RECONTROL

Health & Nutrition

New Client Intake

All information provided is confidential and will not be viewed by persons other than Sherie Holland, Board Certified Drugless Practitioner and Certified A4M Lifestyle Health Coach dba RECONTROL Health, LLC and other authorized persons if noted by client.

Please take the time necessary to fill out this form.

This will require you to take time in a quiet and relaxed environment where you can focus completely on yourself.

Note: This form is for information gathering only. I will not be giving medical/prescriptive information or advice based on this form. Provide information at your own comfort and feel free to leave anything blank that you don’t feel comfortable filling out.

I will not accept medical labs/results or medical information of any kind from your doctor/practitioner/nurse etc. If you wish me to look at your labs understand all records must come to me through you (the client) and that we will be looking at them together with the full and complete understanding of me educating you on how to take your knowledge further to discuss the labs with your doctor. It is strictly for informational purposes for you to be more knowledgeable about reading your personal labs for your personal empowerment.

There will be NO diagnosing, prescribing or advising personalized treatments for specific conditions of any kind regarding medicines, supplements or protocols of any kind. We may discuss your personal issues during a discovery session, but I will not be treating any specific medical condition.

Print full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial that you understand the above statement completely: \_\_\_\_\_\_\_\_\_\_\_

Date read and understood: \_\_\_\_\_\_\_\_\_\_\_\_\_

ATTENTION:

The Disclaimer on the last 2 pages must be understood and signed prior to any professional discussions or recommendations.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Cell number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I’d like occasional text messages: Yes \_\_\_ or No \_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Join our newsletter? Yes \_\_\_ or No \_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your desired outcome of today’s first visit and/or multiple visits if necessary?

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Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marriage Status: \_\_\_\_\_\_\_\_\_\_\_ Children (how many)? \_\_\_\_\_\_\_ Age of Child(ren) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, what does your spouse/partner do for a living: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known history of working and/or living around excess

Toxins/pesticides/chemicals/mold/fungus? Yes \_\_\_ or No \_\_\_

If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been tested for heavy metal or toxin exposure? Yes \_\_\_ or No \_\_\_

If so what kind of testing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medically diagnosed (MD) and self-diagnosed (SD) diseases or sickness (mental or physical):

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IMPORTANT: Are you taking any medications or under the care of a physician for anything besides regular annual exams?: (space is provided on another page for listing medications) Yes \_\_\_ or No \_\_\_

Do you have a regular primary physician? Yes \_\_\_ or No \_\_\_

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please note that if not under the care of a physician I advise that everyone have a licensed medical practitioner to take recommendations to.)

Do you have a good relationship with your physician? Yes \_\_\_ or No \_\_\_

(It is suggested that any changes you make are brought to your physician prior to making them.)

If not, are you open to finding a new one? Yes \_\_\_

Is your physician open minded to helping you with the labs you may need to get to the bottom of your health issues? Yes \_\_\_ or No \_\_\_ or Not Sure \_\_\_

Date of your last physical exam (If female: mammogram, pap smear. Male: Prostate, blood pressure diabetes etc. overall wellness check)? Results?

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

Have you ever been tested for Thyroid disease? Yes \_\_\_ or No \_\_\_

If so, when? \_\_\_\_\_\_\_\_\_\_\_\_ Do you recall the labs they tested? circle: TSH, T4, T3, RT3, Antibodies etc.

If you have any past test, those can be brought to our initial meeting for discussion.

Have you EVER been put on thyroid medications in the past? Yes \_\_\_ or No \_\_\_

Have you ever been tested for/treated for any autoimmune disease? Yes \_\_\_ or No \_\_\_

(Hashimoto’s, lupus, rheumatoid arthritis etc.)

If yes, please explain and include dates of testing and any treatment currently under: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you familiar with adrenal health/testing/fatigue? Yes \_\_\_ or No \_\_\_

Have you ever been told by a clinician that you have had adrenal exhaustion? Yes \_\_\_ or No \_\_\_

If so when? How was this determined and how were you treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If female, have you/are you (circle one):

Perimenopausal (erratic or missing periods)

Menopausal (one full year without a period)

Post-menopausal (how long? \_\_\_\_\_\_\_\_\_\_\_\_\_)

Please describe any symptoms and/or surgeries in relation to the above:

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

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Do you or did you suffer with heavy menstruation and/or PMS? Yes \_\_\_ or No \_\_\_

If Male: do you have excess breast tissue Yes \_\_ or No \_\_ or lack of sex drive? Yes \_\_ or No \_\_

Any other health Issues that you want me to be aware of not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(This is for information gathering only)

|  |  |  |
| --- | --- | --- |
| Medications and/or  Supplements  (Include Brand) | Dosage  (Time of day & how much) | Length of time taking?  Reason for taking? |
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**Getting to know you**

(Only fill out what you feel comfortable with but also know that everything you share can help me support your journey.) Everything is completely confidential.

1. What prompted you to seek Health Coaching now (this can be ONE thing or multiple issues) in the order of highest priority to least. Please be specific and thorough.

2. Describe how you feel about your life at this moment (happy, content, seeking, fearful, sad, etc. Use any adjectives that come to mind when you reflect upon your life as a whole).

3. What are the top 3 challenges or obstacles you face (mental or physical wellness) and how are these challenges affecting your life right now (ex: IBS keeping you from working, anxiety keeping you from social events etc., fatigue etc.):

1)

2)

3)

4. What have you tried (example: dieting to lose weight, psychologist for mood disorders, medicine for physical issues etc.) to overcome these challenges and what has the outcome been (quitting diet, smoking again etc.)? Why do you think it failed?

5. What are your personal goals for the future (live a healthier lifestyle, create more time for yourself, etc., it can be anything that you feel will enrich your life)?

6. Where do you get your energy? What motivates you? What are you passionate about (helping others, volunteering, accomplishing goals, etc.) and how do you enjoy yourself?

7. What do you find works for you to relieve the feelings of stress. In other words, what induces a sense of calm and well-being? (Meditation, reading, etc.)?

8. Where are you most irresponsible (food choices, skipping exercise, etc. BE SPECIFIC and take as much room as you need)?

9. How might you sabotage our professional relationship (lie to me, withhold information, ignore contact, tell me you will do something when you know you won’t, make excuses, etc.)?

10. Do you consider yourself an emotional person (take things personally, cry at the smallest negative comment etc.)?

11. What is your learning style? Do you learn best predominantly by listening, seeing or doing or an equal combination of all three?

12. Do you volunteer anywhere? How do you give back to the world?

13. Is there anyone in your life who is constantly putting you down, making you feel inadequate or who is sabotaging your efforts at a healthier lifestyle? Is that person YOU?

14. When you are given advice are you quick to defend yourself or make excuses?

15. Do you find yourself constantly worried (this could be about anything at all)? Something specific?

16. Have you ever been considered to have anxiety or any mental illness? If so are you seeing a mental health professional? Have you ever taken antidepressants (natural or otherwise)? Did they help? Please list them if so even if they did not offer noticeable improvements.

17. What do you wish was different about your life (this can be anything at all)?

18. If you are involved in a relationship (married or otherwise) does your spouse/partner totally support you in your efforts to become healthier and make a lifestyle change? If not, why not and how does that person sabotage your efforts (this could be bringing in sweets when you are trying to quit sugar or telling you they don’t agree with this style of support etc.)

19. Do you have a spiritual/religious belief you would like to share with me? If so would you like to incorporate it into our time together in any way?

20. If you don’t have a spiritual/religious preference but want more information on how to find a connection or path please note here what your “higher Power” beliefs are.

21. Have you experienced trauma in your childhood? Adulthood? If so have you sought therapy or have moved past it? Are you familiar with Adverse Childhood Experiences (ACE study) and how they affect our health today?

**DIGESTION:**

1. Do you have any digestive issues (constipation, diarrhea, bloating, heartburn, full feeling, gas, excess belching, food sensitivities, etc.) or ever been told you have with IBD, IBS etc.? If so, please elaborate.

2. Do you have acne, eczema or any other skin disorders? Do you suffer from allergies (seasonal or other)? Please explain:

Digestion is a VERY important marker of your overall health and complete honesty with an in-depth explanation is necessary.

1. How many times per day do you experience gas or bloating after a meal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How many bowel movements do you have each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you familiar with the Bristol Stool Chart? Yes \_\_\_ or No \_\_\_

4. Have you been on antibiotics or other prescription drugs for any length of time (at any time in your adult life)? When was your last dose of antibiotics and why was it given?

5. Do you take or have you ever taken over the counter stomach acid reduction medication (prilosec, nexxium, pepto, tums/rolaids etc.)? Yes \_\_\_ or No \_\_\_

6. Have you ever had GERD, indigestion, or heartburn medically or self diagnosed? Yes \_\_\_ or No \_\_\_

If yes, how many years have you had this condition? \_\_\_\_\_

Have you ever noticed that certain foods trigger this? Yes \_\_\_ or No \_\_\_

If so, please list offending foods/drinks:

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

7. Please share any additional information about digestion:

**FOOD**

1. Give me an example of an average of two days (one weekday and one weekend day) worth of each meal (BE VERY SPECIFIC, include every little thing you eat or drink including creamer in your coffee or chewing gum etc.). If you chew gum often, please list that as well. Take extra space if needed.

Breakfast

Lunch

Dinner

Breakfast

Lunch

Dinner

Any additional snacks:

2. Do you feel that any foods are a bigger challenge than others? If so what are they? (sugar, salty etc.)

3. How much water do you drink per day? Is it filtered? City tap? Bottled?

4. What are your core beliefs about food? (Do you believe in a low-fat lifestyle; do you believe whole grains should be a part of your diet? Avoid certain food groups?) If so why (raised that way, don’t want to gain weight, etc.)?

5. What was your diet like growing up? Was your mother or father constantly dieting or telling you to watch what you eat or to “finish your dinner”?

**LIFESTYLE**

1. Is there anything else you feel you would like further help with (ways to live a more peaceful life, finding more balance, spirituality, what exercise is best, how to get better sleep, etc.?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. Do you feel like you have a good support system that can help you succeed in your goals (Spouse, family support with time restraints, encouragement, sharing in food changes, etc.?) Yes \_\_\_ or No \_\_\_

3. Do you set aside “time” for yourself every day (relaxing time, meditation, reading etc. something that does not involve electronics or other people) to do something that is stress relieving? Yes \_\_\_ or No \_\_\_

Do you understand the connection between stress, digestion and weight gain? Yes \_\_\_ or No \_\_\_

4. How often do you exercise per week? \_\_\_\_\_\_

What does your exercise consist of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you self-motivated or do you require someone to be accountable to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. How many hours of sleep do you get (uninterrupted) per night? \_\_\_\_\_\_\_\_

What time do you go to bed? \_\_\_\_\_\_\_\_\_\_ Do you dream? Yes \_\_\_ or No \_\_\_

6. What is your sleep environment like (TV in the room? Light coming in through windows, quiet? Noisy?)?

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

7. Use this space to list anything I have not covered in this form that you feel is important for me to know. This can include past or current information.

Please rate these in order of how stressed they make you feel when you think about upgrades in your life.

(1 being the MOST stressed out 5 being least stressed and enjoy learning more).

If you are comfortable with your Spirituality, please choose 5.

Addressing these CAUSES STRESS < 1 – 2 – 3 – 4 – 5 > DOES NOT CAUSE ANY STRESS & like discussing

Food changes/upgrades: 1 2 3 4 5

Working on Stress: 1 2 3 4 5

Taking time for fun: 1 2 3 4 5

Sleep: 1 2 3 4 5

Exercise: 1 2 3 4 5

Spirituality: 1 2 3 4 5

Meditation/Quiet time: 1 2 3 4 5

In a Discovery Session (a first client meeting), we primarily focus on teaching and education based on the primary needs of the client. For follow-up sessions we will always start with things you rate 5, 4, & 3 then gradually move toward 2 and 1 at your comfort level with my encouragement and support. For those looking to make significant health, mind and lifestyle changes, it does require multiple follow-up sessions to work on all and be holistically successful. Please ask about package pricing for ongoing holistic health coaching. I currently offer 3 or 6 month packages.

Commitment Agreement

Reaching optimal health is a commitment to yourself. If I end up caring more about you than you care about yourself this process will not work. You are ultimately required to do any work to get well. Getting healthy can cost money, take TIME and be frustrating when things don’t happen as quickly as you would expect. Expect bumps in the road. They are a normal part of life, growth and success. I am here to lead you away from “giving up” on that commitment and to provide you with support as you maneuver into a healthier lifestyle. These are changes I would hope you see as a lifetime change and not a “quick fix” to get thin or achieve an unrealistic goal. We are focused on Holistic Living.

I understand the following (initial by each please):

* By signing this form, I am responsible for understanding the guidelines described to me in the wellness fee structure form. (I understand I am only paying for 1 visit and can add on additional visits following this Discovery Session.) \_\_\_\_\_\_\_\_\_
* Things can change as I make changes to my food and lifestyle, so the recommendations and suggestions will likely shift as I grow. \_\_\_\_\_\_\_\_
* A Certified Health Coach (CHC) is here to encourage and support my efforts at making lasting changes, but it is up to me to use the resources and use my own instincts for my own wellbeing. \_\_\_\_\_\_
* Recommendations are made to me as suggestions only. It is ultimately up to me to research each resource thoroughly and commit to my health. \_\_\_\_\_\_\_\_\_\_\_
* If at any time the Certified Health Coach feels that I am not doing the work required to meet the goals we agreed upon (after 1 session and/or multiple sessions), the CHC has the right to cancel the contract and services at any time. \_\_\_\_\_\_\_\_
* If at any time I am not feeling supported by the CHC or feel the CHC is not providing me with the information I need I can cancel my services with her at any time (please ask about our refund policy on package pricing since those will only be refunded by pro-rating the full price listed, not the pay in full discounted, and -$100 for admin fees). \_\_\_\_\_\_

Disclaimer

Please sign before your first consultation appointment.

Sherie Holland, Certified Health Coach, is not a licensed practitioner, physician, dietician, nutritionist, nurse or medical professional. During our professional relationship, I will offer no medical treatments, no diagnoses, or professional psychological counselling. If you have a medical condition of any kind, you must maintain treatment as prescribed by your physician regardless of my recommendations or advice, or any use of recommended online guides, supplementations, websites or products. In the case of medical diagnoses, it is vital to work with your physician to determine the best course of action; and to never replace one treatment for another that goes against your physician’s advice. If you do not have a licensed medical practitioner, we can refer you to one for medical treatment. I FULLY UNDERSTAND the above: \_\_\_\_\_\_\_\_\_(initial)

None of the recommendations, suggestions or written information provided are intended to replace medical advice of any kind. Health Coaching is not a prescriptive service; all consultations/sessions/appointments, written or otherwise should be considered as purely informational and carried out at the individual’s own risk. The information presented is never intended to diagnose, treat, cure, or prevent any disease. Full medical clearance from a licensed physician should be obtained before beginning or modifying any diet, exercise, or lifestyle program; and physicians should be informed of all food changes. This is solely and completely the responsibility of the client. I FULLY UNDERSTAND the above: \_\_\_\_\_\_\_\_\_(initial)

Sherie Holland, Certified A4M Lifestyle Health Coach also dba

RECONTROL Health, LLC claims no responsibility to any person or entity for any liability, loss, or damage caused or alleged to be caused directly or indirectly, as a result of the use, application, or interpretation of the information presented, suggested or recommended.

I fully understand all of the above information included (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature verifying complete understanding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_