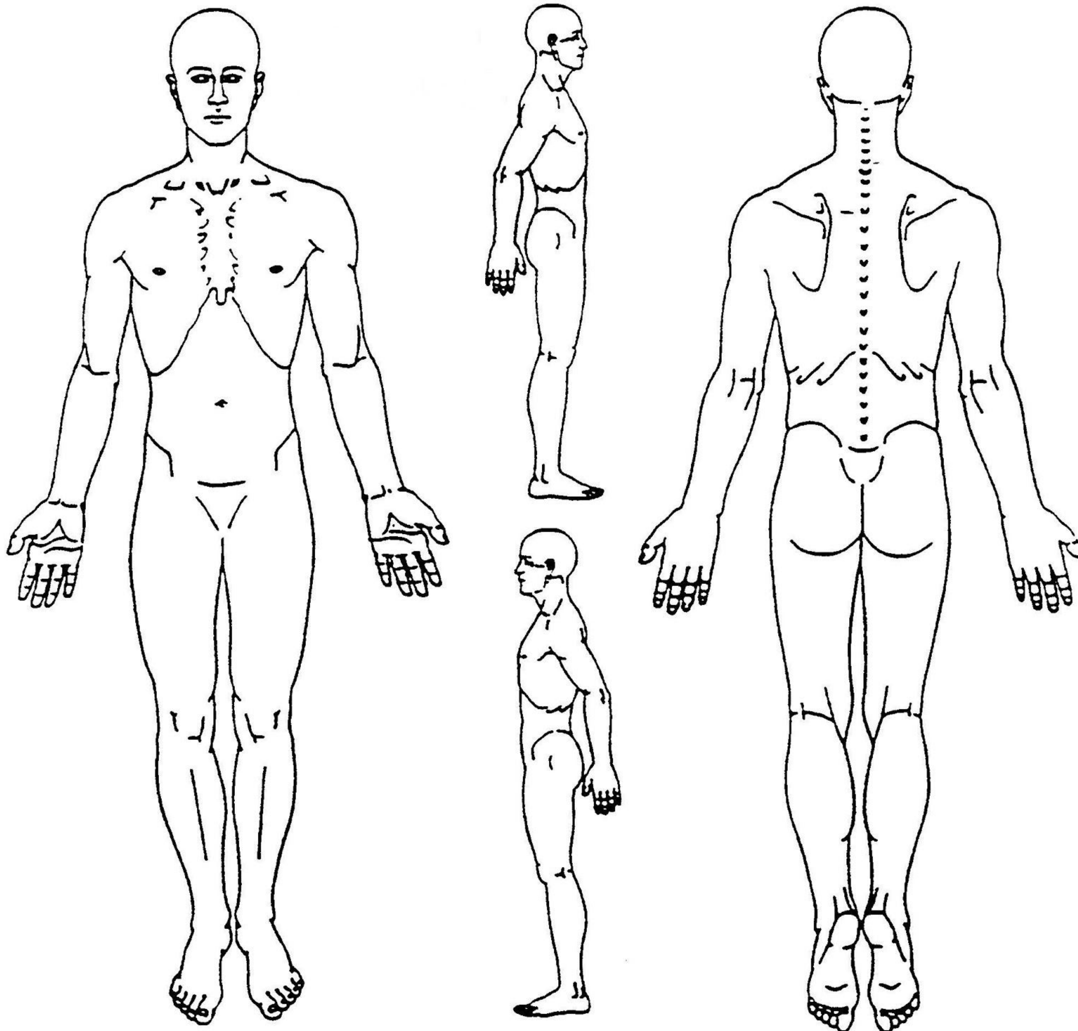
CONFIDENTIAL HEALTH QUESTIONNAIRE

Name:___________________________ ____
Address:___________________________ ____
Children___________________________ Occupation:___________________________
Emergency contact:___________________________
Who may we thank for referring you/How did you hear about us?___________________________
Cell Phone ___________________________ Email Address:___________________________
Birthdate:___________________________ Age: Sex:
What is the reason you are seeing us today?___________________________
How will you know when you are better?___________________________
When did your problem first appear? ___________________________ ___________________________
Mark below all problem areas (P – Pain, N – numbness, I - Irritation, S-muscle strain etc.) and the intensity of pain/discomfort (scale: 1= less, 10= most)



Is it getting worse, better, or staying the same? ____________________________
What makes it worse? ____________________________
Please list the specific therapies, remedies and or treatments that you have tried that:
1. Have helped and continue to help.____________________________
2. Have been ineffective.____________________________
3. Helped at first but no longer do.____
4. Have made you worse.____
5. Have been suggested or prescribed that you do not follow. _____________________________________
Does it affect your daily living and how so?(work, sleep, exercise, etc..)____________________________
____
Are you showing any other symptoms?____________________________
Date and results of last physical:____________________________
List dates and types of surgeries you have had:____________________________
Have you had any serious injuries, if so, what and when?____________________________
___________________________ ____
Have you had any serious illnesses in the past?____________________________
Please list any hospitalizations both inpatient and outpatient treatments:____________________________
Please list any medications you currently take: prescription: Over the counter? How often?
____
Have you ever taken any antibiotics? For what? How long?____________________________
Have you ever broken any bones? ____________________________
Do you or have you ever played any sports? If so what?____________________________
In the process of getting well, what % of the responsibility do you think is your own/practitioner?
______Own_____practitioner.
Is there anything you are unwilling to change in order to get well?____________________________
What has prevented you from getting well in the past?____________________________
What do you feel is a reasonable time frame in which to reach satisfactory resolution of your primary complaint?____
Any additional information which would help us better understand your condition, including familial and congenital health history____
____ _____________________________

LIABILITY WAIVER

This waiver of liability includes any risk of attending vibrational alignment sessions, exchanging or attending any events, workshops or other services provided by The Good. Please see the detail below:

- Clients using these services will understand that they are not offered as a substitute for clinical mental health care or medical care and are not intended to diagnose, treat or cure any mental health or medical conditions. You should also understand that the practitioner is not acting as a medical professional.
- You will understand and agree that you are fully responsible for your own well-being during your sessions, and subsequently, your choices and decisions.
- You will also understand that all comments and ideas offered by a practitioner are solely for the purpose of aiding you in achieving your defined goals in order to improve or enhance your wellbeing or maintenance. You will be able to give informed consent, and hereby give such consent to your practitioner to assist you in achieving such goals.
- You will have read and understood the terms and conditions, Privacy Policy and other documentation relating to confidentiality and adult protection.
- You will have understood that the use of technology is not always secure and accept the risks of confidentiality in the use of email, text, phone, Skype and other technology.
- You hereby release, waive, acquit and forever discharge your practitioner, any agents, successors, assigns, personal representatives, executors, heirs and employees from every claim, suit action, demand or right to compensation for damages claimed or that you may have arising out of your own acts or omissions or acts and omissions of your practitioner as a result of any advice given otherwise resulting from the relationship contemplated by this agreement.
- You further declare and represent that no promise, inducement or agreement not expressed in this agreement has been made.

COVID-19 Information

- 1. Have you had a fever in the last 24 hours of 100°F or above? Yes No
- 2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes No
- 3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus- type symptoms? Yes No

COVID-19 is a highly contagious virus that spreads from person to person. In addition to long-held and explicit sanitation measures this business has always adhered to, new preventative measures have been put in place to further reduce the spread of this novel coronavirus. However, these best practices still offer no guarantee regarding your potential risk of being infected.

Consent for Treatment

I understand that, because vibrational sessions require maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature:

____Date______________________

Parent or Guardian name & Signature (for a minor):____