CLIENT CONSENT TO TREATMENT

All information is kept confidential and secure

Client Name:

D.O.B. (mm/dd/yyyy):

Telephone - Home:

Cell:

E-Mail Address:

Do you give your consent for us to E-mail or text for appointments or promotional materials? Yes No

Address:

City:

Province:

Postal Code:

Emergency Contact:

Relation:

Phone:

Relationship Status: Single/Married/Partner/Separated/Divorced/Widow/Widower

Spouse/Partner Name (if applicable):

# of Dependants:

Occupation/Student/Retired:

Do you enjoy your occupation and/or schooling, retirement? Yes No

What is your primary reason for seeking a relaxation therapy session?

Has anyone assisted you previously for this concern? Yes No - Whom?

What are your expectations after your session? Pain Alleviation/Reduction Mental Clarity Stress Relief Other

How did you hear about New Earth Wellness? Family/Friend Social Media Web Advertising Other

Have you experienced *any* of the conditions below? Indicate by circling and labeling with either a "P" – Experienced over a year ago, or; "N" - Experiencing Now

Metabolism P or N	Dental P or N	Digestion P or N	Reproductive Health P or N
Weight Gain	Toothaches	Heartburn	Pregnancy
Weight Loss	Implants	Abdominal Pain	Menstrual Problems
High/Low BP	Root Canal	Gas/Bloating	Breast Tenderness
Blood Sugar	Amalgam Fillings	Diarrhea	Breast Implants
Thyroid	TMJ	Constipation	Menopausal Symptoms
		Blood in Stool	Fertility Issues
		Ulcers	Hormone Treatment
		Colitis	Complicated Birth
		Liver disease	Traumatic Birth
		Leaky Gut	Prostate
Other (Specify):	Other (Specify):	Other (Specify):	Other (Specify):

Skin P or N	Chest P or N	Eyes/Ears/Mouth P or N	Neurologic P or N
Rash	Chest Pain	Headaches	Numbness
Eczema	Palpitations	Dizziness	Tingling
Psoriasis	Cough	Ringing in ears	Weakness
Acne	Shortness of Breath	Blurred vision	Insomnia
Botox	Asthma	Sinus Problems	Vertigo
Other Injections		Mouth Sores	Parkinson's
		Difficulty Swallowing	MS
Other (Specify):	Other (Specify):	Other (Specify):	Other (Specify):

Immune P or N	Urinary P or N	Sensitivity/Allergy P or N	Cancer P or N
Chronic Fatigue	Frequent Urination	Medications	Breast
Fibromyalgia	Incontinence	Chemicals	Prostate
Yeast Infections	Difficulty Urinating	Foods	Colon
Viral Infections		Plants	
Strep or Mono			
Epstein-Barr			
Lyme			
Other (Specify):	Other (Specify):	Other (Specify):	Other (Specify):

Structural P or N	Speech/Language P or N
Arthritis	Down Syndrome
Bursitis	Stuttering
Osteoporosis	ADHD/Executive Function
Foot/Ankle Swelling	Emotional Regulation
Blood Clots/Phlebitis	Hearing Loss
Varicose Veins	Trauma/Brain Injury
Neck Pain	Slurred Speech
Back Pain	
Sciatica	
Other (Specify):	Other (Specify):

PERSONAL Medical History: Are there any other medical conditions we should be aware of? Toxic Exposure, Seizure, Diabetes, Surgeries (metal plates/screws/rods), Stroke, Injuries/Accidents, Other:

FAMILY Medical History: Diabetes, Heart Condition, Alzheimer's Disease/Dementia, Cancer, Other:

List all medications, herbs & supplements currently taken (include specific purpose if applicable)

Medications	Purpose	Herbs & Supplements	Purpose

The recommended daily water intake beginning the day before the 1st session and for 5 – 7 days after is FIVE 8 oz glasses. Do you expect any difficulty with this? No Yes

If Yes, Reason:

Do you drink purified or filtered water? Yes No

How do you rate yourself in the following categories? 1 = very low 5 = very high

Pain Level 1 2 3 4 5

Stress Level 1 2 3 4 5

Energy Level 1 2 3 4 5

Will you require medical assistance or help getting into the unit at our centre? Yes

No

If YES, please note you will need to bring a caregiver to your appointment.

What best describes your current state of mental health? Excellent Good Average

Improving Declining Serious Debilitated

What best describes your current state of physical health? Excellent Good Average

Improving Declining Serious Debilitated

What emotionally draining relationships are in your life? (Choose any/all that apply)

Significant Other, Children, Job/School, State of the World, Relationship with Yourself, Other:

Do you consider your home environment peaceful or stressful most of the time? Peaceful

Stressful

Do you have trouble concentrating or "brain fog"? Yes No

Do you feel supported? Yes No

What drives you, inspires you or brings joy to your life?

Would you consider your eating habits/nutrition? Excellent Average Needs Improvement

On average, how many hours of sleep do you get daily?

Do you?
Drink Alcohol
Drink Coffee/Tea
Smoke
Use Cannabis
Other Substances

Do you exercise regularly? Yes No

How active are you? Very Average Not at all

Are you sensitive to light or loud noise? Yes No Explain:

Are you in fear regarding your health? Yes No

Regaining and maintaining your well being requires a strong personal commitment. How ready are you to make lifestyle, diet or attitude changes that may be necessary to good health?

Ready Somewhat Not looking to make changes

I have read and completed the form to the best of my knowledge and understand the questions being asked on this form are being asked to better assess my current circumstances relating to my well being.

I further understand that I am voluntarily agreeing to having a relaxation therapy session. The services provided by New Earth Wellness are not intended to diagnose, treat, cure, or prevent any disease.

***Cancellation Policy for Extended Benefits Providers**

Please note that once you have booked an appointment with us it means that we have reserved time in our schedule exclusively for you. If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a cancellation fee for the full amount of the session.

To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your appointment.

You can cancel or reschedule an appointment by emailing us at info@newearthwellness.ca, texting or calling our office at 226-347-2344, or you can connect with your individual practitioner at their personal contacts located on our Meet the Team page on our website at www.newearthwellness.ca.

Signature: ____ Date:

We invite you to visit our website @www.newearthwellness.ca/policies