FOR OFFICE TO COMPLETE
Intake Date:_____
Practitioner:_____
Session Fee: $_____
STAFF DATE/INITIALS_____

INTEGRATIVE WELLNESS PRIVATE SESSION INTAKE

□Wellness Coaching □Transformational Breath® □Restorative Sound □Yoga □Meditation

Thank you for your interest in our integrative wellness services. Please take a moment to carefully read and answer the following questions as accurately as possible. This information will be utilized to design a session especially for your individual needs. All information will be kept confidential. There are certain medical conditions or symptoms in which certain integrative services are not appropriate. A referral from your primary care provider may be required prior to service being provided.

Name:_____ Date of Birth:_____

Home Ph #:_____ Cell Ph #:_____ Work Ph #:_____

Are text reminders ok? _____No _____Yes, my wireless provider is _____

Best time(s) to call:_____Email (for e-news):_____

Address:_____

Occupation:_____ Work hours:_____

Emergency Contact:_____Emergency Phone:_____

How did you hear about us?/Who referred you?_____

May we have your permission to send a thank you for the referral? □ Yes □ No

Reason for calling/Purpose of scheduling appointment (relaxation/injury/emotional resolution/clarity in life path/etc) _____

_____

What are your expectations/What do you hope to accomplish with treatment?_____

_____

Have you previously experienced:	Yes / No	When & Frequency	Type/Results
• Wellness Coaching	_____	_____	_____
• Transformational breath®	_____	_____	_____
• Restorative Sound	_____	_____	_____
• Yoga	_____	_____	_____
• Meditation	_____	_____	_____
• Psychotherapy	_____	_____	_____

Check if you have experienced any of the following. If yes, please explain.

____Frequently suffer from stress	____Bruise easily	____Current pregnancy
____Frequent headaches	____Arthritis or bursitis	____Wear contact lens
____High blood pressure	____Osteoporosis	____Plantar warts
____Cardiac (heart) or circulatory problems	____Broken bones in last two years	____Glaucoma
____Varicose veins	____Numbness or stabbing pains	____Fibromyalgia
____Diabetes or low blood sugar	____Joint swelling	____Menopause
____Epilepsy or seizures	____Lung/Breathing condition	____Asthma

____Cancer: Type/Stage:_____ Chemo? □Yes □No Radiation? □Yes □No

____Digestive condition	____Hernia	____Eating disorder
____Neurological condition	____Fatigue	____Lyme disease
____Carpal tunnel syndrome	____Scoliosis	____Multiple sclerosis
____Dizziness or fainting	____Chest pain	____Rapid heart beat
____Bulging or herniated disc	____Fused vertebrae	____Degenerative disc disease
____Back Pain	____Allergies:_____	

____Injury of the (circle all that apply): Knee Neck Back Wrists Shoulder Hip Other:_____

____Surgery of the (circle all that apply): Knee Neck Back Wrists Shoulder Hip Other:_____

____Tension or soreness in specific area; Please specify:_____

____Any other health conditions:_____

Do you smoke? □No □Yes-How many packs a day?_____

Are you under the care of a Physician/Chiropractor? □No □Yes-Name:_____

Are you under the care of a Psychiatrist? □No □Yes-Name:_____

Please list any medications you are taking and reason prescribed:_____

_____

Are you currently participating in Psychotherapy? □No □Yes-name_____

Do you stretch or exercise regularly? □No □Yes-How often?_____

Do you have any bone, muscle or joint problems that are more aggravated by exercise or activity?_____

Do you have stress in your life? □No □Yes-What are your triggers?_____

Where in your body do you hold tension?_____

What do you do to manage stress?_____

Do you suffer from anxiety, panic attacks, depression, or have you experienced trauma? □No □Yes-Circle all that apply. Do you know your triggers?_____

Do you have any questions or concerns?_____

CONSENT AND WAIVER

I understand that the services I receive are provided for the purpose of relaxation, relief of muscular tension, spasm, pain, emotional resolution, or clarity in one's life path. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the services may be adjusted to my level of comfort. I agree that I have been okayed by a doctor to participate in a wellness program. I understand that wellness practitioners, breath and sound specialists, and yoga teachers do not perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. I further understand this is not a substitute for medical examination, diagnosis or treatment, and that I should see a primary care physician or other qualified medical specialist for any mental or physical ailment of which I am aware. Because services should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly and that it is my choice to proceed. I agree to keep the practitioner updated as to any changes in my medical profile. If I am participating in yoga or another activity-based program, I fully understand that exercise and such practice carries a risk of injury. I also understand that I must judge my own capabilities and will take full responsibility to not exceed my limits.

I hereby agree to assume full responsibility for any risks, injuries, or damages, known or unknown, which I might incur as a result of participating in an integrative program. I release Monarch Wellness, its practitioners, independent contractors, staff, volunteers, owner, and assigns from any liability, claims, demands, and causes of action now or in the future for any conditions that I may incur. I further understand that this acknowledgement of risk and hold harmless is intended to be as broad and inclusive as permitted by the laws of the State of Florida. Further, if I am involved in any legal case, I am aware that the practice and my practitioner are not specialized in legal cases and I will not ask them to testify on my behalf in any legal proceeding.

FEES AND CANCELATION POLICY

I am aware that my practitioner's fee is $_____, and that insurance cannot be billed for these services. I understand that Monarch Wellness has a 48-hour cancelation policy. If I need to cancel or reschedule an appointment, I agree to call the office as soon as possible. I understand and consent to being charged the practitioner's full fee (or the appointment being applied to any pre-paid package) if I miss an appointment or cancel within 48 hours, with the exception of illness or emergency mutually agreed upon.

CONFIDENTIALITY, PROFESSIONAL RELATIONSHIP, AND YOUR RIGHTS

I understand that this is a professional practice which upholds the highest level of ethical standards. I understand that my privacy will be protected, with a few exceptions outlined in Monarch Wellness' Notice of Privacy Policy. This includes mandatory reporting of suspected abuse or neglect of a child, elderly, or disabled person, protective actions of persons at risk of harm to self or others, and valid court orders requiring disclosure. I further understand the relationship with my practitioner will remain professional and I will be treated with respect. If I choose to discontinue services at any time, I will my practitioner or the office know.

I have read the above consent & voluntarily agree to participate with the terms & conditions stated above.

Client Signature_____ Date_____

Parent/Guardian Signature of minor_____ Date_____

Thank you! We are honored to join you on your healing/relaxation journey! ☺