
**Patient Information Form**

- Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_

- Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Text OK? Y\_\_\_ N \_\_\_\_

**- Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**- Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**
- Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dentist**

- Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Concerns and Reasons for Visit**
Please describe your main concerns and why you are visiting us:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Restoration Wellness?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your wellness goals? Please go into detail.

Are you interested in our coaching programs? Y\_\_\_\_\_\_\_\_ N\_\_\_\_\_\_\_\_\_\_\_

**What services and programs are you most interested in?** (circle all that apply)

***Consultations:*** Naturopathic\_\_\_ Ayurvedic\_\_\_ Homeopathic\_\_\_ Functional\_\_\_

PEMF Sessions

Ionic Foot Detox

Body Balancing Session (Healy)

Aroma Touch Technique

Red Light Therapy

Infrared Sauna Session

NLP Coaching

Aroma Touch Technique

**Medical History**

Please **circle** any conditions that apply to you:

- Anxiety / Panic (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Depression (How Long?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Stress (Cause?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Chronic Pain (Where?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Digestive Issues (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Allergies (List)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Insomnia (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Fatigue (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Weight Management Issues (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Nutritional Concerns (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Hormonal Imbalances (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Autoimmune Diseases(List)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Inflammation Issues (Where?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Headaches/Migraines

- Previous Surgeries (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Heart Conditions (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Respiratory Issues (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Skin Conditions­­­­ (Where?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Neurological Disorders (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Battery Operated Limb or Electronic Device (Specify)

- Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any recent testing or bloodwork?

Yes / No  If yes, please specify:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Educational Purposes Notice**
I understand that any therapies, consultations, workshops, products sold, services, classes & wellness plans given here are for the sole purpose of education. I understand that Kimberli A. Almonla, owner of Restoration Wellness does not diagnose illness, disease, or any other condition/physical/mental disorder. As much, the practitioner (Kimberli A. Almonla) does not prescribe medical treatment/pharmaceuticals nor does she manipulate the spine. It has been made very clear to me that the services provided here at Restoration Wellness are not a substitute for medical treatment/exams/diagnosis and that it is recommended that I see a physician for any physical ailment that I may have. I understand that I need to make the practitioner aware of any medical conditions and that I take it upon myself to keep the practitioner (Kimberli A. Almonla) aware of any future medical diagnosis, or problems. I understand that all information is given for educational purposes ONLY and not to be taking the place of the advice or prescriptions given by your medical doctor. None of the information given is approved by the FDA. I assume all responsibility for my own health decisions and treatments. Nothing is intended to treat, cure, diagnose or prevent any disease or conditions

**Sign if you understand this educational purpose notice**:

**Sign Here:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permissions**

 **Please sign below to acknowledge your consent for services.**

- I hereby give permission for Restoration Wellness to provide products, coaching, services and holistic treatments and I understand that I am responsible for myself and consent to these services.

- I understand that all information is confidential and will not be shared without my consent.

- By participating in services offered by Restoration Wellness, I acknowledge that any tea, water, electrolytes, vitamins, supplements, or any other consumables or samples provided in the office are strictly for convenience and are not intended to replace medical treatment or advice. I understand that Restoration Wellness and it’s staff are not responsible for any adverse reactions, side effects, or health issues that may arise from the consumption of these items. I acknowledge that it is my responsibility to consult with a qualified medical doctor regarding any dietary or supplement-related concerns. By signing this waiver, I release Restoration Wellness from any liability related to the consumption of tea, water, electrolytes, vitamin supplements, or any other consumables or snacks provided in the office.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to share:**

- I hereby give permission for Restoration Wellness *to share* my information with:

Dr. Daniel P. Sjogren: (Sign) Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Liability Waiver**

By signing below, I agree to **release Restoration Wellness** and its personnel from any liability related to products, equipment, supplements/vitamins, services, workshops, consultations, programs, classes, workshops, or coaching programs. I understand that there are no refunds, and services are non-transferable. I agree to contact and inform my medical doctor of any changes I make to my health and wellness.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for choosing Restoration Wellness! We look forward to supporting your journey to wellness.

**Restoration Wellness**

113.5 Main Street

Oxford, MA.

(508) 769-3682

Kimberli Almonla, (Owner & CEO)

DNM, HP, AP, M-NLP, CFH, M-LCP