

**Detox Application**  
Sara Thyr, N.D., LLC

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Female  Male Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Why do you want to detox? Check all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> General Cleanse                | <input type="checkbox"/> Have Radiant/Clearer Skin         |
| <input type="checkbox"/> Lose Weight                    | <input type="checkbox"/> Learn About Nutrition/Digestion   |
| <input type="checkbox"/> Reduce Fatigue/Increase Energy | <input type="checkbox"/> Relieve Gas/Bloating/Constipation |
| <input type="checkbox"/> Reduce Allergies/Asthma        | <input type="checkbox"/> Memory Loss                       |
| <input type="checkbox"/> Conquer Food Cravings          | <input type="checkbox"/> Insomnia                          |
| <input type="checkbox"/> Foggy Thinking                 |  |
| <input type="checkbox"/> Other: _____                   |  |

**Current Health Conditions**

Please list any current health conditions, including diseases and illnesses: \_\_\_\_\_

List any medications/supplements you are taking: \_\_\_\_\_

**Please Mark Any Conditions That Are Part of Your Current Health History:**

- | CATEGORY A  | CATEGORY B  | CATEGORY C  |
|---|---|---|
| <input type="checkbox"/> Frequent constipation          | <input type="checkbox"/> Heart surgery                | <input type="checkbox"/> Aneurysm                     |
| <input type="checkbox"/> Frequent diarrhea              | <input type="checkbox"/> Past Eating Disorder         | <input type="checkbox"/> AIDS/HIV                     |
| <input type="checkbox"/> Bloating/Gas                   | <input type="checkbox"/> Diabetes – no insulin needed | <input type="checkbox"/> Active cancer                |
| <input type="checkbox"/> Ulcers                         | <input type="checkbox"/> Bowel surgery                | <input type="checkbox"/> Active eating disorder       |
| <input type="checkbox"/> Allergies                      | <input type="checkbox"/> Stomach surgery              | <input type="checkbox"/> Diabetes – insulin dependent |
| <input type="checkbox"/> Gallbladder problems           | <input type="checkbox"/> Chronic hepatitis            | <input type="checkbox"/> Seizure disorder             |
| <input type="checkbox"/> Sober alcoholic or drug addict | <input type="checkbox"/> Ulcerative colitis           | <input type="checkbox"/> Currently pregnant           |
| <input type="checkbox"/> History of asthma/bronchitis   | <input type="checkbox"/> Active alcoholism            | <input type="checkbox"/> Currently breast-feeding     |
| <input type="checkbox"/> Frequent sinus infections      | <input type="checkbox"/> Chronic fatigue syndrome     | <input type="checkbox"/> Active Kidney Disease        |
| <input type="checkbox"/> Fibromyalgia                   | <input type="checkbox"/> Active asthma                | <input type="checkbox"/> Acute hepatitis              |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Taking depression medicine   | <input type="checkbox"/> Active Hyperthyroidism       |
| <input type="checkbox"/> High blood pressure            | <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Active Crohn’s disease       |
| <input type="checkbox"/> PMS                            | <input type="checkbox"/> Rheumatoid Arthritis         | <input type="checkbox"/> Currently on Psychiatric Med |
| <input type="checkbox"/> Currently in Menopause         | <input type="checkbox"/> Autoimmune disease           |   |
| <input type="checkbox"/> Osteoporosis                   | <input type="checkbox"/> Lupus                        |   |
| <input type="checkbox"/> Osteoarthritis                 | <input type="checkbox"/> Active drug addiction        |   |
| <input type="checkbox"/> Insomnia                       |   |   |

**Please Read and Sign the Following:**

I understand and acknowledge that The Detox is an educational course and not meant as a prescription for any general or specific health condition. The directions given by the instructor is in no way meant to be considered a substitute for one-on-one medical advice and care from a duly licensed doctor. The information conveyed in the course represents the latest nutritional and dietary research and is based upon reliable, sound authority and extensive clinical experience. Nevertheless, I understand that some individuals who consider themselves health authorities may disagree with opinions taught in The Detox. Additionally, I understand that the seminar tuition is non-refundable on or after the day of the first seminar session.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_