Integrated Wellness

CLIENT PROFILE

Name: _____ Birthdate: _____ Occupation _____

Address: _____ City: _____ Zip: _____

E-mail: _____ Home Phone:_____ Work Phone_____

Cell Phone: _____ Referred by:_____

THIS OFFICE DOES NOT RELEASE CLIENT INFORMATION TO THIRD PARTIES. IW SENDS EMAIL OR POST MAIL FOR SEASONAL OCCASIONS

Can we include you in our monthly email Newsletter? YES NO

GENERAL & MEDICAL INFORMATION

Have you ever received Chiropractic Care? YES NO How recently? _____

Have you ever received a professional Massage? YES NO How recently? _____

What type of massage do you prefer? LIGHT MEDIUM FIRM OTHER _____

Have you ever received a BodyTalk Session before? YES NO How recently? _____

Have you ever had an Acupuncture Treatment before? YES NO How recently? _____

Have you ever had Lymph Drainage before? YES NO How recently? _____

Have you ever had a BeautyTek treatment before? YES NO How recently? _____

Have you ever had an Aroma Therapy Treatment? YES NO How recently? _____

Do you suffer from stress?	YES	NO	Do you have diabetes?	YES	NO
Do you have any blood pressure issues?	YES	NO	Do you suffer from arthritis?	YES	NO
Do you experience frequent headaches?	YES	NO	Are you wearing contact lenses?	YES	NO
Do you have any allergies?	YES	NO	Are you taking any medications, Supplements?	YES	NO
How often do you take antibiotics?	_____		Do you have a pacemaker or other implant?	YES	NO
Are you sensitive to touch or pressure in any area?	YES	NO	Do you have cardiac or circulation problems?	YES	NO
Have you had any lymph nodes removed or compromised?	YES	NO	Have you experienced any injuries, illness or surgeries in the past 2 yrs?	YES	NO
Are you pregnant?	YES	NO	Are you breastfeeding?	YES	NO

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN BELOW:

PLEASE CONTINUE ON BACK PAGE

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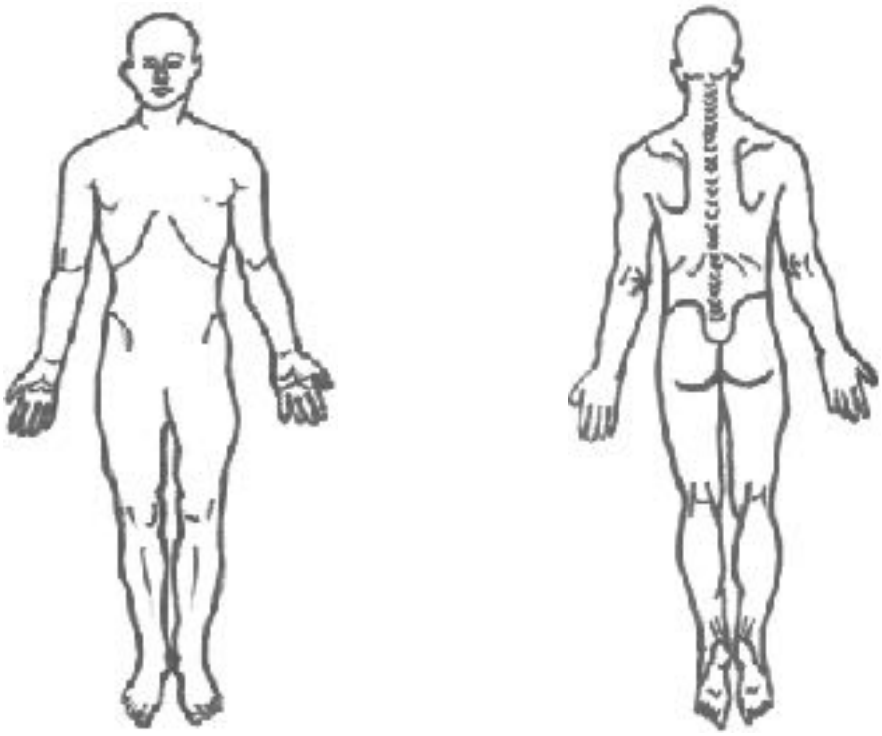
Please mark on the Diagrams below the areas discomfort in your body:



Please list your health concerns and symptoms.

What are your MAIN/LONG TERM GOALS?

DISCLOSURES:

I understand that if medical examination and diagnosis is needed for my physical or mental condition, I will seek a medical specialist. I agree to keep the IW practitioners up to date during my session regarding my comfort. I also agree to update any changes in my IW general and medical record. I understand that my medical records will be kept confidential and will not be released without my written consent. I accept the responsibility of payment at the time of services rendered. By voluntarily signing this form, I hereby authorize IW practitioners to administer treatment. I will be advised of any risks and benefits of therapies that I will receive and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment. **CLIENT INITIALS:** _____

I acknowledge that any appointment cancelled without twenty- four hours notice will be charged to me. **CLIENT INITIALS:** _____

Emergency Contact Person _____ Emergency Phone _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

IW NOTES:_____