



## REGISTRATION ACKNOWLEDGEMENTS AND AUTHORIZATIONS

Should we thank any individual for referring you to Mindful Health?		Date	
Full Name	DOB	Age	<i>Place an X to indicate sex</i> Male Female
Address			
Home Telephone:	Work Telephone:	Mobile:	
		Email Address:	
Emergency Contact Name	Relationship	Emergency Contact Number	

### THANK YOU FOR CHOOSING MINDFUL HEALTH

**WE TRULY ARE DELIGHTED YOU HAVE CHOSEN OUR PRACTICE.**

**IT IS NEVER OUR INTENTION TO BRING NEGATIVITY IN TO A HEALTH AND HEALING ENVIRONMENT, WE MUST HOWEVER INFORM YOU OF THE FOLLOWING. THANK YOU FOR YOUR UNDERSTANDING.**

**WE LOOK FORWARD TO GUIDING YOU TO A HEALTHIER FUTURE.**

**NATURE OF SERVICES RENDERED:** The services offered at Mindful health are counseling in nature and should not in any way be mistaken for medical advice, diagnosis or treatment. Further, supplement, diet and lifestyle recommendations are in no way meant to replace traditional medical care or treatment. Lastly, it is recommended that all participants in Mindful Health's programs be under the care of a primary care physician.

**NOT FOR MEDICAL PURPOSES:** No statements or claims made by Mindful Health, I have been evaluated by the FDA, and no information disseminated by Mindful Health is to be construed as adequate for the purpose of diagnosing, treating or curing disease, nor should it be construed as justification for discontinuing any treatment recommended by a qualified health care professional. In addition, information and/or counseling provided should in no way be considered a substitute for consultation with a licensed health care professional.

**FINANCIAL RESPONSIBILITY FOR ALL MINDFUL HEALTH SERVICES:** I understand and agree to the following policies regarding financial responsibilities. Payment is required at or before each visit. Services provided at Mindful health are not eligible for reimbursement by my Health Insurance Carrier. I am responsible for all charges incurred for all services rendered or product received from Mindful Health I also agree to be

responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Mindful Health to take action to secure payment of an outstanding balance owed.

**NO GUARANTEES:** I recognize that Nutritional Counseling is as much an art as a science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any recommendation or suggestion.

**CANCELLATION AND/OR NO-SHOW POLICY:** Mindful Health urges you to keep every appointment, as consistency will aid the counseling process thereby allowing you to attain your goals in a shorter time span. **We do not call to confirm appointments.** In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Saturday and Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a full charge for each occurrence. Late arrival may result in a shortened appointment.

*Please initial to indicate you have read, reviewed and understand the aforementioned*

**Initials** \_\_\_\_\_

Patient Name: \_\_\_\_\_

**STATEMENT OF UNDERSTANDING:** Self-help requires intelligence, common sense, and the ability to take responsibility for your own actions. By receiving counseling and/or information from Mindful Health, you agree to hold yourself fully responsible for your own health and wellbeing and to hold harmless Mindful Health, from any litigation for any reason.

**PAYMENT/FEE SCHEDULE:** If you have any questions regarding fees for our services, please discuss them with us promptly and frankly. In all cases, it is our intent to fully explain and inform you of all procedures, options and fees in advance. If you ever have questions, please do not hesitate to speak any member of our staff.

Payment may be made with any combination of the following: Cash, Checks, MasterCard, Visa, and American Express. For your convenience, we are able to arrange an extended payment plan through the use of a Finance Company. Please feel free to request an application.

Initial Evaluations are typically two hours and cost \$225.00 excluding any product you may choose to purchase. Follow-up sessions range from \$100.00 - \$150.00 based on time and complexity, forty-five minutes being the shortest available session.

**REVOCATION OF AUTHORIZATIONS:** These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

**PATIENT ACKNOWLEDGMENT:** I certify that the information I provide is correct. I certify that I am here to receive counseling and for no other purpose. I do not represent any third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my counselor the nature and purpose of nutritional counseling in general and my treatment in particular as well as the contents of these Acknowledgements and Authorizations.

I consent to the counseling offered or recommended to me by my counselor. I intend this consent to apply to all my present and future counseling.

Patient's Initials	Date

## PROFILE

*The following information is the basis for the relationship you are creating with your health counselor. Please complete this form as frankly as possible, know all information will be kept in the strictest of confidence. We look forward to guiding you on a successful journey to optimal health.*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Blood Type \_\_\_\_\_

Occupation \_\_\_\_\_ Hours of work per week: \_\_\_\_\_

Marital Status \_\_\_\_\_ Do you have children? \_\_\_\_\_ Ages: \_\_\_\_\_

### **CURRENT HEALTH**

What is the primary concern that prompted your visit?

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Please list your secondary concerns?

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Do you ever feel tired or weak?  Yes  No If so, please detail when this happens: \_\_\_\_\_

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Please list all supplements and/or traditional medication you are currently using:

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Please define the relationship and provide contact information for any holistic and/or traditional healthcare providers you are currently working with:

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*Please indicate if you have any of the following:*

- Acne  Ankle Swelling  Backache  Balance Issues  Blood in Urine  
 Burning During Urination  Constipation  Depression  Diarrhea  Dizziness

- Difficulty Holding Urine
- Dry Skin
- Dry Heels
- Fainting
- Headaches
- Joint Swelling or Stiffness
- Kidney Stones
- Leg Cramps
- Neck Pain or Stiffness
- Numbness
- Rashes
- Tingling in Extremities

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY**

Please detail any injuries, hospitalizations or serious health conditions: \_\_\_\_\_

**DENTAL HISTORY**

Please detail any general dental work you have had: \_\_\_\_\_

Have you had your wisdom teeth removed?  Yes  No Were they impacted?  Yes  No  
Do you bleach your teeth?  Yes  No How often? \_\_\_\_\_

**MENTAL HEALTH**

Do you have recurrent periods of depression?  Yes  No

Does anything specific bring on your depression? \_\_\_\_\_

Do you experience notable anxiety?  Yes  No If so, when? \_\_\_\_\_

Do you have issues with focus and concentration?  Yes  No

**WOMEN'S HEALTH**

Are your periods regular?  Yes  No How many days is your flow? \_\_\_\_\_ Frequency: \_\_\_\_\_

Are your periods painful or symptomatic?  Yes  No How so? \_\_\_\_\_

Are you currently on birth control?  Yes  No What kind? \_\_\_\_\_

**FAMILIAL HEALTH**

Please detail the health issues of any immediate family member.

**WEIGHT**

Current: \_\_\_\_\_ Six Month Ago \_\_\_\_\_ One Year Ago \_\_\_\_\_

What is your goal weight? \_\_\_\_\_ When were you at goal weight? \_\_\_\_\_

What is your motivation to change your weight? \_\_\_\_\_

Are you willing to modify your lifestyle to achieve your goal?  Yes  No

If so, what lifestyle changes do you think you need to make? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please provide a detailed listing of your current health issues and concerns :

Anemia  Arthritis  Asthma  Cancer  Crohn's Disease  Diabetes  Heart Disease  
 Hypoglycemia  Irritable Bowel  Thyroid Disorder  Other: \_\_\_\_\_

### **SLEEP**

How many hours a night do you typically sleep? Weekdays: \_\_\_\_\_ Weekends: \_\_\_\_\_

Do you wake throughout the night?  Yes  No If so, how many times? \_\_\_\_\_

How long have you been waking throughout the night? \_\_\_\_\_

Do you have difficulty: falling asleep?  Yes  No waking up?  Yes  No

Do you wake throughout the night to urinate?  Yes  No If so, how many times? \_\_\_\_\_

### **EXERCISE**

Do you currently exercise?  Yes  No If so, please note your activities below:

**Description of Activities**

**Frequency**

Description of Activities	Frequency
_____	_____
_____	_____
_____	_____

Would you consider using a personal trainer?  Yes  No

### **HABITUATION**

Do you currently smoke?  Yes  No If so, how much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much & often do you drink each of the following:

Wine: \_\_\_\_\_ Beer: \_\_\_\_\_ Liquor: \_\_\_\_\_

Do you drink coffee/soda?  Yes  No How much coffee? \_\_\_\_\_ How much soda? \_\_\_\_\_

Have you ever used narcotics, stimulants or depressants on a regular basis?  Yes  No

How long ago did you discontinue use? \_\_\_\_\_ If not, how often do you currently use? \_\_\_\_\_

### **EATING HABITS**

What do you typically eat?

Breakfast	Lunch	Dinner	Snacks	Liquids
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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have your eating habits changed in the past year?  Yes  No

What did you typically eat a year ago?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you have food cravings?  Yes  No If so, what do you crave? \_\_\_\_\_

\_\_\_\_\_

What foods disagree with you? \_\_\_\_\_

\_\_\_\_\_

How frequently do you eat? \_\_\_\_\_

What percentage of your food is home cooked? \_\_\_\_\_ Who cooks in your home? \_\_\_\_\_

Where is the rest of your food from? \_\_\_\_\_