**Raw Recovery Fasting Retreat Application Form**

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| **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/N  Please 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 |

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| **Do you or have you ever suffered from any of the following?** (If Yes, please give details)  High/Low Blood Pressure Y/N  Epilepsy Y/N  Diabetes Y/N  Thrombosis Y/N  Cancer Y/N  Heart Conditions Y/N  Bulimia Nervosa/ Anorexia Y/N  Are you currently on any medication? Y/N  Do you suffer from any allergies? Y/N  Any relevant details from family medical history?  **Female clients only:**  Details of current/previous pregnancies  Do 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.** |
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