SEDONA WELLNESS RETREAT CENTER

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?

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 Retreat Center 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 beaccepted to participate in all of the Sedona Wellness Retreat Center programs. In such case, I may only qualify for certain programs, which will be explained to me;

3. Recognize and **Understand** that the Sedona Wellness Retreat Center is not a medical facility and as such, does not provide, nor is responsible for, emergency health services and/or critical care services;

4. Acknowledge that the services, therapies and programs provided at the Sedona Wellness Retreat Center may not be standard in conventional medicine and that, as with all medical and health undertakings in life, there is an indefinable degree of risk and that outcomes cannot be guaranteed;

5. Avow that I have and will maintain a relationship with my primary care physician that oversees and tends to my basic medical needs during my affiliation with Sedona Wellness Retreat Center. In the event that I participate in any of the services, therapies and/or programs, or use the information provided by any employee, agent, therapist or member of the Sedona Wellness Retreat Center without my primary care physician's approval, I acknowledge that I am prescribing for myself, which is my constitutional right, but that Sedona Wellness Retreat Center assumes no responsibility and is not liable, in whole or in part, for my actions;

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: