LOVE ALKALINE LIVING WELLNESS SPA

50 S. Belcher Rd Ste 124 Clearwater Fl, 33765

GENERAL HEATH QUESTIONNAIRE

Name ____ Date___________

Phone#_________________________ Email:______________________________

Address:____

City______________________________ Zip code__________________________

Age_____________ Weight_____________ Height________Date of Birth________

Ethnicity________________

How did you hear about us?____

Are you married? Yes / No (circle one)

If Yes, please write name of spouse/partner _________________________________

Do you have children? Yes / No If Yes, how many? __________________________

Do you have pets? Yes/No

Women: Have you ever had a miscarriage? Yes / No (circle one)

Occupation:_________________________________

Do you feel basically healthy? Yes / No (circle one)

Do you consider yourself happy? Yes / No (circle one)

List any negative health symptoms that you are experiencing.

____

____

____

____

____

List any surgeries you have had with dates if possible

____

____

List any pharmaceuticals you are taking or have taken in the last 6 months.

____
____
____
____

List any and all Nutraceuticals you are or have taken in the last 3 months.

____
____
____
____
____

Do you have or have had:

Cancer. Yes / No. If yes, what type ____

What were your treatment protocols____

Do you have or have had any of the following: (circle any that apply)

Chronic pain, High blood pressure, Asthma, Colitis, Multiple sclerosis, Lymes disease, Diabetes, Gingivitis, Periodontal diseases, Heartburn, Acid reflux, Allergies, Chronic fatigue, Excess gas, Bad breath, Psoriasis, Eczema, Dementia, Weight gain, Weight loss, Depression, Arthritis, Headaches, Fibromyalgia, Low energy, Stroke, High Cholesterol, Constipation, Migraines, ADD, Parkinson's disease, ADHD, Sleep Apnea, Gingivitis, Blurred vision, or any other disease?

____
____
____

Do you smoke? Yes / No (circle one) How often, how many per day?______________

Do you drink alcohol? Yes / No (circle one) if so, how often? _____________________

Do you eat meat? Yes / No (circle one) If so, what kind and how often?____

Do you consume fish? Yes / No (circle one) If so, what kind and how often?

____

Do you eat commercially baked sweets? Yes / No (circle one) If yes, how often?

____

Do you eat fried foods? Yes / No (circle one) If yes, how often?

____

Do you eat fast foods? Yes / No (circle one) If yes, how often?

____

Do you drink soda? Yes / No (circle one) If yes, how often and how much?____

Do you drink coffee? Yes / No (circle one) If yes, how often and how much?

____

Do you eat breads or pasta's? Yes / No (circle one) If yes, how frequently?

____

Do you eat candy? Yes / No (circle one) If yes, how frequently?

____

Do you drink fruit juices? Yes / No (circle one) If Yes, how often, what kind, and is it fresh or bottled?

____

Do you take diet pills? Yes/ No (circle one)

Do you experience belching, bloating after eating? Yes / No (circle one)

Do you experience heartburn or acid reflux more than once per week? Yes / No (circle one)

Do you crave Salt? Yes / No   Do you crave Sugar?   Yes / No (circle one)

Are you allergic to any foods? Yes / No (circle one) If yes, what foods?

____

____

Do you feel fatigue or lethargic after eating? Yes / No (circle one)

Do you eat fresh fruits every day? Yes / No (circle one)

Do you eat fresh raw vegetables every day? Yes / No (circle one)

Do you eat dried beans less than three times per week? Yes/ No (circle one)

Do you eat out at restaurants? Yes / No If yes, how often? ________________________

Do you use digestive aids like laxatives, antacids, or acid blocking drugs? Yes / No (circle one) and if so, what kind?_________________________________

Do you become tired or light headed? Yes / No (circle one)

Are you frequently tired for no reason? Yes / No (circle one)

Do you have stiff and sore muscles unrelated to exercise? Yes / No (circle one)

Do you have poor stamina, shortness of breath? Yes / No (circle one)

Do you exercise? Yes / No (circle one) If yes, how often and what types of exercises?

____

Have you ever been exposed to toxic chemicals or heavy metals? Yes / No (circle one)

If yes, please describe. ____

Have you had any vaccines in the past ten years? Yes/no (circle one) If yes, which ones?____

Have you ever had a flu shot? Yes / No (circle one) If yes, how long ago and what kinds?

____

Do you catch colds or the flu easily? Yes / No (circle one)

Do you have fewer than 2 bowel movements daily? Yes / No (circle one)

Are you constipated more than 2 times per month? Yes / No (circle one)

How many hours a night do you sleep? _____________________________________

Do you have sleep issues? Yes / No (circle one) If yes, for how long and what type of issues. ____

Do you feel exhausted in the morning even after sleeping 6-8 hours? Yes / No

Do you wake up during the night to urinate? Yes / No (circle one) If yes, how often?

____

Have you had urinary tract infections in the past? Yes / No (circle one)

Have you had kidney or bladder infections in the last year? Yes / No (circle one)

If yes, how frequently? ____

Have you ever traveled internationally and gotten diarrhea while abroad? Yes / No

Do you have a history of food poisoning and your digestion has not been the same since? Yes / No (circle one)

Do you get unexplained skin rashes, hives, rosacea or eczema? Yes / No (circle one)

Do you grind your teeth when you sleep? Yes / No (circle one)

Do you often not feel satisfied or full after your meals? Yes / No (circle one)

Have you had ankle pain or swelling in the last year? Yes / No (circle one)

Do you have left shoulder pain? Yes / No (circle one)

Have you ever been diagnosed with thyroid problems? Yes / No (circle one)

Do your fingernails chip or break easily? Yes / No (circle one)

Do you have yellowish discoloration on fingernails or toenails? Yes / No (circle one)

Do you have amalgam (mercury) dental fillings commonly known as "silver fillings"?

Yes / No (circle one)

Do you have breast implants? Yes / No (circle one)

Does your skin break out with blemishes? Yes / No (circle one)

Do you have brown spots or age spots on your skin? Yes / No (circle one)

Do you have pain in your muscles and joints? Yes / No (circle one) If yes, where and how often? ____

Is your hair thinning? Yes / No (circle one)

Do you have frequent scalp irritations? Yes / No (circle one)

Are you frequently cold or do you have cold hands and feet? Yes / No_______________

Are you unable to lose weight despite your diet and exercising? Yes / No (circle one)

Do you suffer from low sex drive? Yes / No (circle one)

Do you suffer from headaches or migraines? Yes / No

Do you have mood swings? Yes / No (circle one)

Is it hard to stay in a good mood? Yes / No (circle one)

Are you depressed? Yes / No (circle one)

Are your emotions on a roller coaster? Yes / No (circle one)

Women:

Do you have Pre-Menstrual Syndrome? Yes / No (circle one)

Do you produce a vaginal discharge? Yes / No (circle one)

Do you have menopausal hot flashes? Yes / No (circle one)

Is your menses irregular or absent altogether? Yes / No ________________________

Men:

Do you have premature ejaculation? Yes / No (circle one)

Have you experienced prostate trouble? Yes / No (circle one) If yes, how is your flow?

____

Have you ever had a high PSA report? Yes / No (circle one) If yes, what was it?

____

Doctor or Physicican Information:

Are you working with a Doctor at this time? Yes / No (circle one)

Doctors Name: ____Phone_________________

Doctors Name: ____Phone_________________

If you have a medical portal, please provide the name of the portal website, username and password____

Massage Therapist Name: ______________________________Phone_________________

Acupuncture Name: ___________________________________Phone_________________

Chiropractor Name: ___________________________________Phone_________________

Physical Therapist Name: _______________________________Phone_________________

Personal Trainer Name: ________________________________Phone_________________

Emergency Contact Person: _____________________________Phone_________________

Please read and sign the Live / Dried Blood Assessment Waiver on the following page.

We look forward to seeing you at your appointment.

Love Alkaline Living Wellness Spa

Live / Dried Blood Assessment Waiver

I fully understand that you are not diagnosing or treating for any disease or health care condition. I fully understand that if I have any disease or health condition, I must seek qualified medical advice from a licensed physician.

I fully understand that recommendations, suggestions, and references to meals, menus or nutritional supplements are for general health maintenance and do not involve any diagnosing or prescribing for the treatment of any disease or health condition.

I fully understand that you are dedicated to educating your clients to help themselves to better health with emphasis on education and self-care. I understand that what you teach may not be universally accepted and agencies or other health authorities may not agree with this approach where clients must be responsible for developing and maintain their own health.

I hereby certify that I am not an employee, agent, or otherwise affiliated with the Federal Food and Drug Administration or an affiliated agency. I further understand: According to the Federal Food, Drug, and cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is designed to mean: Articles intended for use in diagnosis, cure, mitigation, treatment or prevention of disease. In other words, to "say" that a vitamin, mineral, or other food supplement will have any effect on disease symptoms thereof, that particular nutrient then becomes a drug under the law as written. Therefore, any suggested nutrition is not intended as primary therapy for any disease or symptom, but, is an added schedule of food supplementation provided solely to upgrade and enhance the quality of food delivered through the diet.

I fully understand that Nutritional Live Blood Assessment is intended for educational and nutritional information only and is not to be considered medical advice.

I give my permission for you to obtain a drop of blood from my fingertip for use in examining my blood under the microscope. I further agree to hold you harmless and release you from any liability in obtaining this sample of blood using a sterile lancet and lancing device commonly used in blood glucose testing. I also understand this test will be conducted using the proper procedure for obtaining and disposal of blood, slides, lancets, alcohol swabs, tissue, cotton, and any other items necessary in sharps containers: as well as gloves and apparel will also be used to help prevent contamination of sample. <u>Please note that results of assessment are not the property of the client nor the property of the administer. Neither party has rights or claims to the research. As such, we do not release any information to the client regarding results to live/dried assessment.</u>

I have read and understand what is written above.

Signature____ Date: ______________

Far-infrared Sauna Agreement and Waiver

Consent to use the far infrared Sauna is conditional upon provision of accurate answers to the following questions and signing the Far-infrared Sauna Agreement.

Name: ____ Phone:_______________________________________

Address____

Dehydration will actually increase carbohydrate utilization and cause less fat to be burned for energy. It is recommended drinking a minimum of 8 oz. Water prior to entering the sauna and a minimum of 8 oz. of water after sauna use. In the event tha6t any dizziness, light headedness, pain or discomfort is experienced, immediately discontinue sauna use.,

1. <u>Do You Smoke?</u> Yes ____ No____

Sorry, smokers are not permitted in the sauna. The wood surface absorbs tobacco odor released from the pores of the body and will cause damage to the sauna and may cause allergic reactions to other clients.

2. <u>Are you taking medications?</u> Yes____ No____

If Yes, have you consulted with your Doctor or Pharmacist about using the Far infrared Sauna while taking your medications? Yes___ No____

Individuals who are using prescription drugs should seek the advice of their personal physician or a pharmacist for possible changes in the drugs effect when the body is exposed to far infrared waves or elevated body temperature. Diuretics, barbiturates and beta-blockers may impair the body's natural heat loss mechanisms. Some over the counter drugs such as antihistamines may also cause the body to be more prone to heat stroke.

3. <u>Do you have a Pacemaker or Defibrillator?</u> Yes _____ No ______

The magnets used to assemble our units can interrupt the pacing and inhibit the output of pacemakers. Please discuss with your doctor the possible risks this may cause.

4. <u>Are you pregnant?</u> Yes _____ No______

Pregnant women should consult a physician before using the sauna because fetal damage can occur with a certain elevated body temperature.

5. <u>Do you have Hemophilia or prone to bleeding?</u> Yes_____ No______

The use of Infrared should be avoided by anyone who is predisposed to bleeding.

6. <u>Do you have Diabetes with Neuropathy, Parkinson's, MS or Lupus?</u> Yes ____ No ____

If yes, have you consulted with your Doctor or Pharmacist about using the Far infrared Sauna? Yes ___ No___

Parkinson's, Multiple Sclerosis, Central Nervous System Tumors and Diabetes with Neuropathy are conditions that are associated with impaired sweating.

7. <u>Do you have difficulty sweating?</u> Yes ___ No___

An individual that has insensitivity to heat <u>should not use</u> the sauna

8. Do you have any implants? Yes___ No___

Metal pins, rods, artificial joints or any other surgical implants generally reflect far infrared waves and this are not heated by this system, nevertheless you should consult your surgeon prior to suing an Infrared Sauna. Certainly, the usage of an Infrared Sauna must be discontinued if you experience pain near any such implants. Silicone does absorb far infrared energy. Implanted silicone or silicone prostheses for nose or ear replacement may be warmed by the far infrared waves. Since silicone melts at over 200 deg C (392 deg F), it should not be adversely affected by the usage of an Infrared Sauna. It is still advised that you check with your surgeon and possibly a representative from the implant manufacturer to be certain.

9. Do you have a recent joint injury? Yes ___ No ___

If you have a recent (acute) joint injury, it should not be heated for the first 48 hours after an injury or until the hot and swollen symptoms subside. If you have a joint or joints that are chronically hot and swollen, these joints may respond poorly to vigorous heating of any kind. Vigorous heating is strictly contra-indicated in cases of enclosed infections be they dental, in joints or in any other tissues.

10. Are you under 18 years old? Yes ___ No ___

The core body temperature of children rises much faster than adults. This occurs due to a higher metabolic rate per body mass, limited circulatory adaption to increased cardiac demands and the inability to regulate body temperature by sweating. Consult with the child's Pediatrician before using the sauna. Anyone under 18 must be accompanied by an adult.

11. Cardiovascular Conditions

Do you have unstable Angina? Yes_____ No _____

Have you had a recent Heart Attack? Yes ___ No ___

Do you have Severe Arterial Disease or any other cardiovascular conditions/ problems? Yes ___ No ___

Individuals with cardiovascular conditions or problems (hypertension / hypo tension), congestive heart failure, impaired coronary circulation or those who are taking medications, which might affect blood pressure, should exercise extreme caution when exposed to prolonged heat. Heat stress increases cardiac output, blood flow, in an effort to transfer internal body heat to the outside environment via the skin (perspiration) and respiratory system.

12. Additional factors to consider before using our Far-infrared Sauna

Menstruation- heating of the lower back area during menstruation may temporarily increase the menstrual flow.

Alcohol- Contrary to popular belief, it is not advisable to attempt to "Sweat Out" a hangover. Alcohol increases the heart rate, which may be further increased by heat stress.

Fever- an individual that has a fever should not use the sauna.

Elderly- The ability to maintain core body temperature decreases with age. Primarily due to circulatory conditions and decreased sweat gland function.

Far-Infrared Sauna Agreement

Please read carefully

1. Smokers are not permitted in the sauna. The wood surface absorbs tobacco odor released from the pores of the body and will cause damage to the sauna and may cause allergic reactions to other clients.

2. The use of drugs, medication or alcohol prior to or during the sauna session may lead to dizziness or unconsciousness.

3. Please consult your physician if you are in doubt of your ability to use the Far-infrared Sauna for health reasons.

4. No clients under the age of 18 permitted in the Far-infrared Sauna unless accompanied by a supervising adult.

5. Please discontinue the use of the sauna if you feel light-headed, dizzy or heat exhausted.

6. Sauna sessions should be limited to a maximum of 30 minutes and temperatures must stay below 150 deg.

7. It is advisable to drink plenty of water before and after sauna sessions. Water bottles are permitted in the sauna. It is advised not to eat at least one to two hours prior to your sauna session to avoid any ill feelings.

8. Clients using any medications must consult a physician or pharmacist prior to the use of the sauna.

9. Pregnant women should consult their physician prior to the use of the sauna. Excessive temperatures have a potential for causing fetal damage during the early days of pregnancy.

10. Do not use any chemicals or lotions prior to your sauna session. These items may block pores and affect perspiration as well as stain the wood of the sauna.

I acknowledge and accept the risks inherent in the use of the Far-Infrared Sauna. I voluntarily assume the risk of injury, accident or death, which may arise from the use of the Far-Infrared Sauna. I and any of my heirs, executors, representatives or assigns hereby release from all claims or liabilities for personal injury or property damages of any kind sustained while on the premises, during the use of the far-infrared Sauna and from any advice provided by an employee, independent contractor or any representative. I agree that this Application and Waiver is in effect for all Far-Infrared Sauna sessions and will not expire unless requested by either party and understand it is my personal responsibility to consult with my Doctor regarding my participation.

Client Signature:____ Date:________________

Love Alkaline Living Wellness Spa does not provide medical advice or treatment. Far-infrared Sauna use may or may not be appropriate for you. Please consult your health care provider for medical advice. The information provided is for general information purposes only and does not address individual circumstances or medical conditions. Do not attempt to self-treat any disease with a Far-infrared Sauna

LOVE ALKALINE LIVING WELLNESS CENTER

THERAPIES DISCLAIMER/WAIVER/LIABILITY RELEASE

The therapies used in Love Alkaline Wellness Center are in no way a substitute for medical care. There are no medical claims being made from the use of these products. Statements made have not been evaluated by the FDA; however, The Biomat is an FDA approved medical device. They are not intended to diagnose, treat or cure any medical conditions or diseases.

In consideration of possible risk of injury while participating in **Ion Cleanse Detoxification**, **Biomat**, **Vitamin D/Red Light therapy**, and as consideration for the right to participate in the Activity, I hereby, for myself, my heirs, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Activity.

Please answer **Yes** or **No** for the following questions.

Yes / No (circle one) Sun allergy *** Vitamin D Bed not recommended Yes / No (circle one) Silicone Implants * If yes, Keep Biomat below 110 deg. Yes / No (circle one) Rods, Pins, * If yes, keep Biomat below 110 deg. Yes / No (circle one) Artificial joints/Surgical Implants *** If yes, keep Bio mat below 110 deg. Yes / No (circle one) Transplant/ anti- rejection meds ** If yes, **do not use** Foot Detox therapy Yes / No (circle one) Pacemaker or Defibrillator ** If yes, do not use Foot Detox Therapy If yes, keep Biomat at 1-2 lowest heat settings. Yes / No (circle one) adrenal suppression * If yes, not advisable to use bio-mat (raises core Temperature) Yes / No (circle one) Pregnant or nursing ** If yes, **do not use** Foot Detox Yes / No (circle one) Low blood sugar ** If yes, you should eat before using foot detox	Yes / No (circle one) Multiple Sclerosis * If yes, should avoid Biomat (heat inducing Vasodilatation) Yes / No (circle one) Systemic lupus erythematosus * If yes, should avoid Biomat (heat inducing Vasodilatation) Yes / No (circle one) menstruating * If yes, please note Biomat may temporarily Increase blood flow Yes / No (circle one) taking corticosteroids * If yes, you may experience some redness of skin If so, discontinue use until you have completed Your medication. Yes / No (circle one) open wounds If yes, where? (___feet ___arms ___legs) Yes / No (circle one) Haemophilia * If yes, should avoid infrared usage Biomat or any type of heating that induces vasodilatation Yes / No (circle one) Collagen Sensitivity *** If yes, should avoid Vitamin D Bed

Remember HYDRATE before and after all therapies. Water is essential to both rehydrate and remove toxins.

By signing below, I acknowledge that I have carefully read this "Waiver and Release" and Fully understand that it is a Release of Liability and are in agreement with all the above. I expressly agree to release and discharge L.A.L (Carla Gilmore) and all of its affiliates or staff from any and all claims or causes of action and I agree to voluntarily give up or waive any right that I otherwise have to bring a legal action against (L.A.L) Carla Gilmore for personal or property damage.

Signature: ____

Printed Name: ____

Email Address: ________________________________Phone:________________Date:______________