



Tel: (337) 984-9276
 Fax: (337) 984-9012
www.IndependenceWPC.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Date:	
Address:	City:	State:	Zip:
Home phone:		Work phone:	
Cell phone:		Email address:	
Best time/place to contact you:			
Date of birth:		Age:	
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Height:		Weight:	
Marital status: M S W D		Spouse/guardian name:	
Occupation:			
Employer's name & address:			
Spouse's Occupation/Employer:			
Name of person responsible for account:			
Who may we thank for referring you? _____			

Addressing What Brought You Into This Office:

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgeries)

Type of Surgery	When? (Year)	Were you satisfied with the results?
1		
2		
3		
4		

Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements *(Attach your list of medications)*

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Allergy	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Constipation
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Migraines	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Thyroid Problems				

Other (please explain) _____

Stressors

Because one or more types of stress is the underlying cause of **ALL ILLNESS**. Which area(s) of stress do you believe are the most responsible for your condition?

1. Physical stress (injuries, posture, etc.)
 - a. _____
 - b. _____
2. Chemical stress (toxins, foods, etc.)
 - a. _____
 - b. _____
3. Mental/emotional stress (worry, anxiety, etc.)
 - a. _____
 - b. _____

Is there anything else that you can tell me that might help me to help you?

_____ I consent to a professional and complete wellness examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____

Date: _____

Signature: _____



PULSE SYSTEM: PULSED MAGNETIC CELLULAR EXERCISER

Consent for Demonstration, Session or Purchase

Disclaimer

The Pulse System produces magnetic energy, which passes freely through tissue for the purpose of cellular exercise to promote and support a sense of wellbeing. The Pulse System is not a medical device. The FDA has not evaluated the Pulse System. It is not intended for the diagnosis, treatment or cure of any medical condition. If you are experiencing the symptoms of a medical condition you should seek the advice of a medical professional. If you are unsure whether a demonstration or exercise program of pulsed magnetic cellular exercise is right for you, consult with your licensed health care provider(s). As with any exercise program, you may experience natural reactions that include but are not limited to nausea, headache, fatigue or muscle aches.

Precautions & Recommendations

- Additional hydration is recommended before and after a session with the Pulse System.
- Do not use the Pulse System if you have an implanted electronic device including: pacemaker, defibrillator, cochlear hearing device, etc.
- Remove all the following from your person: Electronic or battery operated devices, keys, wallets, jewelry and hearing aids.
- Do not use the Pulse System if you are pregnant.
- Do not use during active bleeding, hemorrhaging, during heavy menstruation or if you have blood clots.

Informed Consent

I hereby request a Pulsed Magnetic Cellular Exercise session. I understand that the Pulse System creates a fully adjustable pulsed magnetic field. I understand that the information shared by the demonstrator are his/her personal opinions and are intended for educational purposes only.

Beyond what is stated above, I understand that other risks associated with a pulsed magnetic exercise session are unforeseeable and that the demonstrator, the manufacturer, the marketer, employees, agents and affiliates cannot accept any liability for loss or damages incurred as the result of the Pulse System session. I reserve the right to use the knowledge I have gained in the care of my own body in any legal manner I may choose. I have read this form and voluntarily agree to the Pulse System session on my person assuming all liability for any and all results or consequences.

Print Patient Name: _____

Date: _____

Signature: _____