

Bloom Within Holistic Health

Health History Form and Health Intake Questionnaire

PERSONAL INFORMATION

Today's Date:

Full Name:

Date of Birth:

Age:

Gender:

Email:

Phone:

Home Address:

Client's Occupation:

Have you lived or traveled outside of the United States? If so, when and where?

HEALTH AND WELLNESS GOALS

What are your health and wellness goals? Why are they important to you?

PERSONAL HEALTH AND FAMILY HISTORY

Health Information

What's the most important thing you'd like to share about your health story?

Do you have any of the following? If so, please list:

- Primary care provider:

- Other physicians or specialists:

- Practitioners, therapists, healers, etc.:

Please list any natural supplements or medications you take (include details if possible and duration):

Medical Information

Do you have any of the following? If so, please list.

Medical diagnoses or conditions:

Allergies and Intolerances/details:

☐ Allergies

☐ Seasonal

☐ Animals

☐ Foods

☐ Medications

☐ Supplements

History of serious illnesses, hospitalizations, injuries, or surgeries:

How often have you taken antibiotics?

How often have you have taken oral steroids?

Were you a full-term baby? A preemie? Breast-fed or Bottle-fed?

Is there anything from your childhood pertaining to your health you'd like to share?

Do you have any other notable family or personal health information you'd like to share?

PHYSICAL HEALTH INFORMATION

Current Weight:

Goal Weight:

Height:

How many hours do you sleep per night on average?

How would you describe your quality of sleep?

How is your energy level most days (circle)?

Very Low 1 2 3 4 5 Very High

Do you experience any pain, stiffness, or swelling on a regular basis? If so, please explain:

Do you have any of the following concerns? (Check all that apply.)

Metabolic health

- ☐ Blood Sugar Imbalances
- ☐ Elevated Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Elevated Triglycerides
- ☐ Other:

Digestive health

- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Other:

How many bowel movements (on average) do you have per day? _____

How do you feel your gut health is (circle)? Bad Poor Okay Good Excellent

Reproductive health/ Hormonal health

- Infertility
- Irregular Menstrual Cycle
- Low Libido
- Thyroid Condition
- Pregnant
- Postpartum/ 4th trimester
- Trying to conceive
- Signs or Symptoms of Hormonal Imbalance (please list):

- Other:

Women Only

Describe your cycle:

What is your average cycle length: _____ days

What is your average period length: _____ days

Number of total pregnancies:

Number of total miscarriages:

Number of total abortions:

Synthetic birth control? Brand?

Have you ever been on synthetic birth control? When? Brand?

Color of menstrual blood?

Marital Status:

Are you sexually active?

- Yes
- No

Immune health

- Autoimmune Conditions (please list):

- Low Vitamin D Level
- Frequent Illness or Infection
- Allergies and Sensitivities (please list):

- Other:

Brain health

- Brain Fog
- Difficulty
- Concentrating
- Forgetfulness
- Other:

How open are you to lifestyle changes for your wellness goals (circle)?

Very Low 1 2 3 4 5 Very High

What treatments have you tried?

Has anything been successful?

Do you have any pets or farm animals? If yes, where do they live?

NUTRITION INFORMATION

How would you describe your past relationship or history with food? Do any specific memories about food or eating come to mind?

Describe your current relationship with food.

Do any of the following apply to you? (Check all that apply.)

- ☐ Challenges with Preparing Meals
- ☐ Difficulties Chewing or Swallowing
- ☐ Poor Appetite
- ☐ Challenges with Access to Food

Do you regularly use any of the following? (Check all that apply.)

Alcohol: Yes No If yes, how often: _____

Tobacco Products: Yes No If yes, how often: _____

Other Substances: Yes No If yes, how often: _____

If yes, what substances: _____

Do you follow a specific eating approach/practice for personal, health, or religious reasons (e.g., vegan, ketogenic, kosher)? If so, please explain:

What does a typical day of eating look like for you? List a few foods/meals and drinks you usually consume in the corresponding categories:

Breakfast:

Lunch:

Dinner:

Snacks:

Dessert:

How much of the following do you consume each week?

Tea:

Coffee:

Soda:

Other Caffeine:

Dairy:

Cheese:

Bread:

Sugar:

Candy/Chocolate:

Dessert:

Alcohol:

What, if anything, would you like to change about your nutrition?

Are you open to a new nutritional intake?

How open minded are you to change (circle)?

Very Low

1

2

3

4

5

Very High

All information provided is for health education
purposes only and is not intended to diagnose,
treat, or cure disease(s).

Bloom Within Holistic Wellness

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? If yes, are these symptoms associated with any particular food or supplement(s)?

MENTAL AND EMOTIONAL HEALTH INFORMATION

How would you describe your overall mental and emotional health?

How do you like to support your mental health and cope with stress?

Using a 1–5 scale (where 1 = never and 5 = always), rate how often you experience each of the following:

Anger ____ Excitement ____ Fear ____ Joy ____ Love ____ Sadness ____ Stress ____ Worry ____

Did you feel safe growing up?

Have you or your family recently experienced any major life changes? If yes, please comment:

Have you experienced any major losses in life? If so, please comment:

Do you feel safe, respected, and valued in your current relationship?

Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?

SPIRITUAL HEALTH INFORMATION

What role does spirituality play in your life, if any?

LIFESTYLE INFORMATION

What are the important relationships in your life?

How many hours per week do you typically work?

What hobbies or recreational activities do you enjoy?

How would you describe your relationship with movement and physical activity, including exercise, sports, and everyday movement? How often do you intentionally move your body or work up a sweat?

What does a typical day look like for you?

ADDITIONAL COMMENTS

Is there anything else you'd like to share? Your Story?

Wellness Client

Wellness Client's Signature

Date

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Bloom Within Holistic Wellness

Holistic Health Assessment & Wellness Coaching Agreement

Practitioner Credentials:

Nicole Heise, A.S., IHP-BC

Board-Certified Integrative Health Practitioner | Integrative Nutrition Health Coach

Hormone Health Expert | Holistic Fertility Specialist | Whole Foods Supplement Specialist

1. Professional Scope & Legal Disclaimer

I understand that Nicole Heise is a Board-Certified Integrative Health Practitioner (IHP-BC) and health coach, and is not a licensed medical doctor, physician, or psychologist. Nicole Heise does not practice medicine, diagnose, treat, prevent, or cure any medical condition or disease. Natural health evaluations, functional wellness assessments, protocols, and coaching programs offered through Bloom Within Holistic Wellness are non-diagnostic and educational in nature. They are designed exclusively to help clients identify underlying lifestyle and functional imbalances, support the body's natural self-healing mechanisms, and build sustainable health habits.

2. Comprehensive Services & Educational Scope

By signing below, I voluntarily give permission to Nicole Heise to provide me with personalized wellness coaching, natural health education, and bio-individual lifestyle guidance. Educational topics, functional strategies, and wellness protocols may include, but are not limited to:

* Nutritional Optimization & Bio-Individual Coaching: Tailored whole-food nutrition strategies, macronutrient/micronutrient education, healthy eating habits, and hydration guidance.

* Hormone, Menstrual Cycle & Reproductive Wellness: Cycle-synced strategies, hormone balance education, fertility optimization, and preconception wellness planning.

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Bloom Within Holistic Wellness

* Integrative Protocols & Functional Wellness: Custom-guided detoxification protocols, gut-restoration programs (including micro-biome balancing, CBO, parasite clearance, and intestinal cleanse support), homeopathics, adaptogens, and professional whole-food supplementation from top holistic brands.

* Nervous System & Environmental Health: Stress management, nervous system regulation, sleep architecture, recovery strategies, physical movement guidance, and environmental toxin reduction.

* Additional Bio-Individual Guidance: Other holistic health education and integrative wellness modalities as appropriate for individual client needs.

3. Client Responsibility & Medical Care Coordination

* Medical Care: I acknowledge that wellness coaching is not a substitute for medical care, medical advice, or treatment. I agree to maintain care with a licensed medical provider for any health conditions, diagnoses, or treatments.

* Medications & Supplements: I understand that I should consult my primary prescribing physician with my wellness choices. I agree to consult my healthcare provider about dietary supplements or wellness protocols.

* FDA Acknowledgment: Statements regarding dietary supplements, herbs, and natural protocols have not been evaluated by the Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any disease.

* Non-Entrapment Attestation: I attest and affirm that I am seeking services with Nicole Heise solely on my own behalf for personal health optimization, and not as an agent or representative for any federal, state, or local agency conducting an investigation or entrapment.

4. Client Acknowledgment & Informed Consent

I acknowledge that I voluntarily participate in this health coaching program. I assume full personal responsibility for the lifestyle choices I make and understand that results depend on

individual consistency and bio-individual factors. I have read, understood, and agree to all statements contained in this agreement, and I consent to working with Nicole Heise as my holistic health mentor.

Wellness Client's Signature

Date

Parent or Guardian Signature
(for children under 18)

Date

Print name

Date

1. Scope of Practice & Wellness Coaching Acknowledgment

I understand that Nicole Heise / Bloom Within Holistic Wellness LLC is providing natural health education and holistic wellness coaching designed to help clients build healthy, sustainable lifestyle habits.

As a client, I acknowledge and understand that:

* Nicole Heise is not a licensed physician or psychologist and does not diagnose, treat, prescribe for, or cure any medical condition or disease.

* These services are intended to help identify potential underlying lifestyle/wellness imbalances, support the body's natural ability to function optimally, and empower informed lifestyle choices.

* Wellness coaching services and recommendations are not a substitute for professional medical advice, diagnosis, or treatment.

* I agree to seek the care of a licensed healthcare provider for any medical concerns, diagnoses, or medical treatments and to continue working with my primary healthcare team as needed.

2. Initial Service Selection (Select One)

Please select your preferred initial intake pathway:

* ☐ Option 1: Initial Live Phone Consultation — \$125 (Currently Unavailable – Check to join interest list)

* Includes a 60-minute live phone consultation reviewing your complete health history, lifestyle factors, and main wellness goals.

* Followed by a personalized, written wellness protocol and actionable recommendations tailored to your root-cause needs.

* ☐ Option 2: Initial Asynchronous Review — \$100 (Primary Coaching Model)

* Skip the live phone call. Submit your completed health history and intake forms electronically for a full, in-depth evaluation.

* Receive a comprehensive, custom-written wellness protocol and recommendations delivered directly to your email.

3. Ongoing Support & Follow-Up Services

Following your initial evaluation and protocol setup, you may select your preferred ongoing support model.

* Clinical Guidance & Communication Style: While I honor and prioritize asynchronous messaging whenever that is your preferred method of support, I will always make professional recommendations on which format best serves your needs. If complex topics or detailed protocol updates arise that cannot be adequately or safely addressed via text, I may suggest scheduling a follow-up phone consultation.

* ☐ Ongoing Support Option A: Full Support Health Membership — \$75/week or \$300/month

* Flexibility: Can be paused or canceled at any time with notice prior to your next billing cycle.

* Real-Time Asynchronous Guidance (Mon–Fri): Communication via text message, email, or voice messaging. Designed for real-time guidance, breaking down your protocol, ingredient label reviews, healthy lifestyle swaps, recipe ideas, and minor protocol tweaks.

* High-Frequency Messaging Add-On (+\$25/week): Applies if you require high-volume daily messaging or complex protocol adjustments between milestones.

* ☐ Option B: Monthly Asynchronous Email Check-In — \$75 / month

* Flexible, bio-individual support on your schedule.

* Our most popular alternative for dedicated care without continuous weekly messaging. Perfect for clients who want routine, high-level accountability at any time of day that fits their schedule.

* Your Monthly Check-In: Share everything you're experiencing via email submit your questions, current symptoms, and health updates all in one place whenever it's convenient for you.

* Personalized Feedback & Tweaks: Receive targeted protocol adjustments, customized wellness recommendations, and actionable tools tailored specifically to your unique bio-individual needs.

* Note: Includes a focused email dialogue (a couple of messages back-and-forth) to answer follow-up questions, refine your adjustments, and make sure you feel confident in your next steps. For ongoing, high-frequency messaging, please refer to Option A.

* [] Ongoing Support Option C: Individual Follow-Up Phone Consultations — \$85 per session (Currently Unavailable – Check to join interest list)

* 60-minute scheduled phone consultation to evaluate progress, review goals, answer detailed questions, and adjust your root-cause protocol verbally.

4. Payment Terms & Financial Policy

* Payment Due Prior to Services: Full payment is required prior to all scheduled phone consultations, protocol reviews, or membership access.

* Accepted Payment Methods: Digital invoice payment. Services will not commence or be scheduled until payment is successfully processed.

5. Cancellation, Rescheduling & Refund Policy

We value your time and allocate dedicated schedule slots solely for your care. Late changes leave gaps in the schedule that prevent us from supporting other clients in need.

* Notice Requirement: A minimum of 72 hours' advance notice is required to cancel or reschedule any scheduled phone consultation.

* Cancellations/Rescheduling Prior to 72 Hours: If you cancel or request to reschedule at least 72 hours before your scheduled appointment time, your pre-paid fee can either be applied as a credit toward your rescheduled session or fully refunded to your original payment method.

* Late Cancellations, Late Rescheduling & Missed Sessions (Less than 72 Hours): Cancellations or reschedule requests made with less than 72 hours' notice, as well as missed/no-show appointments, will incur a \$75 cancellation fee.

* If you paid the \$125 initial consultation fee and cancel with less than 72 hours' notice, \$75 will be retained as the late cancellation fee, and the remaining \$50 balance may be refunded or credited toward a future booking.

* Any outstanding balances must be settled prior to scheduling future sessions or receiving continued services.

6. Accuracy of Information & Client Authorization

By signing below, I certify that all health history and personal information I provide is complete, true, and accurate to the best of my knowledge. I agree to all of the terms, scope of practice acknowledgments, service selection choices, payment terms, and cancellation policies outlined above, and I consent to allow Nicole Heise to serve as my holistic lifestyle mentor.

_____ Wellness Client's Signature	_____ Date
_____ Parent or Guardian Signature	_____ Date
_____ Print name	_____ Date

Congratulations and Welcome, you are on the path to taking your first step towards health and wellness! 😊

Please email completed form to: nicole@bloomwithinholistic.com