Empowered by Nature
Lorraine Hughes, RH (AHG)
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If you cannot keep your appointment you are required to give 24-hour notification.
PLEASE ARRIVE ON TIME

Please fill out the attached questionnaire and bring it with you to session. It is also wise to bring any medications and supplements that you are currently using as well as any medical test results that you may have received pertaining to your health. **Please make a chronological list of your health history from birth to the present, noting any surgeries, diagnosed illness/disease** and so forth. If you have other concerns or questions, please bring them along as well.

You are encouraged to attend this session alone or with partners that will allow us to talk in detail without distraction.

- **Please do not wear perfume, essential oils or aromas to your session**
- **Please do not eat any colored food, candy or gum prior to your session**
- **Please wear little or no makeup to your first session**
- **Do not eat or drink anything 1 hour prior to your session**

Please bring a complete listing of all the meals and snacks you have eaten the 3-5 days prior to your session AS THIS IS AN IMPORTANT FACET OF YOUR ASSESSMENT.

It is my hope that in taking time to answer these questions you will be encouraged to look more deeply at your concerns and begin the process of learning and understanding, which will continue with your session. My intention is to provide education, encouragement, insight, inspiration and some straightforward, no-nonsense guidelines to natural living, healing and staying in balance.

The fee for the initial session is **$ 150.00** ,(cash, check) which must be paid at the time of the visit. Any herbal formulas, supplements, etc are an additional charge. The fee for follow up appointments is **$ 75.00** for a full hour and **$ 50.00** for a half hour. Suggested frequency of follow-up appointments may be weekly at the beginning, with reduction in appointments as progress is made to bi-weekly, monthly and finally every three months as maintenance. This schedule is flexible and is contingent upon each individual case.

If you have any questions, please do not hesitate to call (845) 416-4598 or send an email to lorrainehughes54@gmail.com

By initialing below you understand that there is a 24 hour cancellation policy in effect for all appointments and that you will be charged a $25.00 missed appointment fee which needs to be paid prior to any new appointment or pick up of herbal remedies / supplements.

X_____ **Printed Name & Date** _____

LIABILITY WAIVER AND CONSENT TO SERVICES/LIFESTYLE CONSULTATION

I understand that Lorraine Hughes is not licensed to diagnose or treat any physical or emotional conditions. I am totally responsible if I choose to implement any techniques that I learn from Lorraine Hughes and realize I need not accept any information that she discusses with me. I will not discontinue any physical or emotional treatment that I am currently undergoing.

I understand that all suggestions regarding diet, nutritional supplementation and herb/compounds or preparations, remedies, flower essences purchased here or elsewhere are based upon the observations of Western (Herbal), Ayurveda and Chinese Medicine and are not intended to replace standard medical treatment or advice from licensed health care professionals.

I understand that at the present time, there is no licensing or legal standard for herbalists practicing in the United States. All nutritional supplements, herbs, extracts, remedies, etc are taken at my own risk. As with any ingested substance, allergic reaction is a possibility in some individuals. I have been informed of the risks and consequences involved. I agree that I and my heirs, guardians, legal representatives and assigns will not make a claim or file any action against Lorraine Hughes for injury or damage resulting from negligence or other acts, howsoever, caused in connection with my consultation. I hereby waive, release and discharge Lorraine Hughes from all actions, claims, demands I, my heirs, guardians, legal representatives or assigns, now have, or may hereafter have for injury or damage resulting from my consultation.

I also understand that Lorraine Hughes and Empowered by Nature will not be held responsible for errors/ingredients on the part of any manufacturer or supplier of products sold here or elsewhere.

I hereby consent to and authorize Lorraine Hughes Barefoot Doctor techniques such as moxa, cupping and/or other alternative modalities based upon energetic assessment. Neither the Practitioner, Lorraine Hughes, nor the company, Empowered by Nature, shall be liable for special, indirect, or consequential damages resulting from any services rendered in the areas of energy healing modalities.

I have carefully read this agreement and fully understand the content. I am aware that this is a waiver and release of potential liability and a contract between Lorraine Hughes of Empowered by Nature and myself and signs it of my own free will.

Signature_____Date_____

Printed Name_____

Address:_____

_____

Phone numbers where you can be reached

Email address for those who wish to be on our mailing list

Any information shared in sessions is confidential and will not be disclosed to any party, be they family or medical provider. If you wish me to speak with a member of your family or a professional, you will need to sign a consent form. I am bound by the ethics of my profession to honor client confidentiality at all times.

Client History and Concerns Form

Name_____Date_____
Referred by:_____Phone _____
Age & Birth date _____Height_____Weight_____

Please answer each question with as much detail as possible.

What is your current concern? **Give duration and symptoms.**

Are you currently seeing a MD or other practitioner for this problem?

Are you allergic to anything?

Please list the medications and supplements/herbs that you take on a daily basis:
(use a separate sheet if necessary)

Have you done any long-term drug or antibiotic therapy?

Describe your digestion & appetite. Is it slow, fast, gurgling – are you always or never hungry?

Do you have daily bowel movements? Please describe – along with any discomfort or problems experienced such as erratic bowels, alternating constipation and diarrhea

On average how many times daily do you urinate? What about at night?

Describe your typical night's sleep pattern: (trouble falling or staying asleep, waking frequently)

On a scale of 1 – 10 with 10 being the best, rate your energy level. Please describe how you feel when you get out of bed in the morning.

Are you frequently thirsty or never thirsty?

Do ever experience a taste in your mouth? –(if so please describe)

Do you break out in a spontaneous sweat during the day or do you sweat at night?

Do you have mucus or secretions from any part of your body (rectal mucus, vaginal discharge, runny eyes or ears) please describe the color, smell and the texture

Do you frequently experience pain in your body? If yes, please tell where and try to describe it: dull and achy, sharp and stabbing, moving from place to place – cold and tingly, etc.

Do you have any recurrent rashes or skin problems (eczema, psoriasis) including very dry skin?

Are you either feverish or chilled – do you have hot flashes – are you always cold?

Do you have any problems with your joints?

Do you have any problems with your circulation, including cold hands/feet?

Are you currently sexually active? If so, are you experiencing low libido?

Have you ever been diagnoses with any kind of sexually transmitted disease?

Do you have regular menstrual cycles? How often? Length of cycle?
Pain: Color of Blood: Clotting? Itching?
List any PMS symptoms:

Do you have any history of cysts: uterine, ovarian or breast?

Please list pregnancies, abortions and births – and note any problems experienced.

Were you ever a vegetarian or have you ever followed a strict diet like Atkins, raw foods diet, etc.

Do you use alcohol, cigarettes, soda, diet soda, coffee, tea , fast foods,/restaurant/Chinese food, carbonated water. If so please note the frequency.

Do you cook using a microwave?

What kind of exercise do you practice and how often?

What time of the day are you at your best? What about your worst? What season and type of weather suits you best?

Do you have any food cravings?

What is your current occupation?
Do you have pets?

Have you recently been bitten by any insect?

Please indicate whether your encircled symptom or illness is:

P for past – over 5 years prior to this consult & for how long?
C for current – and for how long?
R for recurring – and how often?

Below is a list of illnesses, **if a doctor has told you** that you have any of these conditions, please circle them.

Cancer	Chronic Fatigue	Lupus	Migraines	Lyme Disease
Panic disorder	Hypoglycemia	Diabetes	Colitis/Crohns	Mitral Valve Prolapse
Stroke	Arthritis	Heart Disease	Angina	Hypertension
Parkinsons	MS	Thyroiditis	HIV/AIDS	Hypotension
Asthma	Hepatitis (any)	Liver disease	Gallstones	Mononucleosis
TB	Pneumonia	Allergies	Hayfever	Hemorrhoids
Acid Reflux	Anorexia/Bulemia	Osteoporosis	Gout	Manic Depression
Anemia	Epstein-Barr	Strep	Candida	Broken bones

Below is a list of symptoms: please circle all that apply now or were serious concerns in the past.

Dizziness	Ringing ears	Ear infections	Blurry vision	Eye pain/infections
Chest pain	Shortness of Breath	Palpitations	Wheezing	Difficulty inhaling
Heart murmur	Tacchycardia	Fainting	Tics/tremors	Muscle twitching
Acne	Nose bleeds	Sinus trouble	Sore throats	Kidney/Bladder infections
Kidney stones	Painful urination	Blood in urine	Incontinence	Cysts/Tumors
Bruise easy	Numb hands/feet	Foot pain	Lump in throat	Dropped uterus or bladder
Phlegm	Lump in throat	Belly pain	Heartburn	No appetite/Constant hunger
Weight gain	Weight loss	Varicose veins	Eye bags	Circles under eyes
Leg swelling	Nerve injury	Nervousness	Depression	Memory loss
Fears	Anxiety	Burning ears	Flushing	Gas and bloating
Recurrent problems with the lungs		Catch colds/flu easily		Tired and drained
Pain in legs or other body parts while walking or exercising				Other

Give a brief history of hereditary/family diseases

Please give a brief overview of your family life (emotional) from birth to the present noting any difficulties or traumas such as incest, abuse, war survivor, rape, death of a parent, spouse, child, divorce, family history of mental illness, alcoholism, etc. Remember that all information is kept confidential. These things directly impact your physical health, so it is important to understand any challenges that you may have experienced or are currently experiencing.

Are you currently seeing a therapist or a counselor?

Is there a history of eating disorders?

What are your major sources of stress and how do you relieve this?

How much television do you watch?

Are you currently taking or have you taken recreational drugs?

What do you do for enjoyment?

What are your home and work environments like? Do you sit/sleep under air conditioning vents, are you always in front of a computer, work with chemicals,etc?

Do you sleep under or on an electric blanket or mattress pad? Do you currently live near high-tension wires or a super-fund site.?

What is the source of your drinking water?

If there is anything you would like to add, please feel free to do so. If you have questions you would like addressed, you may write them here or on another piece of paper so that we can answer them in your session.

Please remember to bring with you to your session:

1) **a list of everything: snacks, etc that you have eaten for three days**
2) **a chronological medical history from birth until the present, including all surgeries.**
3) **any copies of tests or evaluations you have done elsewhere if you feel they are pertinent.**