New Client INTAKE Form

FIRST NAME_____ **LAST NAME**_____ **DATE**_____

DATE OF BIRTH_____ **HEIGHT**_____ **WEIGHT**_____

REFERRED BY_____

ADDRESS_____

CITY/STATE_____ **ZIP**_____

PHONE: HM_____ **WK**_____ **CELL**_____

EMAIL ADDRESS_____

ADDITIONAL CONTACT: NAME_____

PHONE_____**EMAIL**_____

OPT IN for TEXT CONFIRMATIONS Yes or No

PRIOR OCCUPATION_____

CURRENT OCCUPATION_____

REASON FOR VISIT_____

WELLNESS INTERESTS _____

Are there concerns you have that will inhibit you from a standard wellness protocol (For example, physical or financial?): _____

Current supplements or medications (please attach list or write on back of form if more room is needed).

_____

_____

_____

Client CURRENT and HISTORY

Are you currently pregnant? _____

Do you regularly take immuno-suppressant? If so, please list it/them:

_____

Do you have a pacemaker? If so, please list for what reason and when installed?

_____

PLEASE STATE ANY RECENT or PAST INJURIES OR MEDICAL TREATMENTS (surgeries including removed organs or cosmetic): # of Lymph Nodes removed if any:

_____

_____

PHARMACEUTICAL and ENVIRONMENTAL ALLERGIES:

_____

_____

DIETSTYLE PREFERENCES:

Vegan _____ **Pescatarian _____** **Raw _____**
Paleo _____ **Vegetarian _____** **Other _____**

STRESS SCALE:

<---------->
1 2 3 4 5 6 7 8 9 10

Type(s) of Stress: Family Work Finances Home Civic

PAIN SCALE:

<---------->
(no pain) **1 2 3 4 5 6 7 8 9 10** (severe)

ENERGY LEVEL:

<---------->
(none) **1 2 3 4 5 6 7 8 9 10** (great)

Do you have any of the following conditions? (Check all that apply)			
Emotion Changes	**Pregnancy (Currently)**	**Skin Disorders**	**Accidental Injury**
Cancer	**High Blood Pressure**	**Premenstrual Syndrome**	**Acute Pain**
Elevated Cholesterol	**TMJ Syndrome**	**Grief Process**	**Flu (Currently)**
Phlebitis	**Kidney Ailment**	**Heart Ailment**	**Varicose Veins**
Allergies	**Fever (Currently)**	**Sports Injury**	**Chronic Pain**
Ulcerated Colon	**Osteoporosis**	**Neck/Spine Injury**	**Fibromyalgia**
Diabetes	**Other:**		

ARE YOU CURRENTLY UNDER THE CARE OF A HEALTH PROFESSIONAL: ___YES ___NO

HEALTHCARE PROVIDER'S NAME_____NUMBER_____

HEALTHCARE PROVIDER'S NAME_____NUMBER_____

SIGNATURE_____ DATE_____

**A CANCELLATION FEE OF $25 WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS UNLESS A 24 HOUR NOTICE IS GIVEN.*

BIA Notes: Practitioner Use Only

Date:_____

Height:_____

Weight:_____

Reactance:_____

Phase Angle:_____

Notice of Privacy Practices

Name of Practice: **Optimal Health Beyond LLC**

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their client's consent for uses and disclosures of health information about the client to carry out treatment, payment or health care operations. As our client, we want you to know that we respect the privacy of your personal medical records and that we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not clients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing.

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, (Client Name)_____, have received and reviewed a copy of
OPTIMAL HEALTH BEYOND Notice of Privacy Practices.

Signature of Client or Guardian:_____Date:_____

Client WAIVER

Assisted Lymphatic Therapy

I,_____, hereby acknowledge under oath that I am the Client of Optimal Health Beyond, LLC and I hereby give my permission to participate in Lymphatic Therapy and any other services offered by Optimal Health Beyond, LLC.

As an integral part of such permission, I recognize that Lymphatic Therapy is a naturalist, experimental, alternative procedure whose purpose is not in diagnosing, healing, or curing; but to help promote good health and well-being.

Therefore, I hereby agree to hold Optimal Health Beyond, LLC harmless from and against any and all claims, demands, liabilities, actions, causes of actions, damages and/or expenses, of any nature and kind without limitation, arising from my direct or indirect participation in any of the aforementioned therapies.

I hereby acknowledge that I assume the risk of any and I will assume all damages if ever needed. I waive any cause of action that I might have at any time against Optimal Health Beyond, LLC or that I might thereafter accrue as a result of any therapeutic services.

I have had an opportunity to review this waiver and ask any question concerning its meaning or intent. I verify that I have read this entire document, have had reasonable opportunity to ask questions concerning its application, understand its contents, and acknowledge that the various information provided throughout this document is accurate and complete.

I further acknowledge and verify that I have full legal authority to execute this document and there are no requirements, conditions, or obligations, legal or otherwise, which would require the consent or assent of any other person or entity.

Signed this the_____day of_____, 20___.

Signature_____

Printed Name_____