

Midtown Atlanta Wellness Center
Confidential Intake

DATE ____/____/____

NAME _____ DOB _____ SEX: M F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE: (Home) _____ (Cell) _____

OCCUPATION _____ E-MAIL _____

HEIGHT _____ WEIGHT _____

HOW DID YOU HEAR ABOUT US? _____

LIST ANY PHYSICAL OR EMOTIONAL COMPLAINTS _____

LIST ALL KNOWN ALLERGIES _____

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? Y N IF YES, PLEASE EXPLAIN _____

LIST ANY MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING NOT LISTED PREVIOUSLY (INCLUDING OVER THE COUNTER OR HERBAL PRODUCTS)

WITH WHAT HEALTH GOALS MAY WE ASSIST YOU? _____

Contraindication for Colonics

*** Please check all that apply**

- | | |
|--|---|
| <input type="checkbox"/> Abdominal Hernia | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Abdominal Surgery – Date _____ | <input type="checkbox"/> Diverticulitis/ Diverticulosis |
| <input type="checkbox"/> Abnormal distention/masses | <input type="checkbox"/> Fissures & Fistulas |
| <input type="checkbox"/> Acute Liver Failure | <input type="checkbox"/> GI Hemorrhage/perforation |
| <input type="checkbox"/> Anemia **Severe | <input type="checkbox"/> Hemorrhoidectomy |
| <input type="checkbox"/> Aneurysm- all types | <input type="checkbox"/> Intestinal Perforations |
| <input type="checkbox"/> Carcinoma (Cancer) of the Colon | <input type="checkbox"/> Lupus (w/kidney involvement) |
| <input type="checkbox"/> Cardiac Condition | <input type="checkbox"/> Pregnant (due date _____) |
| <input type="checkbox"/> Cirrhosis/Liver disease | <input type="checkbox"/> Rectal / Colon Cancer |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Renal Insufficiencies |
| <input type="checkbox"/> Crohn's Disease | |
| <input type="checkbox"/> Are You Currently Taking Any Medications which may weaken intestinal walls? | |

Client / Therapist Initial
_____/_____

General Health Information:
Please circle any which apply to you.

Contraindications for Infrared Sauna System

- Alcohol (under influence) or Alcoholism
- Cardiovascular Conditions (Hypertension / Hypo tension)
- Diseases Associated with Inability To Sweat (Multiple Sclerosis, Central Nervous Sys. Tumors & Diabetes w/ Neuropathy)
- Defibrillator /Pacemakers
- Elderly (65- above)
- Have a Fever
- Heat Insensitivity
- Hemophiliacs
- Medications (Diuretics, Barbiturates, and Beta Blockers)
- Minor (13 and below)
- Pregnancy
- Recent of Acute Joint Injury (within 48 hrs)

Contraindications for Detox Foot Bath

***Please check all that apply**

- Metallic Implants
- Organ Transplant Recipients
- Pacemakers or ANY BATTERY OPERATED OR ELECTRICAL IMPLANT
- Persons who are on heartbeat regulation medications
- Persons Having an Organ Removed; Especially the Colon
- Persons Taking Medication, the Absence of which would mentally or physically incapacitate them; i.e. Psychotic Episodes, Seizures, etc...
- Pregnant and/or breastfeeding women
- Open Wounds On Feet
- Epilepsy

Client / Therapist Initial

_____/_____

Circle any of the following products or medications you are taking:

- | | |
|------------------------------------|------------------------------------|
| Acidophilus / Probiotics | Chemotherapy |
| Antacids | Cortisone |
| Antibiotics/Antifungal | High/Low Blood Pressure Medication |
| Antidepressant | Hormone Therapy |
| Anti-Inflammatory | Laxatives-Over the Counter/Herbal |
| Aspirin/Non-Aspirin Pain Relievers | Recreational Drugs |

Circle any of the following items that you eat, drink or use on a regular basis and list frequency:

- | | |
|--|--------------------------------------|
| Alcohol (oz day/wk) | Fast Foods # days/wk |
| Artificial Sweeteners | Fasting – Water or Juice (# days/yr) |
| Bread of slices per day | Dieting (Days/Month) |
| Caffeine Intake (coffee, tea, chocolate, other /daily) | Fried Foods (days/wk) |
| Candy daily | Fruits (Day/ Week) |
| Carbonated Beverages/ week | Luncheon Meats |
| Chewing Tobacco | Margerine/Butter |
| Poultry/Sea Food/Red Meat/Pork/Other | Refined Sugar |
| Cigarettes smoked/ day | Salads (Day/Week) |
| Type of Dairy | Vegetables (Day/Week) |
| Water (Oz/ Day) | Hours of Sleep / night |
| | Days of Exercise/ week |

Health Factors:

- | | |
|---|-------------------------------------|
| Are exposed to chemicals at work | Diet Often |
| Are exposed to 2 nd hand cigarette smoke | Do Not Exercise Regular (min 2x/wk) |
| Are under excessive stress (Work / Personal) | Salt food without tasting |
| Are exposed to excessive radiation (Cell Phone/TV/ Microwave) | # Enemas / wk |

Do you take a daily multiple-vitamin/ herbs? If Yes, Explain _____

Daily/chronic Medication(s)? Explain/List _____

Have You Ever Had A Colonic Before? If Yes, Where/When _____

Occasionally Take Pro-biotics? _____

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_____/_____

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Please circle any of the following Midtown Atlanta Wellness Center services which you may be interested in or would like further information on:

<u>Counseling</u> Wellness Coaching Nutritional Counseling Weight Loss Counseling Health Seminars Customized Wellness Programs Career Coaching Life Coaching	<u>Mind/Body/Spirit</u> Hypnotherapy Ear Candling Reiki Acupuncture/Seeding Sound Therapy
<u>Detoxification</u> Colonics/Colon Hydrotherapy Herbal Detox & Cleansing Programs Far Infrared Sauna Pre- Colonic Massage Inch Loss Detox Body Wrap Detox Foot Bath	<u>Massage</u> Swedish Massage/Relaxation Massage Deep Tissue Massage Sports Therapy Massage/Tui Na Lomi Lomi Massage Pregnancy Massage Reiki Massage

Client / Therapist Initial

_____ / _____

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Date _____

Please circle any conditions below which might pertain to you:

***Abdomen: Recurring**

Pain/Gas/Bloating
Abdominal Surgery – Date _____

Colon Problem – Explain

Colon Surgery within last 3 months

Parasites
Parkinson's disease
Perspire Easily

AIDS/HIV/ARC

Allergies:

Dairy/Soy
Shingles/Hives
*Food Sensitivities
Chemical
Environmental

Anemia:

Mild
**Severe

***Constipation**

***Crave Sweets**

Diabetes/Sugar Imbalance

Digestive Problems/Sour Stomach
Diverticulitis/Diverticulosis
Dizziness
*Epstein Barr/Chronic Fatigue
Eyes- Dry/Swollen/circles
Fainting Spells
Fatigue

Ringling in Ears/Head

***Skin Problems**

Psoriasis/Itching
Surgery Date _____
Swollen Ankles/Joints
Thyroid Problems
Tonsillectomy
Tumor: Type _____
Removed?

Angina
Appendectomy
Arterial Hardening
Arthritis/Bursitis
Asthma
***Bad Breath**
Blood Disease

Gallbladder/Gallstones
Gas Shortly after Eating

Ulcers:
Bleeding
Controlled by Diet/Med.

Blood Pressure:
Low
High
**Uncontrolled

Gout
Hair Loss
Headaches/Migraines

Urination:
Frequent
***Painful/Burning**

Blood in Stools
Bowel Movements:

Heart Disease or Pace Maker
Hemorrhoids
Internal
External

Venereal Disease
Vision – Double/Blurred/Poor
Vomiting Blood

Per day _____

Hepatitis
Herpes: Active/Inactive

FEMALES:
Abortion
Menstrual Cycle:
Regular
Irregular
Painful/Abnormal

***Brain Fog**
Broken Rib
Bronchitis/Chronic Cough
Bruise Easily
Cancer

***Itchy Nose/Anus**
Kidney Problems/Stones
Low Back Injury – Date _____
Low Back Pain

Menopause
Nursing Mother
PMS – Mild/Severe

Family History of Colon Cancer

Lung Problems
***Major Joint/Neck Pain**
Mental Illness/Depression

Pregnancy:
First Trimester
Second Trimester
Third Trimester

***Candida**
Cerebral Damage

Mood Swings
Mouth – Bitter/Metallic Taste
Muscle Cramps

Female Surgeries
Vaginal Discharge
Yeast Infections

Coating on Tongue

Cold Hands/Feet
Colitis (Crohn's Disease)

MALES:
Prostrate Problems

**Possible Candida or Parasite Infection*

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_____/_____

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Please Read Completely

1. I understand that during any cleansing/detoxification process I may experience what is known as “cleansing reaction”. A cleansing reaction is basically the cleansing response by the body as the toxic residues, which have been retained in the body, are released and removed by the tissue system of the body. This may manifest as headaches, flu-like symptoms, fatigue, mild dizziness, etc. This process is normal and lasts for a short period of time usually a day or two. However, the up side is these toxins are being removed and the healing process has begun. It is important to go through the process as naturally as possible, meaning without taking medications to ease the symptoms, if possible.
2. I understand that it is unrealistic to expect a lifetime of accumulated waste to miraculously flush out of the organs and tissues of the body in one visit. The cleansing process will take time. But with learning to apply the principles of good health including cleansing, nutrition and exercise, my body can be brought into harmonious balance and optimal health.
3. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
4. These are therapeutic treatments and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
5. I understand that the therapists at Midtown Atlanta Wellness Center (MAWC) are not medical doctors (**with the exception of our on-site Medical Doctor**) and as such cannot prescribe, diagnose or treat medical conditions. Therefore, by requesting MAWC services I am exercising my Ninth Amendment Right to self-diagnose and self-treat through the use of MAWC services and products. I understand that as always any health concerns I have should receive medical doctor consultation before starting any health program..
6. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
7. I **have not** been diagnosed with any contraindications for colon irrigation. I understand that Colon Hydrotherapists are **NOT** physicians and therefore **DO NOT** insert, diagnose or prescribe. I am responsible for my own self insertion. If I experience resistance during the insertion, I will immediately stop my and notify the therapist. If during the last session I experience some discomfort or pain, I am responsible for immediately stopping my session and notifying the therapist.
8. I have read the **Contraindications Box** and filled it in completely and truthfully.

Please Sign Below To Indicate Acknowledgement of Lines 1-8

SIGNATURE _____

*******OUR CANCELLATION AND CHECK ACCEPTANCE POLICY*******

24-HOUR CANCELLATION NOTICE IS REQUIRED FOR ALL BOOKED APPOINTMENTS. AT OUR DISCRETION ANY APPOINTMENT CANCELLED WITHOUT 24 HOUR NOTICE MAY BE SUBJECT TO A CANCELLATION FEE EQUAL TO 50% OF THE SCHEDULED SERVICE. IF YOU DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT, AND DO NOT CANCEL THE APPOINTMENT YOU MAY BE CHARGED A “NO SHOW” FEE OF 100% OF THE SCHEDULED SERVICE. So please be considerate, we have set appointment times aside just for you and the therapists at MAWC come in ready and eager to serve you during your appointed time. Also if you arrive 10 minutes or more late for your appointment you may be asked to reschedule so as not to inconvenience any clients whose appointment may follow yours.

We gladly accept Cash, Checks and Credit Cards payment of services. However, if your check is returned, you will be responsible for immediate payment of the AMOUNT OF THE CHECK PLUS A \$35 RETURNED CHECK FEE.

Please also take note that there are no refunds or exchanges on products and services.

BY SIGNING BELOW YOU AGREE, ACCEPT AND UNDERSTAND THESE TERMS.

Signed: _____ Date: _____

If you are a Federal, State or Local Agent, upon entering these premises you must declare same under the Bivens Act- Article 42 or be held personally responsible and individually liable.