

Dear treasured clients,

Welcome to 2026! We are excited to continue being an integral part of your healing journey so you can participate in your life more fully! Please note the following policies/recommendations:

**\*All cancellations need to be made by calling the office.** A late cancellation is defined as an appointment not cancelled 24 hours prior to your scheduled appointment. If you have a Monday appointment that needs to be rescheduled, please call and leave a message on our office message machine 970-256-8449.

*Please initial* \_\_\_\_\_

\*Your first late cancellation or no-show appointment in each calendar year will not be charged as we certainly understand things happen in life that make it impossible or pose a significant hardship to keep our agreed session time to focus on your health. *Please initial* \_\_\_\_\_

\*After the first "free" late cancellation or no-show appointment in a calendar year, clients will be charged for the full rate of the appointment. *Please initial* \_\_\_\_\_

\*After using your first "free" late cancellation or no-show appointment **and** paying for a late cancellation or no-show appointment, we will ask that you have a credit card on file for scheduling future appointments. We will notify you of the late cancellation or no-show appointment and the amount prior to charging your card.

*Please initial* \_\_\_\_\_

\*Also, we respectfully recommend you do not smoke cigarettes or be under the influence of any recreational mind-altering substance the day of your service so that you may reap the full benefits of the service rendered.

With gratitude and appreciation,  
Your Healing Horizons Healing Team

2026

Signature \_\_\_\_\_

Date \_\_\_\_\_



## Integrated Health Solutions

### *Welcome to Healing Horizons Integrated Health Solutions* **NUTRITION COACHING CONSENT**

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare in order to assist you in achieving your health-related goals. To serve you as efficiently as possible, please answer all the following questions and read and sign all the forms that you are provided. All your information will be held in the strictest of confidence.

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ M F Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Cell \_\_\_\_\_ If we may send you information, please provide your email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

\*I voluntarily consent for Judith Olesen, Nutrition Coach, to provide services to me. A Nutrition Coach is not licensed or certified by any state. However, Ms. Olesen is certified as a Nutrition Coach by the Institute for Integrative Nutrition, New York City, which provides a certificate of completion to students who have successfully met all course requirements, including a written exam. Her certificate is available upon request. A license to practice nutrition coaching is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.

\*I understand that it is important that I contact my other healthcare providers and alert them to my use of nutritional supplements. Nutrition coaching may be a beneficial adjunct to more traditional care, and it may also alter my need for medications. Therefore, I understand it is important to keep my physician informed of changes in my nutrition program.

\*I understand that a Nutrition Coach is not trained or licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases. The Nutrition Coach is not a substitute for my family physician or any other healthcare provider.

\*I agree that if I have any physical or emotional reaction to my use of nutritional supplements, I will discontinue their use immediately and contact the Nutrition Coach to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the supplement(s).

\*I understand that I am entitled to receive information about the coaching methods and the duration of coaching, if known.

\*I may seek a second opinion from another healthcare professional or may terminate nutrition coaching at any time.

\*Healing Horizons Integrated Health Solutions is HIPAA (Health Insurance Portability and Accountability Act) compliant. A complete copy of HIPAA guidelines is available upon request.

\*In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

\*At times you may wish to contact Healing Horizons via email, or vice versa, for communication that may contain protected health information. **Please initial for consent**

\*I understand that the following providers will be present at Healing Horizons collaborative care meetings in which my care may be discussed: *April Schulte-Barclay*, DAOM, LAc; *Joseph Ellerin*, LAc, Nutritional Therapist, LMT, Dip. Hom, CST; *Kimberly Brown*, LAc, WEMT; *Paula King*, PhD; *April Ordaz*, LMT; *Mariel Steel*, LMT; *Judith Olesen*, BA; *Markus Wettstein*, MD; *Adam Henby*, DC. I also understand that other methods of collaboration, such as confidential email and private electronic group communication may be used to coordinate my care in accordance with HIPAA regulations. **Please initial for consent**

**\*I understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to treatment. Healing Horizons gladly accepts cancellations up to 24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment.**

**Please initial** \_\_\_\_\_

I have carefully read, and I understand all the above information. I am fully aware of what I am signing.

**Signature (Patient/Parent/Guardian)** \_\_\_\_\_

**Date** \_\_\_\_\_

Rev 7/7/2026

(970) 256-8449 • 12th Street Plaza • 2139 N. 12th St #7 • Grand Junction, Colorado 81501  
www.hhacumed.com



INTEGRATIVE MIND-BODY HEALING LLC  
3687 G 7/10 Road  
Palisade, Colorado 81526

HEALTH HISTORY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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

Occupation: \_\_\_\_\_ Years Worked: \_\_\_\_\_

Retired:  Year Retired: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Contact Method:  Phone  Text  Email

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Date Form Completed: \_\_\_\_\_

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

Other physicians or specialists: \_\_\_\_\_

Practitioners, therapists, healers: \_\_\_\_\_

\_\_\_\_\_

**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?

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

Please list any supplements or medications you take and the amounts of each:

---

---

---

---

---

---

---

---

**Medical Information**

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

- Medical diagnoses or conditions: \_\_\_\_\_

---

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

---

---

---

---

---

---

---

---

When was the last time you felt well? \_\_\_\_\_

Did something trigger a change in your health? \_\_\_\_\_

What makes you feel better? \_\_\_\_\_

What makes you feel worse? \_\_\_\_\_

### **Family History**

Describe the health of your:

- Mother: \_\_\_\_\_

\_\_\_\_\_

- Father: \_\_\_\_\_

\_\_\_\_\_

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?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Digestive health

- Bloating
- Constipation
- Diarrhea
- Gas
- Nausea
- Stomach Pain
- Other \_\_\_\_\_

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

## Reproductive health

- Infertility
- Irregular Menstrual Cycle
- Low Libido
- Other \_\_\_\_\_

## Immune health

- Autoimmune Conditions
- Frequent Illness or Infection
- Allergies and Sensitivities
- Other \_\_\_\_\_

## Brain health

- Difficulty Concentrating
- Problems With Finding Words
- Problems With Recognizing Faces
- Problems with Organizing
- Brain Fog
- Other \_\_\_\_\_

## NUTRITION

What foods did you grow up eating? \_\_\_\_\_

\_\_\_\_\_

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 you have any food allergies or intolerances? If so, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

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

- Alcohol                       Tobacco Products                       Other 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

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

---

---

---

---

---

**EMOTIONAL**

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 \_\_\_\_\_

How would you describe your overall emotional health?

---

---

---

How do you like to support your emotional health?

---

---

---

How do you cope with stress?

---

---

---

What motivates you?

---

---

---

What do you do on a regular basis that gives you joy?

---

---

---

## LIFESTYLE

Whom do you live with, if anyone? \_\_\_\_\_

What are the important relationships in your life?

---

---

---

How many hours per week do you typically work? \_\_\_\_\_

Using a 1–5 scale (where 1 = very little and 5 = very much), rate how much you find satisfaction in your work: \_\_\_\_\_

What hobbies or recreational activities do you enjoy?

---

---

What role does movement, including sports, exercise, and physical activity, play in your life?

---

---

---

Is there anything you'd like to share about your social life? If so, please explain:

---

---

---

### SPIRITUAL

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

---

---

---

### ADDITIONAL COMMENTS

Is there anything else you'd like to share?

---

---

---