WELCOME TO WHOLE HEALTH CENTER
NEW PATIENT INFORMATION

First Name ______________________________ Last Name __________________________________

Address ____

City, State, Zip ____

Gender _________________Date of Birth _______________________Age_______________________

Telephone-Home ___________________Cell ___________________Work ______________________

Occupation__________________________________ Marital Status _____________________________

Do you give permission to send appointment reminders & clinic updates to your email address?
Yes _______ No _______ We will not sell or give your email to any other agency.

Email Address ____

Emergency Contact Name____

Telephone_______________________ Relationship ____

How did you hear about Savvy Wellness?

Friend or Family (Name) ___________________________ Website____________________________
Other ____

Disclaimer

I understand that Sheree Michelle is not a medical doctor. She does not diagnose, treat, cure or prevent diseases. The services she provides does not substitute for treatments by a licensed doctor. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition. Never disregard professional medical advice or delay in seeking care. Her evaluations are meant to facilitate wellness.

By signing below, you indicate that you understand and acknowledge this disclaimer.

Signature _______________________________________ Date ___________________________________

Savvy Wellness Disclosure Statement

Sheree Michelle, B.S. received her Bachelor of Science degree at the California State University, Hayward. During her career, she worked for Kaiser, DaVita and Bio-Rad. As a Holistic Health Practitioner, Sheree is a trained practitioner with biofeedback technology and a lymphatic drainage therapist. She has also coached people with their nutritional goals. She has cultivated a lifestyle of health, wellness and fitness. Sheree is an avid researcher and reader. Regardless of why people come to her, whether it be stress, allergies, diet or needing to detox, she'll do her best to get you on track towards wellness by offering two different services of Biofeedback (Allergy Elimination) and Lymphatic Drainage Therapy. She is continuing her education with the Institute for Integrative Nutrition.

Service Fees

Initial Biofeedback Evaluation $150
Follow-up Biofeedback Session $90
Prepaid Biofeedback 5-Visit Package $425 (Save $25)

Initial Lymphatic Drainage Evaluation $150
Follow-up Lymphatic Session $90
Prepaid Lymphatic 5-Visit Package $425 (Save $25)

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*Packages may be shared between family members.
*You may also mix both services in the same package of 5 visits.
*Coupons or other special discounts may apply.

Privacy Rights

Please note that Savvy Wellness's services do not fall under HIPAA rules and regulations. You may receive emails from Savvy Wellness containing information relating to your health conditions being addressed that are not HIPAA compliant. Please acknowledge this with your initials here_________

Patient Rights

Each patient who visits this clinic is entitled to receive information about the services, biofeedback technology and an estimated duration of services, if known. The patient may seek a second opinion from another healthcare professional or may terminate services at any time. I have read and understand the above disclosure statement. By signing below you indicate that you understand and acknowledge these rights as a patient.

Patient's Name (please print)
____ Date_________________________________

Signature of Patient or Legal Guardian____

Financial Policy & Consent for Therapy

Thank you for choosing Savvy Wellness. Savvy Wellness wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our Financial Policy. The following is a statement of our Financial Policy in which you are required to read and sign prior to any treatment. To help us help you, please:

1.) Provide us with accurate and updated information on yourself

2.) Pay at the time of service for your entire balance.

3.) Discuss your account balance only with the front office staff. It is important for practitioners to be allowed to provide patient care. If the front office staff cannot help you, do not hesitate to contact the office manager.

Payment for Services

Savvy Wellness does not accept insurance. You are responsible for the complete charge. Payment is due at time of service unless arrangements have been made in advance. We accept cash, check and credit cards (Visa, Master Card and Discover). Full discount packages must be applied at the time of service and cannot be back-dated. We charge a NSF charge if any payment is returned due to insufficient funds.

I have read and understand Savvy Wellness's Financial Policy Agreement and I agree to be bound by its terms.

Patient's Name (please print) ____

____

Signature of Patient or legal guardian Date

Consent for Lymphatic Drainage Therapy

We follow strict adherence to lymphatic drainage therapy being a non-sexual service, clients may remove all or part of their clothing (depending on their comfort level) to improve the therapeutic value of lymph drainage. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

I have read and understand Savvy Wellness's Consent for Therapy and I agree to be bound by its terms.

Patient's Name (please print) ____

______________________________ ______________________________

Signature of Patient or Legal Guardian Date

Describe Symptoms

Please complete this form as thoroughly as possible. It is all relevant to the assessment. All information is **CONFIDENTIAL**.

First Name ______________________________ Last Name _____________________________ Date ________________

Gender ________________ Date of Birth ___________________________ Age _________________

Major complaints, in order of importance to you:

#1 ____ ☐ Severe ☐ Moderate ☐ Slight
Describe your symptoms: ____
When/how did this condition occur? ____
How does this condition impair your daily activities? ____
Treatments you have received for this condition? ____

#2 ____ ☐ Severe ☐ Moderate ☐ Slight
Describe your symptoms: ____
When/how did this condition occur? ____
How does this condition impair your daily activities? ____
Treatments you have received for this condition? ____

#3 ____ ☐ Severe ☐ Moderate ☐ Slight
Describe your symptoms: ____
When/how did this condition occur? ____
How does this condition impair your daily activities? ____
Treatments you have received for this condition? ____

Please rate your commitment to feeling better: 1 2 3 4 5 6 7 8 9 10

What are your goals for your Biofeedback sessions? ____

Do you have concerns about having a Biofeedback session? ____

Do you have any questions about the Biofeedback technology? ____

Other Practitioners You See:

M.D. ____Chiropractor____

Acupuncturist ___________________________________Naturopath ____

Massage Therapist ________________________________Other ____

Diet Summary Information

Daily Health Habits: Please check any that apply: **How Often?**

_____ Caffeine…………………………………………………………….>____
_____ Alcohol……………………………………………………………..>____
_____ Tobacco …………………………………………………………..>____
_____ Fast Foods………………………………………………………..>____
_____ Hours of sleep____
_____ Other ____

Please describe your diet (low-carb, low-fat, vegetarian, etc.)
____
____
____

Please list a typical day in your diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

How much water do you drink per day? ____

Other fluids: ____

If you eat any of the following, please circle and list how much per week:

CANDY ____________ COOKIES/BAKED GOODS ________ CHOCOLATE ________ WHITE FLOUR BREAD __________
MILK ________________ SODA __________ CHEESE _______________ MEAT ____________________________
EGGS _________________ ICE CREAM _______________ PASTA ________________ COFFEE ___________________
ALCOHOL ______________ FAST FOOD _______________ PROTEIN _______________ FRUIT ____________________
DARK GREEN VEGETABLES ____________________________ OTHER ____

Anything else that you want to add about your diet or eating habits?
____
____
____
____
____

Medical Conditions

Please list conditions and surgeries you have had, along with the year diagnosed:

Year	Condition
______	____
______	____
______	____
______	____

Please list all prescription medications you take, including occasional use and inhalers, nose sprays, and eye drops:

Medication/Dose	Purpose	Length of Time	Last Dose
____________________	____________________	______________	____________
____________________	____________________	______________	____________
____________________	____________________	______________	____________
____________________	____________________	______________	____________
____________________	____________________	______________	____________

Please list all supplements you take, including vitamins:

Supplement	Purpose	Length of Time	Last Dose
____________________	____________________	______________	____________
____________________	____________________	______________	____________
____________________	____________________	______________	____________
____________________	____________________	______________	____________
____________________	____________________	______________	____________

Please list any allergies (seasonal, medication, environmental, food, chemical/perfume, pollen, etc.):

____

Please list any occupational concerns (stress, computer work, heavy lifting, etc.):

____

Please tell us about your exercise routine and what it includes (daily, weekly, sporadic, etc.):

____

Musculoskeletal (Please list areas where you have problems, if any):

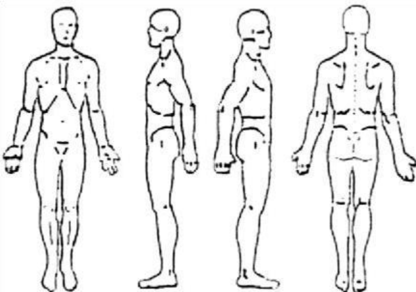
Muscle cramps? ________________________ Muscle pain? ____________________________

Joint Swelling? ________________________ Tendonitis? ____________________________

Arthritis? ____________________________ Bursitis? ______________________________

Please label (A, B, C, D) problem areas on diagram, then answer the questions about each area:

Describe Pain for Each Area



☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other: ____________________

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other: ____________________

☐ Sharp ☐ Burning ☐ Aching

Medical Conditions

Symptoms – Note: For each symptom you currently have, rate it severity from 1-5 (5 being the worst).
LEAVE BLANK IF NOT APPLICABLE

Liver/Gallbladder

_____ Irritability/Anger
_____Depression/Stress
_____ Headaches/Migraines
_____ Visual Problems
_____ Red/Dry/Itchy Eyes
_____ Gallstones
_____Dizziness
_____ Blurred Vision
_____ Feeling of lump in throat
_____Clenching of teeth at night
_____ Muscle cramping/twitching
_____ Tension
_____ Joints/Neck/Shoulder pain
_____ Poor Circulation
_____ Soft/Brittle Nails
_____ Emotional Eater

Kidney/Urinary Bladder

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder control
_____ Weakness/Pain in Low back
_____Decreased Bone Density
_____ Feel cold easily
_____ Low sex drive
_____ Excess sex drive
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities/Root Canals/Dental Issues
_____ Craving/Avoiding Salty Foods
_____ Fear
_____ Hot Flush/Night Sweating

Heart/Small Intestine

_____ Heart Palpitations
_____ Chest Pains
_____ Insomnia/Sleep Problems
_____ Easily Startled
_____Restlessness/Agitation
_____ Vivid Dreams
_____ Lack of joy in life

Lung/Large Intestine

_____ Dry Cough
_____Cough with sputum
_____Nasal Discharge
_____ Post-nasal Drip
_____ Sinus Infection/Congestion
_____ Itchy, red or painful throat
_____ Dry mouth, nose, or throat
_____ Skin rashes/Hives
_____ Snoring /Apnea
_____ Grief/Sadness
_____ Shortness of Breath
_____ Allergies/Asthma
_____ Low Resistance to Colds/Flu
_____ Sneezing
_____ Mild Fever comes & goes
_____ Smoke Cigarettes

Spleen/Stomach

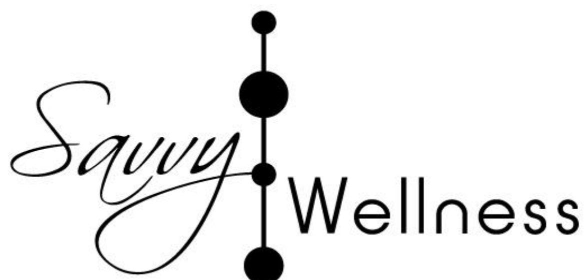
_____ Heaviness anywhere in body
_____ Fatigue/Worse after eating
_____ Hard to get up in the morning
_____ Edema (Swelling)
_____ Muscles feel tired often
_____ Easily bruising/bleeding
_____ Bad Breath
_____ Decreased/Increased appetite
_____ Crave Sweets/Sugars
_____Hypoglycemia
_____ Difficulty digesting oily foods
_____ Nausea/Vomiting
_____ Gas/Belching/Bloating
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion/Heartburn
_____ Over-Thinking
_____ Tendency to gain weight
_____ Brain Foggy

Energy Level (please circle) Low 1 2 3 4 5 6 7 8 9 10 High

HOW TO GET THE MOST OUT OF YOUR BIOFEEDBACK SESSIONS…

It Starts With…

Keeping a POSITIVE mindset. You deserve to be healthy and well… Change doesn't happen overnight & health is a journey so be realistic. Be kind to yourself. Be Inspired. Be Healthy. Be Strong. Be Savvy with your daily choices & CHOOSE yourself because you are worth it!!!



Drink plenty of water the day before & the day of appointment.

Ask questions so you are well informed.

Please avoid wearing fragrances or lotions the day of appointment.

Avoid any known allergens.

Get a good night's sleep & don't overdo it.

WHOLE HEALTH CENTER

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Sheree Michelle