

CONFIDENTIAL TREATMENT INTAKE FORM

Name: _____

Date: _____

Date of Birth: _____

Age: _____

Gender: _____

Address: _____

Phone: _____

City: _____

State: _____

Zip: _____

Emergency Contact:

Email: _____

Name: _____

Phone: _____

Occupation: _____

Which therapy (s) are you seeking?

- Hyperbaric Oxygen
- Far Infrared Sauna
- Frequency Specific Microcurrent
- PEMF
- BioMat
- NuCalm
- Vibration Plate
- IV Myer's
- IV Vitamin C
- IV Ozone (MAH)
- IV Ozone with Ultraviolet (MAH/UVB)
- B12 Injection
- Brain Integration Therapy
- Prolozone

For what medical condition are you seeking treatment(s)? _____

When did this situation begin? _____

Are you currently receiving any other treatments for this condition? **Yes** **No**

If yes, please describe: _____

Medications & Supplements you are currently taking: _____

Allergies – Drug: _____

Food: _____

Environmental: _____

Do you react poorly to B-Vitamins or have a Methylation defect? **Yes** **No**

Do you have any implanted medical device(s)? Yes No

If yes, please describe: _____

MEDICAL HISTORY:

Please circle any condition(s) that you have been diagnosed with, have a history of, or are currently experiencing:

- | | |
|-------------------------|-------------------------------|
| AIDS | Organ Transplant |
| Autoimmune Disease | Thyroid Disorder (hypo/hyper) |
| Adrenal Fatigue | Kidney disease |
| Fatigue/Chronic Fatigue | Kidney stone |
| | Liver disease |
| Addiction(s) | Hepatitis |
| Anxiety/Panic attack | Diabetes |
| Depression | Gout |
| Epilepsy/Seizures | Skin condition |
| Headaches | Fever |
| | Dizziness |
| Abnormal Bleeding | |
| Blood Clots | Heart Disease |
| Phlebitis | High or Low Blood Pressure |
| | Respiratory/Lung Disease |
| Cancer | |

Other: _____

Female Clients:

- | | | |
|----------------------------------------------|-----|----|
| Are you currently, or could you be pregnant: | Yes | No |
| Are you currently menstruating: | Yes | No |
| Do you have breast implants: | Yes | No |

Please describe and provide dates:

Major Surgeries/Accidents/Injuries: _____

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

Patient Cleared to Proceed with: _____

