Dear Prospective Client:

We look forward to working with you. We would like our time together to be as productive and educational as possible. In order to avoid spending a great deal of time gathering information, please complete the enclosed form prior to our appointment. If you are taking complex supplements that are not well known, you may wish to have them with you for the meeting.

Thank you.

Contact / Personal Information	
Name:	Phone:
Street Address:	City, State, Zip:
Birthdate:	Birthtime / Place:
Profession:	Marital Status:
Email Address:	

Please list any major medical problems you have had, such as asthma, hypertension, stroke:		
Medical Condition	**Date Started**	**Hospitalized for this?**
1)		Yes ▢ No ▢
2)		Yes ▢ No ▢
3)		Yes ▢ No ▢
4)		Yes ▢ No ▢
5)		Yes ▢ No ▢
6)		Yes ▢ No ▢
7)		Yes ▢ No ▢

Please list any surgeries you have had:		
Surgery	**Date**	**Reason For Procedure**
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Are you allergic to any medications or supplements:	
Medication or Supplement Name	**Reaction**
1)	
2)	
3)	
4)	
5)	

Please list physicians participating in your care:	
Name	**Specialty**
1)	
2)	
3)	
4)	

Please list any medications you take regularly with dose *__and frequenc__*__y__ (include birth control pills and over-the-counter medications):	
Medications:	
1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

Please list any herbs or nutritional supplements you take:	
Supplements:	
1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

Please list any diseases or conditions in your family:	
Disease or Condition	**Which Relative Has This?**
1)	
2)	
3)	
4)	
5)	
6)	
7)	

Lifestyle:		
Sleep:	**Elimination (Bowel Movements):**	**For Woman:**
Bedtime?	Frequency?	Menstruating?
Rising Time?	Well-formed?	Time Between Periods?
Awakenings?	Same Time?	Length of Period?
Rested Upon Arising?		Symptoms?
Smoking: Yes No If yes, how many per day?		
Recreational Drugs: Yes No If yes, how often and what form?		

Diet:	
Typical Breakfast:	
Typical Lunch:	
Typical Dinner:	
Typical Snacks:	
What Do You Drink Typically:	Do You Drink Alcohol (What/How Much/How Often):
Do You Take Caffeine (If so, what form and how much / how often):	

Digestion:
Are There Any Foods You Don't Tolerate? (List them.)
Heartburn ▢ Gas ▢ Bloating ▢ Sluggish Feeling After Eating ▢
How Soon After Eating Are You Hungry Again?
Describe Your Appetite:

Exercise:	
What Kinds of Things Do You Do For Exercise?	
Frequency of Exercise (Days per Week):	How Much Time (Each Exercise Session):
How Do You Feel After Exercising?	

Emotional and Spiritual	
What is your opinion of yourself?	
If possible, please describe the most negative emotion you experience?	
When do you most often feel this emotion?	

On a scale of 1 – 10 (1 being the lesser, 10 the greater) Please rate yourself:	Faith Hope Charity Generosity Sense of Humor Sense of fun Fear Grief Other(describe briefly):
Do you pray or have a spiritual practice?	
What is your perspective of challenges? Is it just random, or do they serve a purpose in our lives?	
Where would you like to be in 6 months?	
Where would you like to be in 1 year?	
Have you tried to make these changes before? If yes, what has been in the way to have them be successful?	
How much of your time and resources are you willing to invest in order to receive these changes?	
Are you willing to learn an effortless, mantra style meditation?	
Is there anything else you would like to share?	

WAIVER AND RELEASE

Complementary Treatment is not a substitute for a medical treatment. The information and therapy offered to me during a complementary therapy session does not include diagnosis. I hereby, accept full responsibility for any actions taken by myself concerning any foods, complementary medicine remedies herbs, supplements, exercises, and educational therapies suggested or recommended by the practitioner.

I acknowledge that I am seeking complimentary therapy in the form on lifestyle, educational, nutritional, and advice and/or recommendations and not a medical treatment. Under no circumstances, should any suggestions be taken as a diagnosis or directions against a licensed physical or mental health care professional. I acknowledge that any treatment, formula and other advice are not intended to supplement or to perceive as a recommendation or advice to stop taking any prescribed medicine or terminate any medical treatment I am undergoing, if any. I also understand that in case of any emergency I have to contact my local hospital or my local primary care physician. I also understand that I have to take an evaluation from a medical doctor for any medical condition, if I haven't done so yet.

I hereby, on behalf of myself and my heirs, executors, administrators waive, release, remise, discharge and hold harmless The Teal Center therapist and/or any affiliates from any liability resulting from any possible damage or loss during the treatment or consultations. I hereby assume all risk of personal injury, or any other damagers which may result from such treatment or consultation.

I acknowledge that I have carefully read this Waiver and Release and fully understand that it is a waiver, disclosure, consent for services and release of liability.

Name (print)____

Signature____

Date____

If you are submitting this Agreement electronically, typing your name in the space provided above will be considered your signature and constitute your acceptance and agreement of this Agreement