Tri-Life Health, PC Treatment Center

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
- FireFly | F-Scan
- Frequency Specific Microcurrent
- PEMF
- BioMat
- NuCalm
- Vibration Plate
- BioPhoton
- IV Myer's
- IV Vitamin C
- IV Ozone (MAH)
- IV Ozone with Ultraviolet (MAH/UVB)
- B12 Injection
- Brain Integration Therapy
- WAVi Brain Scan
- 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
Autoimmune Disease
Adrenal Fatigue
Fatigue/Chronic Fatigue

Addiction(s)
Anxiety/Panic attack
Depression
Epilepsy/Seizures
Headaches

Abnormal Bleeding
Blood Clots
Phlebitis

Cancer

Organ Transplant
Thyroid Disorder (hypo/hyper)
Kidney disease
Kidney stone
Liver disease
Hepatitis
Diabetes
Gout
Skin condition
Fever
Dizziness

Heart Disease
High or Low Blood Pressure
Respiratory/Lung Disease

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:_____

_____

_____