570.283.0111

Client Initial Intake Form

Basic Information

Name:___________________________________ Birthdate:___________ Gender: ☐Male ☐Female

Address:_____________________________ City:_______________ State:_____ Zip Code:_________

Phone: *Home* (____)____________ *Cell* (____)____________ *Cell Provider* ____________

Occupation:______________________ How Would you like to be notified of appointments? Circle One: Text E-mail Both

Marital Status:___________ Number of Children:______ Primary care Physician:____________________

Email Address:__________________________________ Best Way to Contact: ☐Mail ☐Phone ☐Email

Emergency Contact Information

Name:____________________________ Phone: (____)______________ Relationship:_______________

Primary Complaint(s) *(Please list major symptoms and concerns)***:**____

____

Secondary Complaint(s) ____

____

Are you currently experiencing pain as a result of these symptoms? Yes No

If yes, please describe the pain: ____

When did the pain begin?____

Past Medical History *(Please list any and all medical conditions, dates of occurrence & treatments. Include surgeries, accidents and other traumas. Etc.*

____

____

List of Allergies/Sensitivities ____

Have you taken Antibiotics in the past six months? **Yes** **No**

Medical Information – *Please list all medications and supplements and their intended use*

Medications and Supplements	*Intended Use*	*Dose*	*Effectiveness*

Family History- *Please list any and all diseases / conditions that run in your family:*___________________________________

____

____

Please Check All that Apply to you personally in the last 6 months:

- ☐ Abdominal Pain
- ☐ Addiction
- ☐ Alcohol Use – Freq: _____/wk
- ☐ Anxiousness
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Breathing Difficulty
- ☐ Broken Bones/Fractures
- ☐ Chest Pain
- ☐ Chills / Fever
- ☐ Cold Hands / Feet
- ☐ Colitis
- ☐ Constipation
- ☐ Cramping in:
- ☐ Cystic Tumors
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficulty Concentrating
- ☐ Dizziness
- ☐ Excessive PMS
- ☐ Fainting
- ☐ Fatigue
- ☐ Frequent Colds
- ☐ Genital Trouble
- ☐ Headaches
- ☐ Health Complications
- ☐ Heart Palpitations
- ☐ Heartburn
- ☐ Irritability
- ☐ Kidney Stones
- ☐ Low Blood Sugar
- ☐ Lower Back Pain
- ☐ Muscle Stiffness
- ☐ Nausea
- ☐ Neck Pain
- ☐ Non Rx Drug Use: Freq._______/wk
- ☐ Numbness
- ☐ Poor Appetite
- ☐ Poor Coordination
- ☐ Problems Eating
- ☐ Rectal Pain
- ☐ Relationship Changes
- ☐ Sinus Trouble
- ☐ Skin Eruptions
- ☐ Sore Throat / Cough
- ☐ Swollen Ankles
- ☐ Thoughts of Suicide
- ☐ Too Much / Too Little Sleep
- ☐ Ulcers
- ☐ Weakness in: __________
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Insulin Pump
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Limited Use of Limbs / Paralysis
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Metal Implants
- ☐ Migraine Headaches
- ☐ Neurological Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker/Defibrillator
- ☐ Pregnancy
- ☐ Sciatic Pain
- ☐ Spinal Problems
- ☐ Stroke
- ☐ Thyroid Issues
    - ☐ Hyper
    - ☐ Hypo
- ☐ Tension in Neck and Shoulders

Have you ever consulted with any of the following:

☐ Iridologist	☐ Chiropractor	☐ Reflexologist	☐ Massage Therapist
☐ Medical Doctor	☐ Nutritionist	☐ Life / Wellness Coach	☐ Psychiatrist
☐ Physical Therapist	☐ Rolfer	☐ Acupuncturist	☐ Doctor of Naturopathy

Any Other Specialists

____

How did you hear about us? Check all that apply:

- ☐ Friend:
  Who can we thank? ___________________
- ☐ Driving By
- ☐ Event ______________________________
- ☐ Natural Awakenings
- ☐ Practitioner of Thrive: _________________
- ☐ Facebook
- ☐ Internet Search / Thrive website
- ☐ Yelp
- ☐ Newspaper
- ☐ Television
- ☐ Radio
- ☐ House of Nutrition
- ☐ Other____________________________

What topics are you most interested in learning more about?

Acupressure/Acupuncture TCM	Lyme Support	Reflexology
Aromatherapy/Essential Oils	Magnetic Therapy (PEMF)	Reiki
Detoxification	Massage	Sound Therapy
Holistic Medicine	Meditation	Supplements
Holistic Certification Classes	Metabolic Reboot	Tai Chi/Qi Gong
Homeopathy	Nutrition	Weight Loss
Hypnosis	Organic Skincare/Facials	Yoga
Iridology	Past Life Regression	
Life Coaching	Raw Foods/Juicing	

I verify that, to my knowledge, all of the information listed above is accurate.

Signature:____ ***Date:***______________

647 N. Wyoming Ave, Kingston, PA
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Client Privacy Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved directly and indirectly in that treatment.
- Obtain payment from third-party payers (if applicable).
- Conduct normal healthcare operations such as quality assessments and practitioner certifications (if applicable).

I have been informed by Thrive Wellness Center, LLC of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you may restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Thrive Wellness Center, LLC is not required to agree to my requested restrictions, but if Thrive Wellness Center, LLC does agree then Thrive Wellness Center, LLC is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Thrive Wellness Center, LLC has taken action relying on this content.

Client / Guardian: ______________________________

Signature: ______________________________

Date: ______________________________

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Guidelines for Treatment
HOLISTIC HEALTHCARE & NUTRITION CONSULTATIONS

Services Offered: Holistic Healthcare and Nutritional Consultations utilize Asian and European traditional evaluation techniques. Techniques can include but are not limited to analysis of the tongue, fingernails, pulse, Japanese Hara, and iridology (analysis of the iris). Treatments suggested may include change in diet, juicing, cleansing, and the use of vitamins, supplements, and/or homeopathic remedies aimed at supporting and strengthening the body's natural abilities to heal itself.

Note: Certified Holistic Healthcare Practitioners are not licensed medical doctors. The techniques, analyses, and evaluations utilized during a Holistic Healthcare Examination are not considered medical diagnoses. For a medical diagnosis for any concerns, please see your physician.

Office Hours: Hours are available by appointment

Emergencies: In cases of urgent need, please call our main phone number. If it is after hours, please leave a message and a staff member will return your call the next business day. If you are experiencing a medical emergency, seek immediate medical treatment.

Missed Appointments: If an appointment needs to be cancelled or rescheduled, please make an arrangement 24 hours in advance free of charge. If you give 12 hours notice, you will be charged half the price of your service. If you don't call to notify us and/or don't show to your appointment, you will be charged the full amount of your service.

Prior to Your Appointment: For an initial appointment, please arrive 15 minutes early in order to fill out the initial paperwork. Do not eat or drink anything (except water) for an hour prior to any appointment. Please avoid wearing makeup or nail polish, if possible.

I have read and understand the above guidelines, and agree to the following:

I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

***Signature:*___________________________________ *Date:*_________________

<u>THRIVE WELLNESS CENTER</u>
<u>CANCELLATION POLICY</u>

Please be considerate of our practitioners time by honoring our cancellation policy:

Thrive Wellness Center asks that you give 24-hour notice prior to cancelling your appointment. If client does NOT provide at least 24-hour notice, a $25 cancellation fee will be charged to the card on file. If no card is on file, a bill will be sent to the client's address. We understand emergencies occur and are happy to grant a one-time pass for extenuating circumstances.

I have reviewed and understand the cancellation policy.

Client Signature ____

Date _______________________

<u>THRIVE WELLNESS CENTER</u>
<u>NO CALL / NO SHOW POLICY</u>

100% of service price will be charged to the card on file for each No Call/No Show appointment. If no card is on file, a bill will be sent to the client's address. We understand emergencies occur and are happy to grant a one-time pass for extenuating circumstances.

I have reviewed and understand the No Call/No Show policy.

Client Signature ____

Date _______________________