**Raw Recovery Fasting Retreat Application Form**

|  |
| --- |
| **PERSONAL DETAILS**Name: D.O.B: Age:Address: Email:Contact Tel. No:Mobile:Occupation:GP’s Details: |
| Have you done a water or juice fast before? Y/NPlease give short explanation below if you have ever done a short or long fast before!Current physical condition/ presenting symptoms?What are your expectations for your stay at Raw Recovery Fasting Retreat?Current emotional status? How happy are you? Rate from 1-10, 10 being very happy. |
| **MEDICAL HISTORY/GENERAL HELTH (complete all relevant sections with dates)**Height:Weight:Current blood pressure (if known):Major Operations/Illnesses**:** Skin Complaints:Muscular Skeletal Disorders:Cardiovascular Disorders:Respiratory Disorders:Digestive Disorders:Diagnosis with Anorexia Nervosa/ Bulimia Nervosa **YES/NO**Nervous /Stress Related Disorders:Hot or Cold Person |

|  |
| --- |
| **Do you or have you ever suffered from any of the following?** (If Yes, please give details)High/Low Blood Pressure Y/NEpilepsy Y/NDiabetes Y/NThrombosis Y/NCancer Y/NHeart Conditions Y/NBulimia Nervosa/ Anorexia Y/NAre you currently on any medication? Y/NDo you suffer from any allergies? Y/NAny relevant details from family medical history? **Female clients only:**Details of current/previous pregnanciesDo you suffer with problem periods/PMS?Bowels movements per day :Formed, loose, or alternates between the two?Please answer all questions!**LIFESTYLE**General Diet Information give a rough idea what you would eat.Breakfast:Lunch:Dinner:Do you snack in-between meals? If yes, what on? Do you take vitamins and Supplements? If yes, what are they?Daily tea/coffee intake: Daily water intake:Do you drink alcohol? Y/N If Yes, how many units per week?Do you smoke? Y/N If Yes, how many per day?Energy Level 1-10 ten being very good. |
| Sleep Pattern Hours? And at what time you go?Stress Level:1-10 ten being very stressed.Relaxation/Exercise: and how many times per week?**Please Read:*** The medical history/symptoms list is correct to the best of your knowledge
* You understand any dietary changes or any desire that you have to wean your- self off Pharmaceutical drugs you are advised to consult with GP/MD

**Natalie will check through this form and then you will be informed if she accepts you onto her fasting programme.****Please feel free to give any more information that you may think might be relevant.** |
|  |