

## INDIVIDUAL BODY LANDSCAPE CONSULTATION ❖ \$185

Body Landscape Nutritional Consultation is available either in person, via video chat (Skype or FaceTime), Phone (USA and Canada), Email or postal mail.

**Call to schedule an appointment: 510 844-4164.**

Follow-up consultations are available in person, or via Skype or FaceTime, or by phone (USA or Canada only): \$59 for 30 minutes. By appointment only.

At least one person must order the Body Landscape Consultation to order the Relationship Compatibility.

All information provided will be kept strictly confidential.

### YOUR INFORMATION

Mr Mrs Ms Dr Sister Rev Please circle one (optional)

First and Last Name

Address

City\* State/Province/Region\*

Postal/Zip Code\* Country

Phone Number\* Email

Gender:\*

- Male  
 Female

DOB\* Time\* (HH/MM)

Above time is:\*

- Local Standard Time  
 Local Daylight Savings Time  
 Adjusted one hour back to Standard Time  
 Don't know

Calendar:\*

- Western (solar) Calendar  
 Chinese (lunar) Calendar

Accuracy:\*

- Exact  
 Approximate  
 Per Birth Certificate  
 Unavailable

Birth City\* State/Province/Region\* Country

### PERSONAL HABITS

What do you usually eat for breakfast?

For lunch?

For dinner?

As snacks?

How many times do you snack per day?

How many meals do you eat per day?

Are you currently following a diet regimen? If so, please describe:\*

Stamina: In general would you say you are a person of:\*

- High Energy  
 Moderate Energy  
 Low Energy

How often do you exercise?

Smoking?\*

- Yes, I currently smoke  
 No, I have never smoked  
 Smoked but have quit  
 Occasionally smoke (not daily)

Alcohol Consumption?\*

- Never  Occasionally  Often

Have you ever been addicted to alcohol?\*

- Yes  No

Have you ever been addicted to non-prescription drugs/street drugs?

- Yes  No

How many cups of caffeinated beverages do you drink per day?\*

(Select the type of beverage and then enter the number of cups)

- Not Applicable  
 Coffee .....  
 Black or Green Tea .....  
 Other .....

Continued on next page...

INDIVIDUAL BODY LANDSCAPE CONSULTATION, *continued*

Please list any medications you are currently taking, and your prescription start date:

.....  
 .....  
 .....  
 .....

Please list all vitamins, supplements, and herbs you are currently taking:\*

.....  
 .....  
 .....  
 .....

**HEALTH QUESTIONNAIRE**

Please indicate any symptoms you currently have:

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Skin rash             | <input type="checkbox"/> Liver problems      | <input type="checkbox"/> Leg cramps                      | <input type="checkbox"/> Fatigue                            |
| <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Food allergies        | <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Restless legs                   | <input type="checkbox"/> Headaches                          |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Blood clots           | <input type="checkbox"/> Kidney infection    | <input type="checkbox"/> Swelling in arms or leg (edema) | <input type="checkbox"/> Migraines                          |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Uclers                | <input type="checkbox"/> Bladder infection   | <input type="checkbox"/> Scoliosis                       | <input type="checkbox"/> Low grade fever                    |
| <input type="checkbox"/> Heart problems        | <input type="checkbox"/> Frequent indigestion  | <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Depression                      | <input type="checkbox"/> Anxiety                            |
| <input type="checkbox"/> Heart attack          | <input type="checkbox"/> Nausea                | <input type="checkbox"/> Blood in urine      | <input type="checkbox"/> Insomnia                        | <input type="checkbox"/> Fear                               |
| <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Vomitting             | <input type="checkbox"/> Frequent urination  | <input type="checkbox"/> Stroke                          | <input type="checkbox"/> Anger                              |
| <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Acid reflux           | <input type="checkbox"/> Painful urination   | <input type="checkbox"/> Hyperthyroidism (overactive)    | <input type="checkbox"/> Worry                              |
| <input type="checkbox"/> Chronic cough         | <input type="checkbox"/> IBS                   | <input type="checkbox"/> Prostate problems   | <input type="checkbox"/> Hypothyroidism (underactive)    | <input type="checkbox"/> Sadness                            |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Uterine problems    | <input type="checkbox"/> Vision Disability               | <input type="checkbox"/> Impatience                         |
| <input type="checkbox"/> Respiratory allergies | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Hearing loss        | <input type="checkbox"/> Osteoarthritis                  | <input type="checkbox"/> Gout                               |
| <input type="checkbox"/> Sinusitis             | <input type="checkbox"/> Appendicitis          | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Rheumatoid arthritis            | <input type="checkbox"/> High Blood Pressure (hypertension) |
| <input type="checkbox"/> Nose bleeds           | <input type="checkbox"/> Decreased appetite    | <input type="checkbox"/> Ear aches           | <input type="checkbox"/> Joint pain                      | <input type="checkbox"/> Low Blood Pressure (hypotension)   |
| <input type="checkbox"/> Gum disease           | <input type="checkbox"/> Abdominal pain        | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Chronic fatigue                 |   |
| <input type="checkbox"/> Cold sores            | <input type="checkbox"/> Blood in stools       | <input type="checkbox"/> Fainting            |  |   |
| <input type="checkbox"/> Canker sores          | <input type="checkbox"/> Gall stones           | <input type="checkbox"/> Low back pain       |  |   |
| <input type="checkbox"/> Skin allergies        | <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Neck pain           |  |   |

Please indicate any symptoms you have had in the past:

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Skin rash             | <input type="checkbox"/> Liver problems      | <input type="checkbox"/> Leg cramps                      | <input type="checkbox"/> Fatigue                            |
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| <input type="checkbox"/> Heart problems        | <input type="checkbox"/> Frequent indigestion  | <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Depression                      | <input type="checkbox"/> Anxiety                            |
| <input type="checkbox"/> Heart attack          | <input type="checkbox"/> Nausea                | <input type="checkbox"/> Blood in urine      | <input type="checkbox"/> Insomnia                        | <input type="checkbox"/> Fear                               |
| <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Vomitting             | <input type="checkbox"/> Frequent urination  | <input type="checkbox"/> Stroke                          | <input type="checkbox"/> Anger                              |
| <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Acid reflux           | <input type="checkbox"/> Painful urination   | <input type="checkbox"/> Hyperthyroidism (overactive)    | <input type="checkbox"/> Worry                              |
| <input type="checkbox"/> Chronic cough         | <input type="checkbox"/> IBS                   | <input type="checkbox"/> Prostate problems   | <input type="checkbox"/> Hypothyroidism (underactive)    | <input type="checkbox"/> Sadness                            |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Uterine problems    | <input type="checkbox"/> Vision Disability               | <input type="checkbox"/> Impatience                         |
| <input type="checkbox"/> Respiratory allergies | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Hearing loss        | <input type="checkbox"/> Osteoarthritis                  | <input type="checkbox"/> Gout                               |
| <input type="checkbox"/> Sinusitis             | <input type="checkbox"/> Appendicitis          | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Rheumatoid arthritis            | <input type="checkbox"/> High Blood Pressure (hypertension) |
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| <input type="checkbox"/> Gum disease           | <input type="checkbox"/> Abdominal pain        | <input type="checkbox"/> Dizziness           |  |   |
| <input type="checkbox"/> Cold sores            | <input type="checkbox"/> Blood in stools       | <input type="checkbox"/> Fainting            |  |   |
| <input type="checkbox"/> Canker sores          | <input type="checkbox"/> Gall stones           | <input type="checkbox"/> Low back pain       |  |   |
| <input type="checkbox"/> Skin allergies        | <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Neck pain           |  |   |

*Continued on next page...*

INDIVIDUAL BODY LANDSCAPE CONSULTATION, *continued*

When did you have these symptoms? \*

.....  
.....  
.....  
.....

How long have you had these symptoms?

.....  
.....  
.....  
.....

Please list any surgeries you have had: \*

.....  
.....  
.....  
.....

Please list any other current health symptoms or concerns: \*

.....  
.....  
.....  
.....

When did you have these surgeries?

.....  
.....  
.....  
.....

How did you hear about us?

.....  
.....  
.....  
.....

**PAYMENT AND DELIVERY**

Individual Body Landscape Consultation

Total: \$185.00

Payment Method \*

Select your preferred method of payment to complete your order

- Pay with credit card or Paypal (invoice sent by email)
- Mail a check or international money order

Please provide my consultation by: \*

- In person
- Video chat (Skype or FaceTime)
- Phone (USA and Canada)
- Email
- Postal mail

*Thank you for your order*