HEALTH HISTORY

NAME:_____ DATE:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

DATE OF BIRTH:_____ AGE:_____ EMAIL:_____ REFERRED BY:_____

Health Condition	Do you have? Yes or No Describe
Diabetes—Type 1 or Type 2	
High Blood Pressure	
Heart Conditions/ Pacemaker	
HIV	
Cancer/ Chemotherapy	
Use of Blood Thinners (Coumadin or Warfarin)	
Skin (Sensitive, psoriasis, eczema, acne, etc)	
Is there any chance you could be pregnant?	___Yes ___No Date of last menstrual cycle: _____

Are you currently taking any *prescriptions* or *over the counter medications*? Please explain.

_____

_____

Are you currently taking any *vitamins, minerals, or food supplements*? Please explain.

_____

What is your goal and/ or desired outcome?_____

_____

Is there anything you want our therapist to know as they work on you?_____

How many cups (8 ounces) of coffee do you drink/ day?	__0	__1	__2	__3 or more
How many sodas (8 ounces) do you drink/ day?	__0	__1	__2	__3 or more
How many glasses (8 ounces=1 cup) of water do you drink /day?	__8-16 ounces (1-2 cups)	__17-40 ounces (3-5 cups)	__40-63 ounces (5-7 cups)	__64 ounces or more (8+ cups)
How many alcoholic beverages do you drink/ week	___0	___1-3	___4-6	___7 or more

Would you like to be contacted by one of our Nutrition Professionals to further discuss your health goals, including weight loss, hormones, sleep, energy, digestion, skin, etc ___Yes ___No

OVER

54 Garden Center Broomfield, CO 80020 (303) 466-3232

Informed Consent

I have informed Summit Chiropractic Care Center, LLC, Living Well, LLC, and all staff of all my known physical conditions, medical conditions, and medications, and I will keep them informed of any changes.

All health care procedures carry some risks. Risks associated with Body Wraps and Body Contouring include but are not limited to skin reactions including hiving, burning, detoxification symptoms including headache or loose stools.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that herbal, nutritional, or dietary recommendations or weight loss modalities (i.e., body wraps, body contouring) can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success or effectiveness of any specific dietary, nutritional, or herbal recommendations, or weight loss modalities (d) I am free to act upon or disregard the recommendations of Summit Chiropractic Care Center, LLC, Living Well, LLC, and all staff as I so choose. I hereby release Summit Chiropractic Care Center, LLC, Living Well, LLC, and all staff from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Summit Chiropractic Care Center, LLC, Living Well, LLC, and all staff and participate in a professional relationship with them pursuant to the statements herein.

Cancellation Policy: We require 24-hours notice for cancellation on any massage, body wrap or body contour. There is a $30 cancellation fee if we do not receive 24-hours notice.

Packages: If a package is purchased for Body Contouring, Body Wraps or Massage a discount may be given. If at any time a person discontinues care and requests a refund, the refund will be issued based on the actual cost of care, not the discounted rate. There is no guarantee in results.

Client's Name (print) Client's Signature Date

If Minor, Client's Representative (print) Signature of Client's Rep. Relation to Client Date