CHINTAMANI THERAPEUTICS, LLC

APPLICATION FOR SERVICES

PERSONAL INFORMATION

NAME:	*First*	*Middle Initial*	*Last*			
DATE:	*EMAIL ADDRESS:*		*ALTERNATE EMAIL ADDRESS:*			
ADDRESS:	*Street*		*City*	*State*	*Zip Code*	
ADDRESS:	*Mailing, if different than physical.*		*City*	*State*	*Zip Code*	
TELEPHONE:	*Home*	*Cell*		Work		

DATE OF BIRTH:	AGE:	SEX:	HEIGHT:	WEIGHT:	BLOOD TYPE:	LAST BLOOD PRESSURE & DATE:

MARITAL STATUS:	OCCUPATION:		
EMERGENCY CONTACT:	Name		Relationship
TELEPHONE: *Home*	*Cell*	Work	
ADDRESS: *Street*	*City*	*State*	*Zip Code*

PRIMARY CARE PHYSICIAN:	RELIGION:

INTERESTS / HOBBIES:

SUPPLEMENTS AND MEDICATIONS

Please list all supplements and medications that you that you have taken and are currently taking.

PAST	CURRENT

MEDICAL HISTORY

PRESENT HEALTH PROBLEMS

PROBLEM / SYMPTOMS:

DATE SYMPTOMS BEGAN:

TREATMENTS / MEDICATIONS:

PROBLEM / SYMPTOMS:

DATE SYMPTOMS BEGAN:

TREATMENTS / MEDICATIONS:

PROBLEM / SYMPTOMS:

DATE SYMPTOMS BEGAN:

TREATMENTS / MEDICATIONS:

PROBLEM / SYMPTOMS:

DATE SYMPTOMS BEGAN:

TREATMENTS / MEDICATIONS:

PAST HEALTH HISTORY

Age at Onset	List you past major illnesses, injuries and surgeries.

Women: List your history of pregnancies, abortions (if any) and contraceptive usage.
Also indicate the length of your menstrual cycle.

OTHER RELATED QUESTIONS

Please circle yes or no to each question. Give brief description for each yes answer.

Yes	**No**	Are you pregnant or currently breastfeeding?
Yes	**No**	Do you have any physical limitations or special needs?
Yes	**No**	Do you have any active infectious diseases?
Yes	**No**	Do you have any current illnesses such as cancer, including but not limited to, colon cancer?
Yes	**No**	Do you have any history of hypertension?
Yes	**No**	Do you have any history of angina pectoris?
Yes	**No**	Do you have any history of nasal problems or throat problems?
Yes	**No**	Do you have any history of esophageal, stomach or hiatal hernia problems?
Yes	**No**	Do you have any history of skin problems, i.e. dermatitis, impetigo, eczema, etc?
Yes	**No**	Do you have any history of eye disorders, i.e. glaucoma, conjunctivitis, pink eye, etc?
Yes	**No**	Do you have any history of contagious disorders, i.e. hepatitis B, etc?
Yes	**No**	Do you have any history of auto-immune disorders , i.e. mononucleosis, HIV, AIDS, etc?

CONTRAINDICATIONS FOR COLON HYDROTHERAPY

Please circle any of the following conditions that you have had or now have.

Congestive Heart Failure	Abdominal/Colon Surgery	Fissures/ Fistulas
Aneurysm	Intestinal Perforations	Rectal or Prolapse Problems
Crohn's Disease	GI Bleeding	Colon Cancer
Diverticulosis	GI Hemorrhoids	

PAYMENT INFORMATION

Please check the appropriate payment option to make your deposit.

	Personal Check (attach check here)			
	Credit Card (complete the requested information)			
	Account #:	Expiration Date:	Type: Visa/MC/Dis	Security Code:
	I hereby authorize Sedona Wellness RetreatCenter to charge $_____ to the credit card listed above.			
	Signature:		Date:	

ATTESTMENT, ACKNOWLEDGEMENT AND CERTIFICATION

By my signature below, I, _____, hereby

1. Attest that all information provided by me in this application is true and accurate to the best of my knowledge;

2. Understand and Acknowledge that after my application has been received and reviewed that I may not be accepted to participate in the PK Program. In such case, I may qualify for the Pre-Detox Program or will be referred to a medical doctor;

3. Recognize and **Understand** that employees, agents, therapists and/or PK Consultants of Chintamani Therapeutics LLC are not Medical Doctors, Osteopaths or Naturopaths and that they do not hold themselves out to the public as a representative of any of the said professions;

4. Understand that employees, agents, therapists and/or PK Consultants of Chintamani Therapeutics LLC do not diagnose or prescribe. Nutritional information is offered only to help me to cooperate with my doctor in attaining our mutual goal of building health. In the event that I use the information provided without my doctor's approval, I acknowledge that I am prescribing for myself, which is my constitutional right, but that Chintamani Therapeutics LLC assumes no responsibility and is not liable, in whole or in part, for my actions;

5. Understand that all treatments and procedures given to me are performed with the intent to balance body functions and nutrition and not intended to treat diseases or symptoms as defined by the medical profession;

6. Certify that I have read and fully understand all of the above statements and that I am signing this application (four pages in all) of my own free will.

Signature: _____ Date: _____