Holistic Wellness Services Intake Form

Date:_____

Name:_____ Date of Birth:_____
Address: _____ City: _____ Zip:_____

Phone #: _____ Alt Phone #:_____
Email: _____
Preferred contact: Business #____ Cell#____ Home#____ Email____

Occupation: _____Referred by:_____

HEALTH HISTORY (Please list both past and present information)
Doctor: _____ Phone #:_____ Address: _____
Current Medications (conditions they treat):_____
Surgeries (Please list and date):_____

_____

Please list the presence and location of any internal pins, wires, artificial joints of special equipment:

_____

List other current therapies (i.e. physiotherapy):_____
Motor Vehicle Accident? YES NO Date(s):_____
Other Accident(s)? _____ Date(s):_____

<u>Top 3 reasons for seeking holistic services:</u>

Please check off all applicable boxes below (past and current):

Cardiovascular
- o High blood pressure
- o Low blood pressure
- o Chronic congestive heart failure
- o Heart disease
- o Myocardial infarction
- o Phlebitis
- o Cardio-vascular accident
- o Stroke
- o Pacemaker
- o Varicose veins
- o Blood clots
- o Osteoarthritis
- o Lymph edema
- o Other

Infectious Diseases
- o Hepatitis
- o Tuberculosis
- o HIV
- o Other

Musculo-skeletal
- o Bone or joint disease
- o Tendonitis
- o Bursitis
- o Fractures
- o Osteoarthritis
- o Rheumatoid arthritis
- o Sprains/strains
- o Swelling
- o Stiffness
- o Spasms/cramps
- o Pain (check area) __Jaw __Neck __Shoulder __Elbow __Wrist __Hip __Knee __Ankle __Back

Digestive
- o Constipation
- o Gas/bloating
- o Nausea/vomiting
- o Irritable bowel syndrome
- o Liver/gall bladder

Skin
- o allergies (anaphylactic)
- o Athletes foot
- o Warts
- o Cold sores
- o Eczema/psoriasis o Other (contagious)

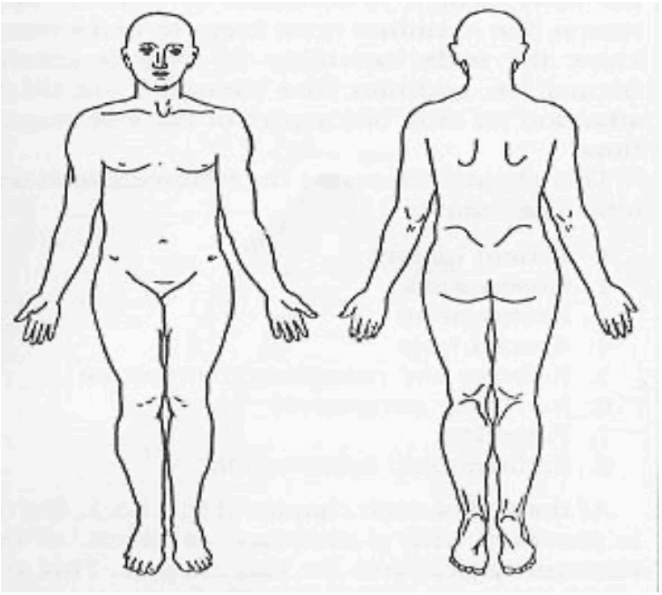
Respiratory
- o Chronic cough
- o Bronchitis
- o Shortness of breath
- o Asthma
- o Emphysema
- o Smoking
- o Other

Reproductive
- o Pregnancy (trimester __)
- o PMS
- o Other

Nervous System
- o Herpes/shingles
- o Numbness/tingling
- o Chronic pain
- o Fatigue
- o Sleep disorder
- o Loss of sensation
- o Other

Other
- o Drug/alcohol addiction
- o Nicotine/caffeine addiction
- o Diabetes
- o Vision/hearing loss
- o Headaches/migraines
- o Cancer
- o Epilepsy
- o Allergies (please list)

INDICATE AREAS OF PAIN OR DISCOMFORT



CLIENT CONSENT STATEMENT

It is my choice to receive holistic services. I understand that an assessment by the practitioner is required to determine the best course of treatment. I agree to communicate with my practitioner at any time if I have any questions, if I feel uncomfortable, or I feel that my wellbeing is being compromised. I will consent to the practitioner working only on those areas of my body that I am comfortable with. I am aware that I may remove only the clothing with which I am comfortable and may terminate the treatment at any time at my discretion. I understand and am aware of the posted fees and cancellation policy. I am also aware of the possible side effects from a service such as temporary muscular discomfort (24- 48hrs post treatment), possible dizziness. I understand the practitioner will recommend remedial exercises and home care. I am aware that the clinic is not responsible for any lost, stolen or damaged articles.

Paige Dayvis is a Licensed Ecclesiastical Holistic Practitioner, a Specialist in Holistic services. Paige Dayvis is not a medical doctor. Any ideas shared during a session should be researched by you and/or your doctor to determine if it is a good option for you.

FEE SCHEDULE

$130 / 60 min Session
$195 / Initial 90 min
$195 / 90 min Session
$260 / 120 min Session

CANCELLATION POLICY
Missed appointments and those cancelled without the required 24 hours notice will be subject to the full cost of the appointment.

Signature (18 years of age or older):_____ **Date:**_____
Parental/Guardian Signature:_____ **Date:**_____