Holistic Questionnaire

All Questions Must Be Answered

Please Print Name____ Date____________

Address________________________________City________________ST______Zip____________

PHONE-Home____________________Cell____________________Work____________________

E-mail address ____

What is your preferred form of contact for reminders and messages?

(Please check "2")

By landline ☐ By cell ☐ By email ☐

Do you give us permission to leave a full message on this number *(stating the center's name and a brief message on why we are calling you)?* **Yes ☐ or No ☐**

If no by what means may we contact you?____

Marital Status _____ Number of children you have? _______ Woman only: Are you pregnant? ____________ What trimester? __________

Occupation____ Sex _________ Date of Birth______________

Are you under a Doctor's care? ________If so, please explain____

Doctor's Name: ____________________________Phone________________ Major Physical Complaints______________

____

List any surgeries you have had____

List all medications & supplements you now take regularly (including over the counter) ______________________________

____

Please give details of any other allergies you may have: ______________________________________

____

Are there any other details you feel should be mentioned about your health? If **YES** please state:

____

____

WHAT ARE YOU EXPECTING TO RECEIVE FROM GENTLE WELLNESS CENTER?

Is there anything specific you would like to work on? What are your long-range goals??

____

____

How did you hear about Gentle Wellness Center?

☐Friend ______________________ **Yelp ☐ Facebook ☐ Twitter ☐ Google ☐ LinkedIn ☐**

Holistic Questionnaire (Continued)

If you are a Federal, State or Local agent, upon entering these premises you must declare same or under the Bivens Act, Article 42, be held personally and individually liable.

I have read the above and declare that I am not an agent. ***Please initial:___________***

I have read and received a copy of the Notice Designed to Comply with the State of California Guidelines in The Business and Professions of the SB-577

Please initial:___________

Supplements: I take full responsibility for any products I choose to try, to assist my health during or after any sessions. ***Please initial:___________***

All Special Packets – Discounts – Series are non-refundable and non-transferable.

Please initial:___________

24 Hour Cancellation Policy:

I UNDERSTAND THAT **24-HOUR NOTICE** ***IS REQUIRED FOR ALL*** **CANCELLATIONS.** ***I WILL*** **PAY IN FULL** ***FOR ANY LATE*** **CANCELLED APPOINTMENTS.**

MY SIGNATURE IS AUTHORIZATION TO **CHARGE MY CREDIT CARD** ON FILE FOR THESE CHARGES.

MY SIGNATURE:____DATE: __________________

Credit Card: If you have not already provided us with your credit card to secure future appointments, please provide it below. *If you have provided the credit card information already, we must still have your signature.

Card # ____ Expiration: ________________

***Signature: ____________________________________Date: _____________Security Code:________**

Please read carefully before signing

"The purpose of Gentle Wellness Center and all our staff is to provide services and offer information to clients. Our services and information are for the purpose of vocational and advocational self-improvement. All procedures are directed towards the establishment of this goal."

I have honestly answered all above questions and am not intentionally withholding information about my health. I am agreeing to office policies and procedures of Gentle Wellness Center.

Signature: ____ Date: ______________