Keep Young Medical Massage/Keep Young Wellness Center
Allen T. Stanley, Prac.

BY COMPLETING THIS FORM, WE WILL BE ABLE TO FOCUS ON THE AREAS OF MOST BENEFIT TO YOU. WE ARE HERE AS A RESOURCE TO GIVE SUGGESTIONS, IDEAS AND OFFER SERVICES. IT IS OUR DESIRE TO EMPOWER YOU TO LIVE THE HEALTHIEST LIFE POSSIBLE. THIS WILL TAKE EFFORT, TIME, AND THE WILLINGNESS TO MAKE THE CHANGES NECESSARY. WE BELIEVE THE BODY AND THE MIND HAVE THE POWER AND ENERGY TO CREATE NEW LIFE WITHIN YOU!

NAME_____ DATE_____ DOB_____
PHONE_____ HOW DID YOU FIND US?_____
ADDRESS_____

CITY_____ ST_____ ZIP_____

OCCUPATION_____
EMAIL_____

HEIGHT_____ SEX MALE OR FEMALE

WEIGHT _____

WHAT ARE YOUR GOALS FOR THIS VISIT?

1-_____
2-_____
3-_____
PLEASE LIST YOUR HEATH CONCERNS
_____
_____
_____
DO YOU CURRENTLY EXERCISE? Y N DO YOU HAVE MAJOR STRESS IN YOUR LIFE? Y N

HOW DO YOU RELAX? _____
WHAT WAS YOUR RELATIONSHIP WITH YOUR PARENTS LIKE WHEN GROWING UP?
_____

_____

WHAT IS YOUR WATER INTAKE LIKE?

_____

_____

WHAT PAST MEDICAL HISTORY HAVE YOU HAD?

_____

_____

_____

ANY FAMILY MEMBERS WITH MEDICAL CONDITIONS?

_____

_____

_____

LIST ANY MAJOR SURGERIES, TRAUMAS,
ALLERGIES_____

_____

_____

LIST ANY MEDICATIONS YOU ARE ON AND
WHY_____

_____

_____

_____

LIST ANY HERBS OR SUPPLEMENTS YOUR
TAKING_____

_____

_____

_____

HOW MANY HOURS DO YOU SLEEP?_____

HOW MANY MEALS DO YOU EAT A DAY? _____

WHEN DO YOU EAT THESE MEALS?

_____

DO YOU EAT ALONE OR RUSHED? _____

HOW MANY SERVINGS OF FRUITS DO YOU EAT IN A DAY? _____

HOW MANY SERVINGS OF VEGGIES DO YOU EAT IN A DAY? _____

ARE YOU ON A SPECIAL DIET? _____

HOW MUCH CAFFEINE DO YOU DRINK IN A DAY?

_____

DO YOU DRINK ALCOHOL OR SMOKE?

_____

HOW OFTEN DO YOU EAT OUT?_____

PLEASE LIST WHAT YOU ATE IN THE PAST 24 HOURS AND
DRANK_____

_____

_____

_____

_____

THE ELIMINATION CHANNELS OF YOUR BODY ARE KEY TO YOUR HEALTH. PLEASE ANSWER THE FOLLOWING QUESTIONS AS BEST AS YOU CAN. WE TALK ABOUT BOWELS QUITE A BIT HERE!

HOW OFTEN DO YOU MOVE YOUR BOWELS? _____

ARE THEY HARD TO PASS, NORMAL OR SOFT? _____

DO YOU HAVE HEMORRHOIDS? DO THEY BOTHER YOU? _____

DO YOU EXPERIENCE BAD BREATH? _____

DO YOU USE LOTIONS ON YOUR SKIN? _____

WHAT HAIR AND SKIN PRODUCTS DO YOU USE?

_____

PLEASE ALSO LIST ANY HESITATIONS YOU MAY BE HAVING, AS WE WANT YOU TO FEEL COMFORTABLE IN SHARING WITH US. WE APPRECIATE YOUR HONESTY AND YOUR WILLINGNESS TO TRUST US IN HELPING YOU. WISH TO SHARE YOUR THOUGHTS? **REMEMBER 90% OF OUR DISEASES AND DISORDERS COME FROM OUR EMOTIONAL UNBALANCES. WE DO OFFER TREATMENTS AND EDUCATION ON CORRECTING THESE UNBALANCES AND CORRECT THEM ON A DAILY BASE.**

_____

_____

_____

WE ARE NOT DOCTORS, WE DON'T PRESCRIBE MEDICATIONS, WE DON'T ACCEPT INSURANCE, WE DO NOT INTEND TO DIAGNOSE, TREAT, PREVENT OR CURE ANY DISEASE. IF YOU ARE MAKING LIFESTYLE CHANGES, HAS MEDICAL NEEDS, IS TAKING PRESCRIPTION DRUGS, PREGNANT, THEY SHOULD SEEK THE ADVICE AND SUPPORT OF THEIR MEDICAL PHYSICIAN PRIOR TO EMBARKING ON A NEW LIFESTYLE PROGRAM. FOLLOWING OUR ADVICE, HEALTH PROGRAM OR THERAPIES IS A PERSONAL CHOICE.

BY SIGNING THIS FORM, YOU INDICATE THAT YOU VOLUNTARILY ACCEPT TO UNDERTAKE THIS HEALTH PROGRAM AND YOU RELEASE ALLEN T. STANLEY, PRACTITIONER AND ALL TEAM MEMBERS FROM ANY AND ALL COMPLICATIONS THAT MAY ARISE FROM ANY OF THE SUGGESTED OR OFFERED THERAPIES, INCLUDING BUT NOT LIMITED TO RED LIGHT THERAPY, AO SCAN, TERAHERTZ, SOMATIC, MEDICAL MASSAGE, ULTRASOUND, MPS ACUPUNCTURE, THETA CHAMBER, RAIN ION CHAIR, ZIP SYSTEM, AO INFINITY WAND, RF FOOT DETOX AND ESSENTIAL OILS.

RESPONSIBILITY AND LIABILITY FOR MAKING ANY CHANGES IN YOUR DIET, EXERCISE PROGRAM ARE YOUR SOLE RESPONSIBILITY AND YOUR RIGHT.

X_____(INITALS) PLUS, WHEN YOU PREPAYMENT FOR AO SCANS OR DISCOUNTED BUNDLE PACKAGES ON ANY EQUIPMENT, THERE IS **NO REFUNDS OF ANY KIND**. YOU MAY GIFT THEM TO OTHERS AND ONLY GOOD FOR 12 MOS.

X_____(INITALS) MUST PREPAID FOR ALL AO SCANS OR CONSULTATIONS, THROUGH WEBSITE

CLIENT_____ DATE_____

PRACTITIONER

_____ DATE_____