Cupping & Complementary Medicine Clinic

DNA FORMULATED REMEDIES
Consent, Medical, Consultation & Case Study Form

Registered Patient Form

Private & Confidential

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Date: ……

1: Personal Details

Title & Name					
Address					
Tel		**Mob**			
Email					
Date of Birth		**Age**		**Gender**	Male/Female

2: Current medical health concern

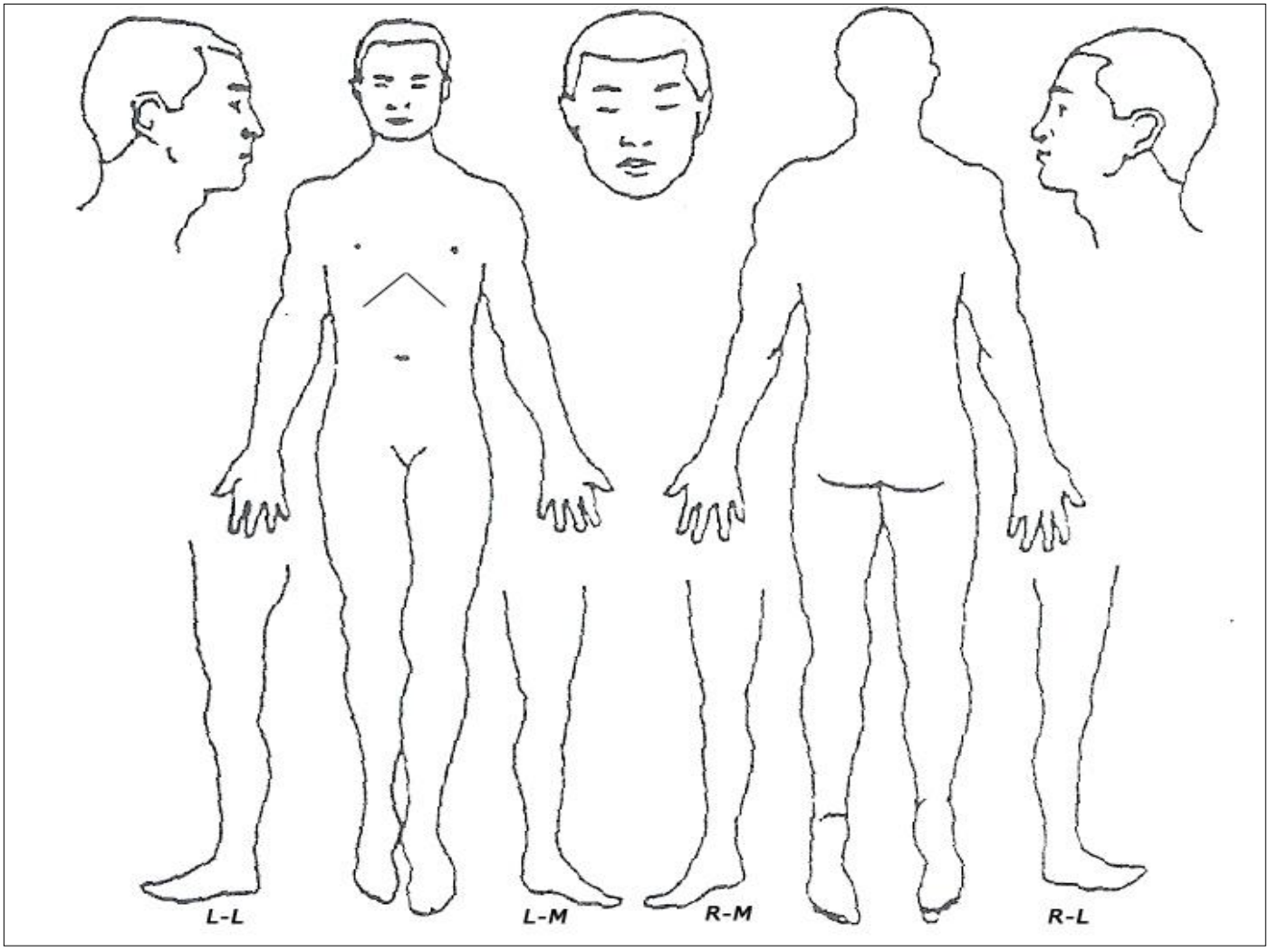
Details

4: Current Medication & Supplements being taken

Details

5: Problem Areas

Please mark the location of your pain on these figures



11: Authorisation/Consent

I, the undersigned, do hereby confirm that I am the above-mentioned patient, I have read and understand the content of this form and also the before and after treatment plan.

I hereby accept full and complete responsibility for my health and all conditions thereof related. I understand and acknowledge that Health Elements, or any therapist or representative thereof make any claims, medical or otherwise, regarding the use of these services or any other products to cure or treat any disease or injury.

I understand the remedies are designed to be a health aid and is no way to take place of a doctor's care when it is indicated. Information exchanged during any session is educational in nature and should be used at your own discretion. All Client information is held in strict confidence.

I give permission to the Therapist to administer the remedies. I am fully responsible for this decision and do not hold the Practitioner liable for any injuries or other outcomes. The undersigned hereby forever release, discharge, acquit, and hold harmless from any and all claims, actions, suits, demands, liabilities, judgments and proceedings particularly related to or arriving from the personal demonstration of any of the above mentioned by Health Elements, or any representative thereof.

CANCELLATION POLICY

I understand that unless I call or cancel my appointment/treatment within the 24 hour notice. I will be charged in full for the missed appointment/treatment.

I have read, understand and agree to all of the above.

I confirm that the information on this form is correct and accurate and no material information has been omitted. If I become aware that any of the information in this form is incorrect or out of date, I will inform my Complementary Medicine Practitioners immediately.

If you are under 18 years of age, please have your parent or legal guardian sign below.

I have read and agree to the terms of the preceding paragraphs. All the information is true to the best of my knowledge

Signature:_____ Date: _____

Additional Notes/ Information Update