![Hurley_logo[1]]()



**Hurley Wellness & Hyperbaric Center**

1807 South Main Street

Kannapolis, NC 28081

(704) 938-1589

**WELCOME TO OUR STATE OF THE ART WHOLE BODY DETOXIFICATION & WELLNESS CENTER**

Thank you for choosing Hurley Wellness Center for your health care needs. Our wellness clinic is here to provide the highest quality of care. Be advised: Due to increase prevention policies, HWC requires a photo ID.

**OFFICE POLICY**

Please provide your signature below to indicate your understanding of, and agreement with, the stated policies.

* All paperwork MUST be filled out PRIOR to your scheduled appointment. If paperwork is not filled out, you may be asked to reschedule your appointment.
* Please answer all questions asked on the paperwork given to you. Be as specific as possible to ensure Dr. Hurley has all the necessary information to begin her assessment. If something does not pertain to your case, please write N/A or No.
* All clients will be seen in accordance with their scheduled time. Please arrive 10 minutes early for registration, restroom, etc. If you are late for your appointment, you may be asked to reschedule or pay a late fee.
* Please turn your cell phone on silent before entering the clinic. If you need to make a call, please step outside.
* Please do not bring children to the clinic unless that child has an appointment with Dr. Hurley.
* Please do not wear strong perfumes, colognes, scented lotions, etc., since many patients are chemically sensitive.
* All clients are required to pay a $25 booking fee that will be deducted from the total amount at the time of service with a 48 hour cancelation notice requirement.
* No returns or refunds on supplementation or products.
* Appointment Reminder calls and emails are made only as a courtesy. Your scheduled appointments are your responsibility.
* No refunds will be issued on any lab test ordered. A $10 fee will be charged if add on orders are placed at a later date.

With my signature I indicate my understanding of, and agreement with, the above policies.

 Client’s Signature: Client’s Printed Name: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 **CONSENT AND RELEASE**

I, the undersigned, indicate that I am not a representative of the government or any investigative institution.

I understand and acknowledge that no claims of “curement” are being made. I am aware that during the assessments and some therapies, there may be palpation (physical and biological) involved to establish functional support protocols designed specifically for me. I also understand that I might be asked to take nutritional supplements before, during and after any analysis or therapy administered and will do so at free will.

I understand that I may also volunteer to take nutritional supplements during the research process and will do so of my own free will. I further understand and acknowledge that no claims of any kind are being made by Hurley Wellness Center as to the effectiveness of any of the nutritional supplements suggested. Realize chronic complaints have occurred over time with multitudes of variables, we believe there are 6 steps in obtaining optimal wellness, we believe all 6 steps need to be supported in order to obtain and maintain that optimal wellness. No one is going to live or die for you. We are here to educate and make suggestions for your path to wellness, we will even hold your hand on your journey to wellness but ultimately it is your choice.

**Fee and Payment**

I understand Dr. Hurley does not participate in private health insurance programs, Medicare, Medicaid, or any other supplemental insurance. I understand that I will be expected to pay in full at the time of service and that Hurley Wellness Center accepts cash, check, Visa, or Mastercard. If I require any copies of medical health records, there will be a charge. If laboratory test are ordered, payment must be paid prior to testing.

I also understand that Dr. Hurley charges for time she spends on my behalf when not in my presence, including telephone consultations, emails, medical record reviews, and preparation of written documents, including review and signing. I understand she charges the same hourly rate as for clinic visits.

**Missed Appointments/Cancellation/Rescheduling**

* All clients are required to pay a $25 booking fee that will be deducted from the total amount at the time of service. Clients are charged a fee for a missed appointment and for those cancelled or rescheduled with less than 24 hours prior to their scheduled visit. Fees are charges at the regular hourly rate according to the amount of time that has been reserved on Dr. Hurley's schedule.
* Unless cancelled at least 24 hours in advance, your missed appointment will be charged the full amount.

**Late Arrivals and Returned Check**

Late arrival for an appointment results in shortened length of treatment time. If you are more than 15 minutes late, you may be asked to re-schedule your appointment. I understand that I will be billed for the total time of the original scheduled visit. Therefore, we ask that you arrive at least 10 minutes prior to your scheduled appointment time in order to check in, weigh, drink water, and use the restroom facilities if necessary prior to the start of your visit with Dr. Hurley.

If a check is returned due to insufficient funds, a fee of $30 will be assessed to the patient’s account.

With my signature I indicate my understanding of, and agreement with, the above policies.

 Client’s Signature: Client’s Printed Name: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional Supplements Disclosure**

Nutritional supplementation is often a central component of your treatment because vital nutrients help you heal yourself. In our experience, most clients with chronic health problems have functional deficiency states which interfere with their healing. Replacing specific nutrient insufficiencies, often at high doses, is one of our most effective tools to help clients improve their health.

Some people feel benefits from supplements within one month, while others require several months to feel substantially better. Especially in the early phases of your treatment, you might actually feel worse before you begin to feel better.

It is important to us that our treatment plans are built on the highest quality nutritional supplement available. Our suggested supplementation is standardized and pharmaceutical grade. Therefore, the specific supplements we recommend have been chosen after considerable and ongoing investigation into quality and effectiveness. The supplementation suggested are ones that we determine through bio-feedback from blood chemistry, saliva analysis, stool analysis, etc and provide what we believe to be the greatest benefit to our clients. Most of these products are specialized nutritional formulas which are not available at local stores or online and are only available to health care providers.

Like other places where you may purchase supplements, we do have financial interest in the sale of supplements. Income generated from these sales are used to cover the cost of providing this and other clinic services, including continued investigation into new and better products as well as helping to keep our fees for office visits lower. We are aware that many of the stores in the local area sell excellent products, and we encourage you to shop around and compare. *We want you to feel no pressure to buy these products from us.*

With my signature I indicate my understanding of, and agreement with, the above policies.

 Client’s Signature: Client’s Printed Name: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapies Disclosure**

Most of the therapies provided by Hurley Wellness Center feature State of the Art equipment. Many, but not all, therapies are FDA approved. The ones that are not approved by the FDA are used strictly for clinical research or are ones that HWC deems supportive to the body. We have daily, weekly, monthly, and annual company maintenance checks on equipment. However, occasionally there may be an equipment malfunction due to no fault of our own. If malfunction prevents you from completing a scheduled therapy session, you will be provided either an equal exchange therapy or a partial refund for any unused time.

Hurley Wellness Center reserves the right to refuse a therapy due to preexisting health issues or any other reason. Be aware that health issues may interfere with therapy results. We suggest that you consult with your physician prior to any therapy.

With my signature below, I indicate that I have read and understood the statement above.

 Client’s Signature: Client’s Printed Name: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Prepaid Visits, Therapies or Lab Analysis**

If I am purchasing a therapy package, individual therapy, or lab analysis, then it is to be used in full within 365 days of the date the contract was signed. After 365 days all prepaid therapies, visits, and lab analysis that are unused are forfeited. I understand that NO refunds or exchanges of **ANY** unused therapy will be given for any reason other than death of the signed client. At that time a death certificate must be presented to Herb Basket INC. for funds to be delivered. If such has occurred, the spouse or, person listed above, fiduciary or executor of state may have the package transferred to them. A partial refund may be available for the spouse, but the stipulations will be that the therapies that were completed will be charged to the package holder at original cost (not the discounted price) and there is a **$300** administrative fee charged to the package holder. These will be totaled and deducted from the package cost to assess the remaining balance that may be refunded to the client’s spouse.

 Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### CONFIDENTIAL CLIENT INFORMATION

#### PLEASE PRINT

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_

SSN \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_

Hurley Wellness Center requires that each and every client provide a social security number.  This number is used as your client identification number.  Social security numbers are not held in any electronic devices and can only be obtained through a court order.  Please be aware; if you do not provide a social security number, Hurley Wellness Center withholds the right to refuse wellness health care.

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complaint History**

**Complaint 1**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your complaint first begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced this complaint before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you experience your symptoms?

□Constantly (76-100% of the time) □Occasionally (26-50% of the time)

□Frequently (51-75% of the time) □Intermittently (1-25% of the time)

**Complaint 2**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your complaint first begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced this complaint before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you experience your symptoms?

□Constantly (76-100% of the time) □Occasionally (26-50% of the time)

□Frequently (51-75% of the time) □Intermittently (1-25% of the time)

**Complaint 3**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your complaint first begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced this complaint before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you experience your symptoms?

□Constantly (76-100% of the time) □Occasionally (26-50% of the time)

□Frequently (51-75% of the time) □Intermittently (1-25% of the time)

**Complaint 4**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your complaint first begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced this complaint before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you experience your symptoms?

□Constantly (76-100% of the time) □Occasionally (26-50% of the time)

□Frequently (51-75% of the time) □Intermittently (1-25% of the time)

**Continue on back of this paper if additional complaints**

#### List ALL medications you take. (Prescriptions and over-the-counter – use additional pages if needed)

#### Drug name: Dosage: How long have you taken this and for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

####  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

####  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### List ALL supplements you take. (Use additional pages if needed)

#### Name of Supplement: Dosage: How long have you taken this and for what condition?

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

####  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

####  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### List ALL previous hospitalizations, surgeries, accidents, fractures and illnesses (Use additional pages if needed)

#### (Example: All past Auto, Sports, Work, Home related, etc.)

#### 1. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### 2. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### 3. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### 4. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you had and dental work? (metal fillings nor or in the past, dental surgeries or implants, partial plates, false teeth, root canals, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you smoke or have you ever? Yes □ No □ (please check) If yes, how long and how many daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have any known allergies? Yes □ No □ (please check) If yes, what are the known allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Rate your energy level (scale: 1- low energy up to 10-high energy)

Waking \_\_\_ Afternoon\_\_\_ Evening\_\_\_

Is your energy level better, worse or the same after eating? Better □ Worse □ Same □ (please check)

1. Blood Type is extremely important when assessing Nutritional and Diet needs.

 Do you know your blood type? Yes □ No □ (please check)

 If yes, please circle your blood type: O/A/B/AB

 If no, would you like it typed today? Yes □ No □ (please check) **(Additional $63)**

1. Do you receive chiropractic care? Yes □ No □ (please check)

If yes, do you receive chiropractic care regularly and when was the last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Liquid Intake**

Give an approximate number of 8 oz. servings for the following liquids you drink: (check any boxes that apply)

Please Fill Uut The following Pages

1. Water \_\_\_\_\_\_\_\_\_ (Day/Week)

2. Coffee \_\_\_\_\_\_\_\_ (Day/ Week) Caffeine□ Decaf□ Sugar□ Artificial Sweetener□ Stevia□ Cream□ Cow Milk □ Nut Milk□ Soy Milk$□$

3. Soda\_\_\_\_\_\_\_\_ (Day/Week) Caffeine□ Decaf□ Diet□

4. Tea \_\_\_\_\_\_\_\_ (Day/Week) Green Tea□ Black Tea□ Sugar□ Artificial Sweetener□ Stevia□ Unsweet□

5. Juice \_\_\_\_\_\_\_ (Day/Week)

6. Milk \_\_\_\_\_\_\_ (Day/Week) Cow Milk□ Nut Milk□ Soy Milk□ Goat Milk□ Almond Milk□ Other□

7. Alcohol\_\_\_\_\_\_ (Day/Week) Wine□ Beer□ Liquor□ Straight□ With Mixer□

8. Energy Drinks\_\_\_\_\_\_\_ (Day/ Week)

Check **ALL** “body signals” (symptoms/pains) you may have had or do have now:

\_\_\_ ADD/ ADHD \_\_\_ Depression \_\_\_ Hepatitis \_\_\_ Multiple Sclerosis

\_\_\_ Alcoholism \_\_\_ Diabetes \_\_\_ High Blood Pressure \_\_\_ Neck Pain

\_\_\_ Allergy \_\_\_ Diarrhea \_\_\_ High Cholesterol \_\_\_ Parkinson’s Disease

\_\_\_ Alzheimer’s \_\_\_ Skin Issues \_\_\_ High Blood Sugar \_\_\_ Pneumonia

\_\_\_ Anemia \_\_\_ Emphysema \_\_\_ HIV/ AIDS \_\_\_ Raynaud’s

\_\_\_ Appendicitis \_\_\_ Epilepsy/seizures \_\_\_ Irregular menstruation \_\_\_ Rheumatoid Arthritis

 \_\_\_ Asthma \_\_\_ Fibromyalgia \_\_\_ Irritable Bowel \_\_\_ Ringing in Ears

 \_\_\_ Arthritis \_\_\_ Gall Bladder \_\_\_ Kidney problems \_\_\_ Sinus infections

\_\_\_ Back pain \_\_\_ Goiter \_\_\_ Low Blood Pressure \_\_\_ Stroke

 \_\_\_ Cancer \_\_\_ Gout \_\_\_ Lyme Disease \_\_\_ Thyroid Problems

 \_\_\_ Celiac / Gluten Dis. \_\_\_ Headaches \_\_\_ Lupus \_\_\_ Ulcers

\_\_\_ Chronic Fatigue \_\_\_ Heart Attack \_\_\_ Migraine \_\_\_ Vertigo/dizziness

\_\_\_ Constipation \_\_\_ Heart Disease \_\_\_ Miscarriage \_\_\_ Anxiety

\_\_\_ Eye complaints \_\_\_ Ear Complaints \_\_\_ Aches/Pains \_\_\_ Head Injury

**Please check all of the following conditions your family has experienced:** If cancer, what type did they have.

Mother: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_ Heart Disease \_\_Parkinson’s \_\_MS \_\_ Stroke

Father: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_ Heart Disease \_\_Parkinson’s \_\_ MS \_\_ Stroke

GrandMother (M): \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_Heart Disease \_\_Parkinson’s \_\_ MS \_\_ Stroke

GrandFather (M): \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_ Stroke

GrandMother (P): \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_ Stroke

GrandFather (P): \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_ Stroke

Sisters: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_ Stroke

Brothers: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_ Stroke

Children: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes \_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_ Stroke

List any other health conditions that you or your family have had that are not listed:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Level of exercise (please circle): None, Moderate (days per week)\_\_\_\_\_\_\_\_, Strenuous (days per week) \_\_\_\_\_\_\_\_
* Have you experienced any unexplained or rapid weight changes in the last six months? Yes □ No □ (please check)

 If yes, how many pound? \_\_\_\_\_\_\_

**Please mark off the area of your complaint on the diagram below.**

Use the following symbols:

**P= pain, N= numbness, T= tingling, B= burning, C= cramping**



**Females Only:**

* What age did your cycle begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Were your cycles regular□, light$□$ , or heavy□ (please check)
* Did you or do you have a painful cycle? Yes □ No □ (please check)
* Do you take or have you taken birth control pills? Yes □ No □ (please check)

If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you take or have you taken hormone replacement therapy? Yes □ No □ (please check)

If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you have any children? Yes □ No □ (please check)

If yes, how many and male or female? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Was the pregnancy full term? Yes □ No □ (please check)
* Did you have any complications before during or after pregnancy? Yes □ No □ (please check)
* If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Did you nurse? Yes □ No □ (please check)

 If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Check all that apply: Vaginal delivery□ Forceps□ Suction□ Episiotomy□
* Did you suffer from post partum depression? Yes □ No □ (please check)
* When was your last pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did the results indicate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* When was your last mammogram or thermography?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did the results indicate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Are you interested in learning more about thermography offered through Hurley Wellness Center? Yes □ No □ (please check)
* Any sex drive complaints? Yes □ No □ (please check)
* How many times do you wake to urinate at night? \_\_\_\_\_\_\_\_\_\_\_

**Male Only:**

* When did you last have your PSA checked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What was your last PSA score? \_\_\_\_\_\_\_\_\_\_\_\_
* Do you still wake with an erection? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Any sex drive complaints? Yes □ No □ (please check)

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Any pressure while urinating? Yes □ No □ (please check)
* Do you have a poor slow while urinating? Yes □ No □ (please check)
* How many times do you wake to urinate at night? \_\_\_\_\_\_\_\_\_\_\_

**All Clients:**

* How many children did your mother have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Which birth number are you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Was your delivery - Check all that apply: Vaginal delivery□ Forceps□ Suction□ Csection\_\_
* Were you breast fed? Yes □ No □ (please check)
* Can you give us an estimate of how many antibiotics you have taken in your life \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When did you have your last cold or flu? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you ever experienced issues with your ears, nose or throat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you had tubes for your ears? Yes □ No □ (please check) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have asthma? Yes □ No □ (please check) Are you currently medicated for it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have COPD? Yes □ No □ (please check)
* Have you ever had a collapsed lung? Yes □ No □ (please check)
* Do you have blood sugar complaints? Yes □ No □ (please check)
* Have you ever had MRSA? Yes □ No □ (please check)
* Do you have any open wounds? Yes □ No □ (please check) Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have apnea or any other sleep disorder? Yes □ No □ (please check)
* Do you use a CPAP or BiPAP or have you been told you need to? Yes □ No □ (please check)
* Do you have any type of implants in your body? Please list, including dental. Please list any complaints associated with implants \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What did you last eat and at what time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What did you last drink and at what time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When was your last bowel movement? Was it typical? (ie- constipated, diarrhea) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you ever been in a automobile accident moving more than 25 mph? Yes □ No □ (please check)
* Have you ever hit your head or been hit in the head? Please discuss details below.