GREEN STAR WELLNESS

NEW YORK CITY

7 W 22nd Street, 8th Fl.
New York, NY 10010
(917) 828-6020

# INTAKE FORM

Name_____Date of Birth _____

Address_____

City_____ State_____Zip_____ Male_____ Female_____

Email_____Phone _____

Occupation_____

Emergency Contact: Name _____ Phone _____

Are you currently seeing a healthcare professional? Yes _____ No_____

If yes, please provide your doctor's contact information

_____

Are you currently taking any medications? Yes _____ No _____

If yes, please provide the name and reason for each medication:

_____

_____

*If you have questions please feel free to ask them before, during, or after your session
** Please note, all the information submitted during this visit and all future visits is strictly confidential.

GREEN STAR WELLNESS NYC POLICIES

1. *All therapies provided by* **GREEN STAR WELLNES NYC** *are alternative procedures whose purpose is not to diagnose disease or disorder but to help promote good health and well-being.*
2. *A referral from your primary health care provider is required if you have a condition or are following a prescribed treatment.*
3. *Please be on time. If* ***you are late*** *a shortened session* ***will be charged at the full rate****.*
4. *Payment is due in full at the time of your visit. We accept cash, check and credit card.*
5. *Weekend sessions must be paid for in full in advance.*
6. ***We require 24 hours notice for all cancellations or postponements; a full session will be charged for failure to notify within the allotted time frame. We send friendly reminder texts/ emails 1-2 days before appointments as a courtesy ONLY.***
7. *All Series must be used within 1 year of purchase. No credits/refunds will be given after expiration.*

I have read and agree to all policies above,

Date: _____Printed Name: _____

Signature: _____

Credit Card #: _____Exp date: _____

GREEN STAR WELLNESS NYC RELEASE & WAIVER OF LIABILITY

CONFIDENTIALITY

Green Star Wellness NYC will keep the client's information private and will not share the client's information with any third party including doctors or other practitioners, unless the client submits a written request for the information to be shared or unless compelled by law.

PERSONAL RESPONSIBILITY

The client expressly assumes the risks of the treatments and therapies, including risks of trying new therapies or supplements, and the risks inherent in making lifestyle changes. The client releases Green Star Wellness NYC of any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in law or equity, which the client ever had, now has or will have in the future against Green Star Wellness NYC, arising from the client's past or future participation in, or otherwise respect to, Green Star Wellness NYC treatments and therapies.

Date: _____Printed Name: _____

Signature: _____

*Please review the below list of conditions, and check every condition that has affected your life recently (R) or in the past (P)*

_____ Abdominal Hernia
_____ Abdominal Surgery
_____ Acute Abdominal Pain
_____ Acute Crohn's Disease
_____ Allergies (general/seasonal)
_____ Arthritis
_____ Asthma
_____ Auto-immune condition
_____ Back Problems
_____ Blood Clots
_____ Breast Implants
_____ Broken/Dislocated bones
_____ Cancer
_____ Carcinoma of the Rectum
_____ Chemical Dependency
_____ Chronic Pain
_____ Cirrhosis
_____ Constipation/Diarrhea
_____ Depression,Panic Disorder,Anxiety
_____ Diabetes
_____ Diverticulitis
_____ Eating Disorder (Bulimia/Anorexia)
_____ Eczema
_____ Edema
_____ Gastrointestinal Disorder
_____ GI Bleeding
_____ Hay Fever
_____ Headaches
_____ Heart Conditions
_____ Hemorrhoids
_____ Hepatitis (A,B,C)
_____ Herpes
_____ High Blood Pressure
_____ IBS (irritable bowel syndrome)
_____ Insomnia
_____ Intestinal Perforation
_____ Liver Disease
_____ Metal Implants/Screws (in bone)
_____ Miscarriage
_____ Muscle Strain/Sprain
_____ Pacemaker
_____ Parasites
_____ Pregnant/Lactating
_____ Prostate Cancer
_____ Recent Colon or Rectal Surgery
_____ Scoliosis
_____ Seizures
_____ Sinus Infections
_____ Thyroid Problems
_____ TMJ disorder
_____ Ulcerative Colitis
_____Vascular Aneurysm
_____ Whiplash

**Women:** Do you have a history of fibrocystic breast, uterine or endometrial dysplasia?
Yes_____ No _____
Do you use contraception? Yes_____ No_____
Are you Menopausal? Yes_____ No_____

**Men:** If you checked Prostate Cancer, are you currently undergoing chemotherapy?
Yes_____ No _____

*Please check all symptoms you have experienced from the list below; mark C for current and P for past; if a symptom does not apply to you please leave blank*

_____ Acid Reflux
_____ Acne
_____ Athletes Foot
_____ Bad Breath
_____ Canker Sores
_____ Chronic Heartburn
_____ Congested Chest
_____ Cold hands/feet and Raynaud's Phen.
_____ Decreased Sex Drive
_____ Hot Flashes
_____ Increased Bruising
_____ Infertility
_____ Irregular Periods
_____ Kidney Stones
_____ Lack of Concentration
_____ Lack of Coordination
_____ Lightheadedness
_____ Low Grade Fever (continuous)

_____ Decreased Wound Healing
_____ Difficulty in breathing/Asthma
_____ Dry Eyes, Skin
_____ Earache
_____ Enlargement of Lymph Glands
_____ Excessive Hunger
_____ Extreme Fatigue
_____ Extreme or Sudden Weight Change
_____ Fever
_____ Fluid Retention
_____ Food Allergies
_____ Food Intolerance
_____ Fungus Infection
_____ Hives
_____ PMS
_____ Poor Appetite
_____ Psoriasis or Skin Eruptions
_____ Recurrent Cold
_____ Running Nose, Itchy Eyes
_____ Sore Throat
_____ Sugar Cravings
_____ Sweating Abnormalities
_____ Tingling (w/out any apparent nerve damage)
_____ Unhealthy Nails
_____ Vaginal Discharge
_____ Weak and Achy Muscles
_____ Yeast Infection

*If any of the conditions listed above or on the previous page need to be detailed, or if there is anything else you wish to share please do so*:_____
_____
_____

*Please describe your lifestyle/diet (circle day or week):* Is your diet gluten free? Y____ N____

| | | | |
|---|---|---|---|
| Water | _____/times a day/week | Vegetables | _____/times a day/week |
| Coffee | _____/ times a day/week | Fruit | _____/times a day/week |
| Tea | _____/times a day/week | Soy | _____/times a day/week |
| Protein | _____/times a day/week | Wheat | _____/times a day/week |
| Carbs | _____/times a day/week | Nuts/seeds | _____/times a day/week |
| Dairy | _____/times a day/week | Sweets | _____/times a day/week |
| Red Meat | _____/times a day/week | Sodas | _____/times a day/week |
| Poultry | _____/times a day/week | Exercise | _____/times a day/week |
| Fish | _____/times a day/week | Alcohol | _____/times a day/week |
| Fried Food | _____/times a day/week | Cigarettes | _____/times a day/week |
| Eggs | _____/times a day/week | Recreational drugs | _____/times a day/week |

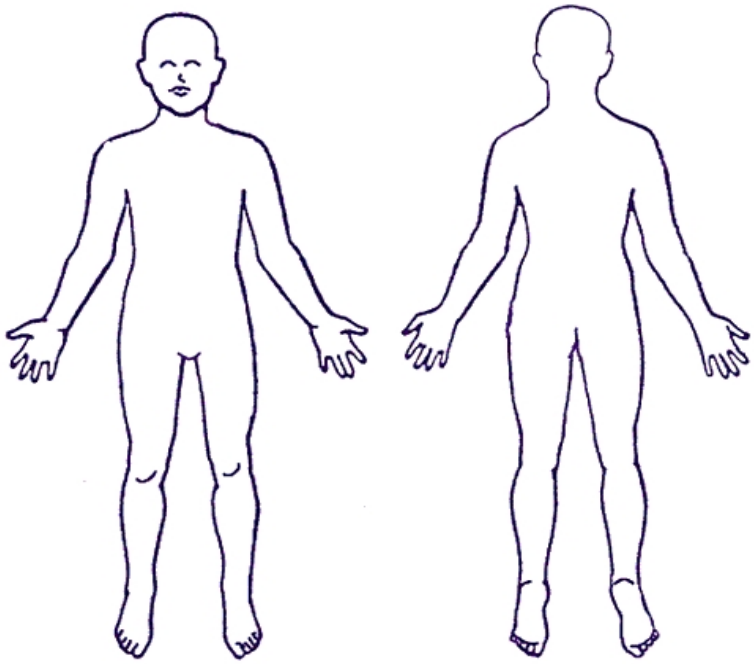
*Please list all supplements you are currently taking:* _____
_____
_____
_____

*Please select the treatment you would like to receive today:*
_____ Colonic
_____ Lymphatic Colonic / Shamanic Colonic
_____ Vibrational Medicine Healing
_____ Lymphatic Drainage/Lymph Star Pro
_____ Reiki
_____ Ion Cleanse Foot Detox

*Have you ever had the selected treatment before?* Yes_____ No_____
*How many sessions have you had before?* _____
*How recent was your last session?* within 1 week _____within 1 month_____within 1 year_____

<u>For massage and/or Lymphatic Drainage/Lymph Star Pro Clients:</u>

*Please indicate with an X the areas that you are feeling discomfort (if any):*



For Colonic Clients:

What brings you for a colonic session?_____
Are you currently on a cleanse? Yes _____ No_____
How many bowel movements do you normally have per day? _____ per week? _____
Do you strain to have a movement? Yes_____ No_____
Does the movement feel complete? Yes_____ No_____
Usual consistency? Liquid_____ Soft_____ Solid_____ Hard_____ Other___
Usual shape? _____
Usual color? _____
Do you ever see blood in your stool? Yes_____ No_____
Does your stool ever have a very strong odor? Yes_____ No_____

For Reiki Clients:
What brings you for a Reiki session?
_____
_____
_____

NOTES