FLOURISH holistic

Welcome Packet WELCOME!

We are glad that you are choosing to make your health a priority and that you have chosen Flourish Holistic to assist you on your journey! We offer virtual services for alternative healthcare that addresses the root cause of symptoms through comprehensive health assessments and bioenergetic technology to promote total body and emotional healing.

Once you have those completed - take a 1.5-2 inch X 20 hairs and mail the kit/paperwork to 8575 Renee Ct, Whitesburg. Once paperwork is received, I will review the intake paperwork and I will send you a pay link. Once payment has been received, I will then submit the hair sample for analysis. Once I get the results back, I will create a custom protocol for you and schedule a time to talk through your findings and protocol! The findings call should take about 30 minutes. It's that simple! Most analyses are completed and within 7 days!

FLOURISH holistic

Quality matters! Pharmaceutical-grade nutraceuticals excel in potency, purity and absorption, while eliminating artificial ingredients, allergens and toxins.

☑ Shop online at **www.DSSOrders.com/FlourishHolistic**

Registration Code: HG3935

☑ Order by phone toll free: **877-846-7122, Option 1** (8 AM - 6 PM Central)

☑ Available Auto Ship program - FREE shipping and 5% off (after initial enrollment)

☑ Rewards: Purchases earn points for future savings

☑ Free U.S. shipping on orders over $49

COUPON - Save 10% on your first order: **WELCOME**

WHAT YOU CAN EXPECT WHEN WORKING WITH US

BASIC PRINCIPLES OF ALTERNATIVE MEDICINE: • We partner with you! It is your responsibility to do the hard work; we partner with you and provide you with the support, resources, recommendations, and protocols to help you reach your health goals, but the real work is yours to do. • We address the root cause. We take into consideration all factors that can influence health and wellness, including food, toxins, allergies, infections, stress levels and emotional health. We are health detectives working to get to the ROOT of the problem so we can help you understand the why behind your illness or symptoms then we recommend natural protocols including dietary changes to help bring your body back into balance and prevent future disease. Please note we do not medically diagnosis, we simply work with our tools to help your body be the healthiest it can be. • We believe God designed the body to heal itself. We believe the body has a blue-print for health and that by using natural approaches that are compatible with the body, and removing obstacles that are blocking health, the body will heal itself just as it was created to do.

- DISCOVERY CALL: The first step in our partnership is to schedule a discovery call. We will set a time to talk about what your health concerns are and determine whether we will be able to assist you in meeting your goals or not. Please email flourishingholistically@gmail.com to set up this complimentary service. Once we complete your discovery call and determine our partnership you will receive a Welcome Packet to review and return, as well as our Intake Form.
- ASSESSMENTS/SCANS: Once you have completed the paperwork and returned it, we will call you for payment, prior to processing your health assessment or scan. Assessments and scans are completed within 7-10 days of receipt, Rush Kits are completed within 72 hours of receipt. Once the kits are completed, we will schedule a 30-minute call to review the findings and go you're your suggested health protocol. We will send you a google meeting request to accept. If you are unable to keep your appointment, please refer to our cancelation policy.
- EVALUATION CALLS: Since our services are virtual being out of state is not a problem! We offer video or phone calls – its your preference. Unfortunately, we do not serve clients outside of the USA at this time. Your evaluation call(s) will begin on time and with us discussing your intake form, questions you may have, and/or our health assessment/ bioenergetic scan findings. All evaluation calls are 30 minutes. Anything additional will need to be a separate appointment call scheduled and paid for in advance.

- FOLLOW UP CALLS: Most suggested health protocols are not a quick fix. Most clients are seen for 3-6 months before moving on to a maintenance phase protocol. If you are on one of our membership programs, follow up calls will be once per month and post assessment/scan. We will discuss your progress and determine what changes should be made to your protocol to move you into the next phase of your healing plan as needed. We will work together in this way until you reach the level of wellness you desire!

METHODS WE UTILIZE INCLUDE: • Food and dietary recommendations • Practitioner-grade, bio-available supplements • Essential oils • Herbal remedies • Homeopathy •

HOW LONG WILL IT TAKE? For each person, the journey to health takes a different length of time– the average time frame for recovery is 3-5 months, and sometimes longer depending on the severity of symptoms. Because we are not just covering up symptoms, this process is truly healing the body at a core level and preventing future disease.

CANCELLATION POLICY: We value and respect your time! The time we have reserved for your assessment call is dedicated solely to you. If you are unable to meet at your scheduled time slot, please call or email us to reschedule your findings call. If for some reason you choose not to keep your scheduled evaluation and fail to notify us within 48

hours of the appointment, a non-refundable cancellation fee of $30 will be kept from your payment and the balance will be refunded within 24 hours.

SCHEDULING: When scheduling any evaluation, whether health assessment or bioenergetic scan, payment is required to reserve your appointment.

PAYMENT: Payment is required at the time of processing. Flourish Holistic currently accepts the following forms of payment: Cash App or Venmo under the business name Flourish Holistic/ flourishingholistically@gmail.com. Payment must be received ***prior*** to testing. Failure to pay will result in a delay in processing.

INSURANCE: We do not work with insurance.

RETURN POLICY: No refund is applicable for health assessments or bio-energetic scans.

OUR PROMISE TO YOU: Excellent results require hard work and for that to happen, YOU have to partner with us while the body heals itself naturally. If you don't fully believe they can get well, then that tends to be what happens. We are not willing to compromise that belief for those who are skeptical of alternative medicine or not willing to invest in their health. It is an investment and a commitment to yourself! If you are ready to invest in and commit to yourself, we would LOVE to partner with you! If so, please read and sign our client agreement below and fill out the forms on the next few pages. Bring them with you to your first appointment. We look forward to working with you!

CLIENT AGREEMENT

As your practitioner/coach, my role is...

- To be fully present during your appointment call and listening carefully.
- To serve as your accountability partner.
- To stretch you to take responsibility for your health and grow to a higher level.
- Offer honest feedback.
- Create an action plan and protocol for you to get healthy.

As a client, your role is...

- Show up on time for your appointments with no distractions.
- Give 100% of your effort towards following your protocol during your program.
- Take your supplements faithfully and take the action we decide upon.
- Be open and teachable.
- Make your payments at the time of the service is rendered.
- Give at least 48 hour notice for any appointment cancellations.

Client Initial

_____ I understand that health assessments and screenings are not diagnostic tools

_____ I understand that the suggested protocols recommended to me are not medical advice and should not replace any medical advice given to me by my medical doctors.

_____ I understand that Flourish Holistic does not give medical advice.

Signature of Client _____ Date _____

Signature of Practitioner _____ Date _____

SERVICES + PAYMENT DETAILS

- DISCOVERY CALL: This is the first step and gives us each a chance to discuss your health goals and to determine if our services will be a good fit for you. $ FREE

- HEALTH ASSESSMENT: Whether you are ready to take charge of your health or you are new to alternative care, our health assessment will assist in helping you get on track and meet your goals. We will discuss health history, your current concerns, and establish a protocol to help you achieve wellness. This is a virtual service and includes a 30-minute scheduled call. This option does not include the Quest 4 Screening. $75

- SCREENING: We offer Bioenergetic screenings. This service is virtual and is processed via hair sample, then a call is scheduled to discuss findings.
    - The Full Scan is a total body assessment with a 30-minute phone call to discuss findings. In most cases the result call will be scheduled within 7 days of the kit being received and processed. The full scan will include a custom frequency imprint tailored to your body's specific needs according to the findings. $150
    - A Follow Up Screening must be scheduled/completed within 90 days of the original scan for discount. $100
    - The Mini Screening is an assessment of one specific item and will include a 15- minute phone call to discuss findings and is done on the practitioner's discretion. $75
    - Emergency Rush Kits: We understand that emergencies happen, and we want to be available to serve you when you need us most. The rush fee will be added to any full or mini scan being processed as a rush kit. Rush kits will be processed within 72 hours of being received and a call scheduled promptly to discuss findings. ADD ON $50

- MEMBERSHIP OPTIONS: Since most of our clients are on a "healing journey" it takes time. Depending on the severity of symptoms and the client commitment to their protocol most clients will be on a 3–6-month protocol to achieve optimal results and move on to the maintenance phase of just calling us as needed! So, with that, we offer a discounted 3 month membership option. It includes monthly screenings and finding calls and an updated protocol for each updated scan. $350 ($100 savings)

Client Initial _____Date_____ Practitioner Initial_____ Date _____

I understand that payment is due at the time services are rendered. I understand that there are no refunds on services. The above pricing schedule is only valid through 12/31/24. Pricing may be adjusted at any time without notice. Screening are not diagnostic. No medical advice is given. We focus on nutrition and healing.

CLIENT INTAKE FORM

Name:_____ Date:_____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work #: _____Cell #:_____

Occupation:_____ Hours of work per week: _____

Age: ___ Birth Date: _____ Current weight: _____ Weight one year ago: _____

Email address: _____ Relationship status: _____

Children: _____ Ages: _____ Pets: _____

How did you hear about us? _____ Would you like to receive our newsletter?_____

Parent/Guardian Name: _____ Contact Number: _____

Present Complaints: List your main health problems:

1._____When did it start?_____

2._____When did it start_____

3._____When did it start?_____

History of Tick Bite(s) YES or NO If Yes, When?_____

History of Mold Exposure YES or NO If yes, When?_____

At what point in your life did you feel best? _____

_____

What are your health goals?

_____

_____

Medications or nutritional supplements you are currently taking:

_____

_____

_____

Do you have 1-3 bowel movements daily? If not, how often? _____

Section 1– Read each symptom and circle the number that applies.

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

1. 0 1 2 3 Heartburn or Acid Reflux
2. 0 1 2 3 Burping or Gas after eating
3. 0 1 2 3 Bloating after eating
4. 0 1 2 3 Bad breath
5. 0 1 2 3 Sweat has a strong odor
6. 0 1 2 3 Feel better if I don't eat
7. 0 1 2 3 Sleepy after meals
8. 0 1 2 3 Burning pain in stomach
9. 0 1 2 3 Fingernails chip, break, peel
10. 0 1 2 3 Anemia unresponsive to iron
11. 0 1 2 3 Stomach pain or cramps
12. 0 1 2 3 Diarrhea, chronic
13. 0 1 2 3 Diarrhea after meals
14. 0 1 2 3 Black or dark stool
15. 0 1 2 3 Undigested food in stool

Section 2– Read each symptom and circle the number that applies.

16. 0 1 2 3 Skip days between bowel movm.
17. 0 1 2 3 Stools hard or difficult to pass
18. 0 1 2 3 Cramping on lower abdomen
19. 0 1 2 3 Blood in stool
20. 0 1 2 3 Mucus in stool
21. 0 1 2 3 IBS or colitis
22. 0 1 2 3 Yeast Infections
23. 0 1 2 3 Nail fungus or athletes foot
24. 0 1 2 3 Dark circles under eyes
25. 0 1 2 3 History of parasites
26. 0 1 2 3 Coated tongue
27. 0 1 2 3 Anus itches
28. 0 1 2 3 Constipation
29. 0 1 2 3 Stools are loose
30. 0 1 2 3 Bad smelling gas

Section 3– Read each symptom and circle the number that applies.

31. 0 1 2 3 Food allergies
32. 0 1 2 3 Bloating after eating
33. 0 1 2 3 Airborne allergies
34. 0 1 2 3 Wheat or gluten sensitivity
35. 0 1 2 3 Dairy sensitivity
36. 0 1 2 3 Sinus congestion
37. 0 1 2 3 Craves bread and pasta
38. 0 1 2 3 Pulse speeds after eating
39. 0 1 2 3 Nightmares
40. 0 1 2 3 Feel spacy or unreal
41. 0 1 2 3 Alternating diarrhea/ constipation
42. 0 1 2 3 Hives

Section 4– Read each symptom and circle the number that applies.

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

43. 0 1 2 3 Nausea
44. 0 1 2 3 Pain between shoulder blades
45. 0 1 2 3 Skin rashes, acne, eczema, etc.
46. 0 1 2 3 Age or "Liver" spots
47. 0 1 2 3 Greasy foods upset stomach
48. 0 1 2 3 Gallbladder attacks or stones
49. 0 1 2 3 Motion sickness
50. 0 1 2 3 Headache over eyes
51. 0 1 2 3 Easily intoxicated
52. 0 1 2 3 Hemorrhoids or varicose veins
53. 0 1 2 3 Sensitivity to perfumes or chemicals, etc...
54. 0 1 2 3 Pain under right rib cage
55. 0 1 2 3 Insomnia

Section 5– Read each symptom and circle the number that applies.

56. 0 1 2 3 Carpal Tunnel Syndrome
57. 0 1 2 3 Osteoporosis or Osteopenia
58. 0 1 2 3 Legs or foot cramps at rest
59. 0 1 2 3 Pain or swelling in joints
60. 0 1 2 3 Bursitis or tendonitis
61. 0 1 2 3 Joints pop or crack
62. 0 1 2 3 White spots on fingernails
63. 0 1 2 3 Decreased taste or smell

Section 6- Read each symptom and circle the number that applies.

64. 0 1 2 3 Intense Fatigue
65. 0 1 2 3 Brain Fog
66. 0 1 2 3 Memory loss short/long term
67. 0 1 2 3 Pain or swelling in joints
68. 0 1 2 3 Stiff joints in morning
69. 0 1 2 3 Muscle twitching
70. 0 1 2 3 Unexplained fevers
71. 0 1 2 3 Headaches/Migraines
72. 0 1 2 3 Poor concentration
73. 0 1 2 3 Sore soles of feet in morning

Section 7– Read each symptom and circle the number that applies

74. 0 1 2 3 Body jerks as falling asleep
75. 0 1 2 3 Restless leg syndrome
76. 0 1 2 3 Small bumps on back of arms
77. 0 1 2 3 Heart races
78. 0 1 2 3 Worrier, anxious
79. 0 1 2 3 Nosebleeds
80. 0 1 2 3 Bruise easily
81. 0 1 2 3 Gums bleed easily
82. 0 1 2 3 Depressed regularly
83. 0 1 2 3 Numbness or tingling in body
84. 0 1 2 3 Loss of muscle tone

Section 8– Read each symptom and circle the number that applies.

Key: 0=no, symptom does not occur 2=Moderate symptom, occur

1=Yes, mild symptom, rarely occurs 3=Severe symptom, occurs daily

85. 0 1 2 3 Difficulty falling asleep
86. 0 1 2 3 Slow starter in the morning
87. 0 1 2 3 Suddenly dizzy when standing
88. 0 1 2 3 Difficulty holding chiropractic adjustments
89. 0 1 2 3 Arthritis
90. 0 1 2 3 Crave salty food
91. 0 1 2 3 Headache after exercise
92. 0 1 2 3 Chronic low back pain
93. 0 1 2 3 Clench or grind teeth
94. 0 1 2 3 Perspire too easily
95. 0 1 2 3 Hives
96. 0 1 2 3 Bright light hurts eyes
97. 0 1 2 3 Slow recovery from stress

Section 9– Read each symptom and circle the number that applies.

98. 0 1 2 3 Difficulty losing weight
99. 0 1 2 3 Loss of outer 1/3 eyebrows
100. 0 1 2 3 Mentally sluggish
101. 0 1 2 3 Cold hands and feet
102. 0 1 2 3 Hair loss
103. 0 1 2 3 Easily fatigued
104. 0 1 2 3 Seasonal sadness
105. 0 1 2 3 Low body temperature
106. 0 1 2 3 Sensitive to iodine
107. 0 1 2 3 Fast pulse at rest
108. 0 1 2 3 Nervousness
109. 0 1 2 3 Sensitivity to cold
110. 0 1 2 3 Intolerant to heat
111. 0 1 2 3 Flush easily
112. 0 1 2 3 Heart palpitations

Section 10- Read each symptom and circle the number that applies.

113. 0 1 2 3 Crave sweets
114. 0 1 2 3 Awaken during night, hard to fall back asleep
115. 0 1 2 3 Excessive appetite
116. 0 1 2 3 Crave coffee or sugar in afternoon
117. 0 1 2 3 Headache if meals are delayed
118. 0 1 2 3 Get shaky or weak if hungry
119. 0 1 2 3 Sleepy in afternoon
120. 0 1 2 3 Fatigue relieved by eating
121. 0 1 2 3 Afternoon headaches
122. 0 1 2 3 Irritable before meals

Section 11– *Men Only* - Read each symptom and circle the number that applies.

138. 0 1 2 3 Prostate problems
139. 0 1 2 3 Decreased libido
140. 0 1 2 3 Urination difficult
141. 0 1 2 3 Pain or burning with urination
142. 0 1 2 3 Fatigue
143. 0 1 2 3 Pain on inside of legs or heels
144. 0 1 2 3 Feeling of incomplete bowel elimination

Section 16– Read each symptom and circle the number that applies.

Key: 0= Never 2=Weekly

1=Occasionally 3=Daily

165. 0 1 2 3 Use of pesticides in home
166. 0 1 2 3 Use of strong chemicals (bleach, polish, floor wax, window cleaner,etc)
167. 0 1 2 3 Exposed to tobacco, moth balls, incense, varnish, or dust.
168. 0 1 2 3 Treat home for insects
169. 0 1 2 3 Use of perfumes, hairspray, cosmetics, nail polish, etc.
170. 0 1 2 3 Exposed to diesel fumes, exhaust fumes, or gasoline fumes.

Rate your overall stress level on a scale of 1 to 10. (10= high, 1= low)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is affecting your stress level the most?

_____
_____
_____
_____

What do you enjoy most in your life?

_____
_____
_____
_____

What do you worry about most in your life?

_____
_____
_____
_____

When it comes to FULLY committing to your desire to be healthy, what is getting in the way?

_____
_____
_____
_____

Who will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____

_____

_____

_____

List any emotional or personal conflicts that you are exposed to repeatedly:

_____

_____

_____

How is your diet:

☐ Coffee:	_____ cups per:	☐ Day	☐ Week	☐ Month
☐ Soft drinks:	_____ cans per:	☐ Day	☐ Week	☐ Month
☐ Diet soda:	_____ cans per:	☐ Day	☐ Week	☐ Month
☐ Candy:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Chocolate:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Alcohol:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Fast Food:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Milk/cheese:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Fried foods:	_____ times per:	☐ Day	☐ Week	☐ Month

Current Diet Information: Give examples of what foods you typically eat daily:

Breakfast: _____

Lunch: _____

Snacks: _____

Dinner: _____

Liquids: _____

How many meals do you eat per day? _____ What meals do you skip? _____

Do you cook? _____ What percentage of your meals are home-cooked? _____

Health History:

List any major illnesses/diagnosed conditions with approximate dates:

Illness:	Date:	Recovered?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section 12- *Women Only* – Read each symptom and circle the number that applies.

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

123. 0 1 2 3 Painful menstrual cycle
124. 0 1 2 3 Mood swings around cycle
125. 0 1 2 3 Painful breasts at cycle
126. 0 1 2 3 Irregular cycles
127. 0 1 2 3 Heavy menstrual flow
128. 0 1 2 3 Acne at menstrual cycle
129. 0 1 2 3 Yeast Infections
130. 0 1 2 3 Endometriosis
131. 0 1 2 3 Uterine fibroids
132. 0 1 2 3 Fibrocystic breasts
133. 0 1 2 3 Hot flashes
134. 0 1 2 3 Vaginal itchiness
135. 0 1 2 3 Vaginal discharge
136. 0 1 2 3 Night sweats
137. 0 1 2 3 Menopausal symptoms

Section 13– Read each symptom and circle the number that applies.

145. 0 1 2 3 Shortness of breath with moderate exertion
146. 0 1 2 3 Opens windows in closed room
147. 0 1 2 3 Sigh frequently
148. 0 1 2 3 Bruise easily
149. 0 1 2 3 Muscle cramps during exercise
150. 0 1 2 3 Hands and feet go to sleep
151. 0 1 2 3 Dull pain in chest, worse on exertion

Section 14- Read each symptom and circle the number that applies.

152. 0 1 2 3 Pain upon urination
153. 0 1 2 3 Frequent bladder infections
154. 0 1 2 3 Cloudy, bloody, or dark urine
155. 0 1 2 3 Urine has strong odor
156. 0 1 2 3 History of kidney stones
157. 0 1 2 3 Pain in low back
158. 0 1 2 3 Puffy eyes or dark circles under eyes regularly

Section 15– Read each symptom and circle the number that applies.

159. 0 1 2 3 Catch colds/flu easily
160. 0 1 2 3 Runny or drippy nose
161. 0 1 2 3 Swollen lymph nodes
162. 0 1 2 3 Gets boils, cysts, styes
163. 0 1 2 3 Poor wound healing
164. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles or Chronic Fatigue

Family Health History:

☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Other: _____

Please list any surgeries, operations, traumas, car accidents, etc…

_____

_____

_____

What are your hobbies:

_____

Commitment Level to your health: How serious are you about improving your health?

☐ Very serious ☐ Serious ☐ Moderately interested ☐ Other:_____