New Life Holistic Health Intake Form

Important: This is a CONFIDENTIAL questionnaire to help us determine how to serve you best. Please fill it out as completely as possible, even if you do not feel certain questions pertain to your present condition. Thank you.

Name:_____ Date:_____
Gender: M F
Home Address:_____
City:_____State:_____Zip:_____
Email:_____
Birth date:_____ Age:_____
If under 18, person responsible for your account:_____
Home phone:_____ Work phone:_____
Cell phone: _____
Emergency Contact: Name:_____
Contact phone:_____
Marital Status: _____single _____married _____divorced _____widowed _____
Are you a caregiver for dependents? Yes No
If yes, how many children?_____ How many adults_____
Occupation:_____
Number of years in this type of work:_____
Retired: Number of years in retirement:_____
Occupation when in workforce (please fill out the previous line)
Primary care physician: Name:_____
Phone:_____
Insurance coverage (Note: we do not accept insurance at this time)

How did you hear about us? Please circle one and write the name
Current patient:_____
Friend:_____
Radio:_____
Internet:_____
Doctor:_____
Advertisement:_____
Other:_____
Have you had Biofeedback or Applied Kinesiology before? Yes No
If yes, with whom?_____ When_____
For whatcondition?_____
Please indicate if any of the following pertain to you: (indicating "yes" does not make you ineligible for treatment, however, it may restrict some of your treatment modalities)
____hepatitis ____HIV ____high blood pressure ____seizures ____pacemaker ____blood-thinning meds___pregnancy ____Surgically implanted joint/bone replacement or stabilizers

Are you currently under the care of any other health care provider (physician, chiropractor, therapist, massage therapist,
etc.)? Yes No
If yes, please provide the name and title of the practitioner(s), the condition being treated and the length of time you
have been receiving this treatment:
Practitioner Condition Length of treatment to present

_____
_____
_____
_____
_____
_____

Please list all past medical conditions for which you were hospitalized and/or received surgery (include the dates).

_____
_____
_____
_____
_____
_____

Current Health Concerns
Please list your health concerns in order of priority:
1. _____
2._____
3. _____
4._____
5. _____
6._____
What do you believe is causing your most important health concerns?_____
_____
_____
What is your main reason for today's visit?_____
How long have you had this condition?_____
How does it impact your quality of life?_____
Have you seen a physician or other health practitioner about this?_____ When?_____
What was the diagnosis (if any)?_____
_____

Describe any treatment you received and the results:_____
_____
_____
What aggravates this condition?_____
_____
What improves this condition?_____
_____
Habits and Lifestyle
Do you smoke?_____ If yes, what?_____
How much per day?_____ Since when?_____
Do you drink alcohol?_____ If yes, what?_____
How much?_____ How often?_____
Do you exercise regularly?_____ If yes, please describe what you do:_____
Emotional stress scale Please circle
1 2 3 4 5 6 7 8 9 10
Please circle one: No Stress Moderate Extremely stressed
What do you do when you want to release stress and/or just relax?_____
How many hours do you usually sleep per night?_____
When do you go to bed?_____
Do you wake feeling Refreshed? Yes No Sometimes
What is your height?_____ What is your present weight?_____
What was your weight one year ago?_____
What is the most you have ever weighed?_____
When?_____
How often do you have a bowel Movement?__Daily __every other day__Every week___Every 2 weeks___Every 3 weeks

Nutrition

Do you drink coffee?_____
If yes, how much per day?_____
Do you drink caffeinated tea?_____
If yes, how much per day?_____
Do you drink soda pop? regular ….diet…. none (Please circle one)
If yes, for how long?_____
Do you have regular eating habits? Yes No
Do you eat while engaged in other occupations? Yes No
Do you eat more when under stress or feeling depressed? Yes No
Do you experience sudden drops in energy? Yes No If yes, when?_____

Please describe a typical day's diet for you:
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Family History
Please describe your family's health, including current age or age at death, and major illness history:
(diabetes, heart disease, osteoporosis, cancer, allergies, mental illness, etc.)
Member Living?/Age_____ Major Illness or Chronic Conditions
Mother
Father
Sisters/Brothers
Maternal Grandmother
Maternal Grandfather
Paternal Grandmother
Paternal Grandfather
WOMEN ONLY please circle response as appropriate
Are you currently experiencing any gynecological symptoms or problems? Yes No
List any PMS symptoms:_____
_____
If you are menopausal or perimenopausal:
Are you taking hormone replacement therapy? Yes No
List and symptoms or concerns:_____
_____
Number of pregnancies and your age at each_____
Number of live births and your age at each:_____
Natural deliveries?_____ C-sections?_____
Are you currently trying to conceive? Yes No
MEN ONLY please circle response as appropriate
Do you have any history of sexually transmitted diseases? Yes No
Have you ever had a diagnosis of prostate enlargement or cancer? Yes No
Do you ever experience trouble with urination (frequency, hesitancy, pain, dribbling)? Yes No
Do you ever experience trouble with sexual function/libido? Yes No

Symptoms

*** For each symptom you currently have, please rate its severity from 1 to 5 (5 being the worst). Leave blank if not applicable.***

_____irritability/anger _____heart palpitations _____heaviness anywhere in body
_____depression/stress _____chest pain _____fatigue/worse after eating
_____headaches/migraines _____insomnia/sleep problems
_____hard to get up in morning
_____visual problems _____easily startled _____edema (swelling)
_____red/dry/itchy eyes _____restlessness/agitation _____muscles feel tired often
_____gall stones _____vivid dreams _____easily bruising and bleeding
_____dizziness _____lack of joy in life _____bad breath
_____blurred vision _____dry scalp _____decreased/increased appetite
_____feeling of lump in throat _____skin rash _____crave sweets
_____clenching of teeth at night _____cysts/tumor _____hypoglycemia
_____muscle cramping/twitching _____ear infection
_____difficulty digesting oily foods
_____tension _____sore throat _____nausea/vomiting
_____joints/neck/shoulder pain _____lymph swelling _____gas/belching
_____poor circulation _____hot palms/soles _____insulin sensitivity
_____soft/brittle nails _____aversion to heat _____hemorrhoids
_____emotional eater _____bitter taste in mouth _____constipation
_____ringing in ears _____gum problems _____diarrhea
_____eczema _____nose bleed _____abdominal pain
_____Shingles _____facial redness _____indigestion/heartburn
_____herpes simplex _____itchy/burning skin _____over-thinking
_____indecisive _____thirst _____tendency to gain weight
_____fullness below ribs _____dark blue _____brain foggy
_____shoulder/neck tension _____night sweats _____food allergy
_____insomnia 11pm-3am _____excess joy _____excess worry
_____dry cough _____urinary problems _____fatigue
_____cough with sputum _____bladder problems _____arthritis
_____nasal discharge _____lack of bladder control _____sciatica
_____post-nasal drip _____weakness/pain in lower back _____nerve pain
_____sinus trouble _____decreased bone density _____carpal tunnel
_____itchy/red/painful _____feel cold easily _____numbness
_____dry mouth/throat/nose _____low sex drive _____cold hands/feet
_____skin rashes/hives _____excess sexual drive _____bursitis/tendonitis
_____snoring _____poor memory
_____grief/sadness _____loss of hair
_____shortness of breath _____hearing problems
_____asthma/allergies _____cavities/tooth loss
_____low resistance to colds or flu _____craving/avoiding salty foods
_____sneezing _____fear
_____mild fever comes and goes _____hot flash/night sweating

_____smoke cigarettes _____dark under eyes
_____bronchitis _____weak leg/knees
_____rapid weight change
_____emotional instability
_____thyroid problemsMedications/Supplements
Please list any medications and supplements you are currently taking, along with doses and the reason you are taking
them.
Medications_____
_____
Reasons_____
Date Began_____ Dose_____ Helps:Yes or No
Supplements_____
Reason_____
Date Began_____ Dose Helps Yes or No
Please describe any other health concerns not previously covered in this form.
_____
_____
_____
_____
_____
_____
_____
_____
Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when
there are significant changes.
Signature_____
Date_____

NEWLIFE HOLISTIC HEALTH RELEASE AND WAIVER OF LIABILITY, INDEMNITY AND MEDICAL RELEASE

THIS FORM MUST BE SIGNED BY ALL PARTICIPANTS. IF PARTICIPANT IS UNDER 18 YEARS OF AGE, FORM MUST BE SIGNED BY MINOR AND HIS/HER PARENT/GUARDIAN.

IN CONSIDERATION of the undersigned Participant being permitted to voluntarily utilize the NewLife Holistic Health facilities, equipment, programs and services,
participant and, if applicable, Participant's undersigned Parent/Legal Guardian (individually and collectively referred to as "Participant") hereby:

1. ACKNOWLEDGES, agrees and represents that Participant understands that the Center activities involve certain risks for physical injury. Participant further acknowledges that physician evaluation is recommended before starting any physical activity program and realizes that it is Participant's responsibility to ensure that Participant's health status allows for safe exercise.
Participant also acknowledges that there are potential risks of which may presently be unknown. Because of the dangers of participating in the Center activities, Participant agrees to fully comply with the Center's applicable laws, policies, rules and regulations,
and any supervisor's instructions regarding participation in the Center activities. Participant understands that NewLife Holistic Health does not insure participants in Center activities, that any coverage shall be through personal insurance at Participant's expense and that NewLife Holistic Health has no responsibility or liability for injury resulting from Participant's utilization of the Center or participation in the Center activities.
2. FULLY RELEASES, WAIVES DISCHARGES AND COVENANTS NOT TO SUE NewLife Holistic Health, Anthony Malchiodi, its employees from any and all losses, causes of action, claims, damages or liability that Participant, Participant's spouse, child(ren), guests, legally authorized representative, assigns, successors and representatives may have that relates to, arises out of or is any way connected to Participant's use of the Center or Participant's participation in Center activities.
3. AGREES TO DEFEND INDEMNIFY AND HOLD HARMLESS NewLife Holistic Health, its Board, agents, employees against any and all claims of any nature including all costs, expenses, and fees arising out of or resulting from Participant's actions during the Center activities or events.
4. CONSENTS to receive emergency medical treatment which may be deemed advisable in the event of injury, accident or illness while at the Center or while participating in the Center activities.
By signing below, Participant acknowledges that s/he has had the opportunity to review, discuss and ask questions about the terms and conditions contained herein.
Printed Name of PARTICIPANT ACKNOWLEDGES THAT S/HE HAS READ THIS RELEASE AND WAIVER OF LIABILITY, UNDERSTANDS ITS TERMS, UNDERSTANDS THAT S/HE WILL BE GIVING UP SUBSTANTIAL RIGHTS
BY SIGNING IT AND HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE OR GUARANTEE BEING MADE.

Participant:_____
Signature of Participant:_____ Date:_____
MINOR INFORMATION:
Name of Parent/Legal Guardian:_____ Age (If A Minor)_____
Signature of Parent/Legal Guardian:_____ Date:_____ FORM

MUST BE SIGNED BY ALL PARTICIPANTS. IF PARTICIPANT IS UNDER 18 YEARS OF AGE, FORM MUST BE SIGNED BY MINOR AND HIS/HER PARENT/GUARDIAN.

I hereby request and consent to the performance of Biofeedback treatments and other procedures within the scope of practice on me (or on the patient named below, for whom I am legally responsible) by Anthony Malchiodi and/or other licensed practitioners who now or in the future treat me while employed by, working or associated with NewLife Holistic Health.

I understand that methods of treatment may include, but are not limited to: Biofeedback, electrical stimulation, Contact Reflex Analysis, Applied Kinesiology, Nutritional Response Testing, Neuromuscular/ Neurovascular therapy, Quantum Reflex Analysis, Nero-Emotional Technique, Quantum Energy Testing, Muscle Response Testing, Myosomatic Release Technique, Hypnosoma, EFT,Chinese Energetic medicine, and nutritional counseling. I understand that the vitamins/herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the nutritional supplements.

I have been informed that biofeedback and applied kinesiology is a generally safe method of treatment, but that it may have some side effects including: Tiredness, Headaches, Stomach upset, flu like detox symptoms.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking vitamins/herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of biofeedback and applied kinesiology and other procedures, 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(s) for which I seek treatment.

Printed Name of Participant:_____

Signature of Participant:_____

Date:_____

MINOR INFORMATION:

Name of Parent/Legal Guardian:_____

Age (If A Minor)_____

Signature of Parent/Legal Guardian:_____

Date:_____