

Purification Program Intake and Consent Form

Name:		Sex: Male _____ Female _____	
Address:	City:	State:	Zip Code:
Home Phone () ()	Work Phone: () () Ext.	Cell Phone: () ()	Age:
Date of Birth: / /	Physician Name:	Physician Contact Info	
Height:	Weight:	Marital Status:	
Referred By:	Email Address:		
Where may we contact you? Home / Work / Cell What is the best time to reach you?		Have you ever done a cleanse before?	

What brings you here today?

Concern	Onset	Frequency	How this impacts your life
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

PERSONAL MEDICAL HISTORY

Please list any surgical procedures/operations/major injuries:

PERSONAL MEDICAL HISTORY (continued)

Please check the following conditions that apply to you and circle appropriate choices when given.

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism or Substance Abuse | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> History of Infertility |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Infections/Stones |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Seizures, Epilepsy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Serious Injury/Accident (Type _____) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Digestive (Crohn's, IBS, Ulcerative Colitis) | <input type="checkbox"/> (Chlamydia, Warts, Herpes) |
| <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> (Specify Other _____) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Frequent Sinusitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Thyroid Disease (Specify _____) |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hay Fever, Allergies, Eczema | <input type="checkbox"/> Urinary Problems (Incontinence, Infections) |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Heart Attack, Heart Disease, Heart Failure | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Headaches (Migraines, Tension) | <input type="checkbox"/> Other (Specify) _____ |

What vitamins/minerals/herbal supplements are you currently taking?

<u>Brand or Other Name</u>	<u>Dose</u>	<u>Reason for Use</u>	<u>When Started</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there any other information that you would like us to know? _____

**PERMISSION & AUTHORIZATION FORM
REGARDING THE USE OF THE SP PURIFICATION PROGRAM**

PLEASE READ BEFORE SIGNING:

I understand that the SP Purification Program is a natural, complementary health improvement program that includes dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that the SP Purification Program is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

I have to the best of my knowledge, provided a complete health history and list of all medications and supplements. I further understand that because of the potential for the interaction of pharmaceuticals and herbal supplements, the SP Purification Program may require medical clearance by my physician before I can participate.

I understand that no promise or guarantee has been made regarding the results of SP Purification Program or any natural health, nutritional or dietary programs recommended, but rather I understand that the SP Purification Program is a means by which the body's natural abilities can be supported for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.
This permission form applies to subsequent visits and consultations

Signature_____ Date_____