professionals. I realize that insurance policies do not cover the training, products, and information.

Initial _____

I understand that Holistic Health Practitioners counsel on the use of non-invasive, natural alternative and complementary therapies and natural substances such as vitamins, minerals, herbs, etc. and that their goal is to inform me of natural non-invasive alternative and complementary therapies that may possibly assist me in obtaining and maintaining health naturally. I accept that the Holistic Health Practitioner adheres to these standards:

1. Promote only natural, safe, non-invasive therapy provided by God it through nature.
2. Encourage a healthy lifestyle that will enhance the body's own self healing, self recuperating systems.
3. View the individual as a whole person – Mind, Body and Spirit.
4. Promotes a healthy lifestyle that includes proper attitude, nutrition, rest, exercise, etc., while uncovering those negative factors in one's life which can disrupt the natural health cycles.

Initial _____

I fully understand that a healthy or unhealthy condition stems from a complex interaction of physical, emotional, nutritional, environmental, spiritual and lifestyle factors that must be addressed in order to obtain the best possible outcome. The programs designed by The CNH staff are intended to bring about a gradual and remedial effect over time, although CNH clients often reports improved well-being and many health benefits in the short term. **Initial** _____

Responsibility and participation:

I declare that I am present here on my own volition with no coercion from any other individual that I am interested in participating in the CNH health training program. I further declare that I am not here on any mission of deceit or entrapment, but totally and exclusively for the purpose of enhancing my health and well-being. **Initial** _____

I agree to clearly explain what symptoms I am experiencing, medications I am taking, diagnosis I have received, surgeries I have had and health challenges I face. I am ready and willing to fully participate in my individual designed research and education health training program. I understand that I am fully responsible for my own personal health research and that I am engaging in this research in order to enhance my health. I fully agree to inform the CNH staff immediately if there are any problems or concerns with the program as it has been designed for me. **Initial** _____

Consult your primary care physician, disclaimer:

I understand fully that, as with over-the-counter medications, natural alternative and complementary therapies and substances may interfere with medications prescribed by my primary healthcare physician. I acknowledge that any contraindications will be explained it to me. If I have any concerns about the recommendations, I will consult with my primary care physician prior to following any advice received by this office. I clearly state that if I choose not to inform my primary care position prior to consuming any natural alternative and complementary therapies or substances I am doing so of my own accord and I released this office from any liability in this regard. **Initial** _____

Not scientifically proven or FDA approved/possible side effects:

I understand that many of the natural non-invasive therapies and substances utilized and discussed in this office are well researched and have shown positive health benefits in natural medicine practices throughout the United States: however they are not FDA approved. I also understand that, as with all substances, natural included, there is a possibility of unforeseen side effects and allergic reactions that could range from mild to severe. I fully agree to inform the CNH staff immediately if there are any problems or concerns with my program is designed for me. **Initial** _____

Membership:

I fully understand that participation in the CNH research and education programs give me a full and active membership in the Center for Natural Healing. This membership entitles me to receive top-quality nutritional supplements and participate in continuing evaluation reviews.

Initial _____

Confirmation statement:

I, the undersigned, have read and understand the services I will be receiving at CNH with Tiffany N. Burton, HHP and CNH staff. I know and understand that I am expected to exercise my right to choose the therapies and substances to be utilized in my natural health care plan. I understand that the state of Louisiana does not licensed natural medicine practitioners and that the state has not adopted any educational training standards for unlicensed healthcare practitioners. I agreed to give the CNH staff complete information on my health conditions, medications, diagnosis, past surgeries, possible allergies, and any other information that may be relevant to my health. **Initial** _____

Print Name_____

Client Signature_____ **Date**_____

Witness_____ **Date**_____

Lifestyle Modification Consultant Disclosure Form

Required by revised statutes 37:1742.1

Tiffany N. Burton, HHP
Quantum Natural Health Services, LLC
dba/Center for Natural Healing
17487 Old Jefferson Highway
Prairieville, LA 70769 suite A

Louisiana revised statutes 37:142.1 provides that any person who provides information or makes recommendations regarding lifestyle modification, food, dietary supplements or homeopathic remedies for a consulting fee, who is not licensed as a healthcare provider must disclose to all consumers in a plainly worded statement all of the following:

1. The name, business, and telephone number of the vendor.
2. The fact that he or she is not licensed, certified, or registered as a healthcare provider in the state of Louisiana.
3. That any food or dietary supplement being recommended are not medically prescribed drugs.
4. If applicable, the degree or degrees, training, or credentials of the vendor regarding services provided.

Before a vendor provides information or recommendations to a consumer for a fee for the first time, such vendor shall obtain a written acknowledgment from the consumer stating that the consumer has provided with the information in subsection A of the section and such acknowledgment shall be maintained for two years by the vendor. The consumer shall be provided with a copy of the written acknowledgment.

I, _____, perspective consumer and client of Quantum Natural Health Services, LLC dba/Center for Natural Healing, acknowledges that Tiffany N. Burton, HHP, has informed me of the following:

1. Her name, legal business name and the name she is using to do business, and her contact information, including telephone number and address.
2. The fact that she is not licensed, certified, or registered as a healthcare provider in the state of Louisiana.
3. That any dietary recommendations are not medically prescribed drugs.
4. That she has the following academic degree, training and credentials: Holistic Health Practitioner, HHP, Natural Healing to College, 2012
5. That she has provided me with a copy of this acknowledgment

Client Signature _____ Date _____

Witness _____ Date _____