HOLISTIC THERAPIES

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This office does not file for ANY type of insurance including Medicare, but an invoice can be requested.

Personal Information

First and last name		
Address (with city & zip)		
E-mail address		
Telephone numbers		
Date of birth & gender		
Occupation & who referred you		
Emergency contact name & telephone		
Physician's name & telephone		

Family History - specify: **S** – self, **R** – relative A family member or I have a history of the following and specify:

	Y	N		Y	N		Y	N
Abuse history			Diabetes			Lupus		
Accidents or falls			Depression			Numbness - where		
Addictions			Dizziness			Orthodontics		
Allergies - which			Ear problems			Osteoporosis		
Anger problems			Eating disorders			Overweight		
Arthritis			Embolism			PMS		
Asthma			Emotional problems			Sinus problems		
Birth trauma			Epilepsy or other Seizures			Spinal pain		
Blood pressure – high - low			Grief			Spinal surgery		
Broken bones			Headaches			Stress		
Bruises easily			Heart disease			Stroke		
Cancer			HIV			Thrombosis		
Congenital problems			Joint pain/swelling			Varicose veins		

Please take a moment to carefully read the following and sign.

If you have a specific medical condition or symptoms, Color Therapy may be contraindicated and a release from your physician may be required before service is provided. Color Therapy will be given while the body is fully draped. If color/acupressure points are near genital areas and are required as part of the treatment, the client will be advised and the cover can be adjusted by the client.

I have disclosed to the practitioner all my known medical conditions and answered all questions honestly. I further understand that the work I am about to receive is not a replacement for medical attention, diagnosis and treatment. I agree to keep the practitioner updated on any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I fully understand that the practitioner or client has full authority to terminate this treatment.

Signature _____ _____ Date _____

Important: Please list any medications and supplements you are taking and the reasons for it on the back of this form

Name of Medication/drug	Reason for taking it	What is the dosage

Name of Supplement	Reason for taking it	What is the dosage

For office use only:

Date	Notes	CP/ Treatment	Other treatments

Additional Observation Notes:
