CLIENT CHECKLIST

☐ **Plan to dress comfortably for your session.** We also ask you to refrain from wearing any perfumes or colognes. All metal, including jewelry must be removed for the session. Pacemakers and implanted metal are permissible.

☐ **We suggest you be prepared to relax during your session.** It doesn't matter whether a person sleeps, and it doesn't matter if your eyes are open or closed.

☐ **Use the time to relax and heal.** Long walks and hiking, shopping and strenuous exercise are discouraged after sessions. Your health is the most important thing. It should be your priority in life above everything else. Your health allows you joy, love, productivity and creativity to flourish.

☐ **Should you plan more than one visit?** Everyone is different; thus, the number of sessions is dependent on the individual. Please discuss this with the practitioner after your session. Most people need 4-10 visits to see good results. We do have packages available for purchase. After you achieve the level of wellness you wish to achieve maintenance sessions are recommended.

☐ **Factors that can be controlled by the individual which would aid the healing process are:** drinking the required water, eating a good diet and staying away from stimulants such as coffee, tea and nicotine/marijuana, eliminating the use of alcohol or drugs, avoiding emotional, environmental or physical trauma, getting enough rest and the big one…try to avoid STRESS.

☐ **Please reschedule** any blood work, massage, acupuncture, biofeedback, cranial sacral, EMDR, use of the BioMat or any other energy work for 5-7 days after doing a single session. People who perform energy work will be fine doing their work, but do not want to have work done on them.

☐ **Commit to drinking** about 90 ounces to a gallon of water a day for about 5-7 days after a session.

☐ By signing this you are acknowledging is not your primary care physician.

☐ **Cancellation Policy requires 24-hours notification** or you will be asked to pay the session fee. Thanks for understanding.

Signature: _____

Print Name: _____ Phone: _____

INFORMED CONSENT/CLIENT DECLARATION

I hereby voluntarily consent to a relaxation therapy session at Mandira Wellness Center . I have read the program protocol and conditions and agree to comply with all recommendations, to the best of my ability, in order to receive maximum benefit.

I am responsible for the decision to seek this type of relaxation therapy program that could include improvement of the physical, psychological / emotional and environmental aspects of my illness. I recognize that the Mandira Wellness Center staff do not treat any specific disease or illness and they are not licensed, certified, or registered by the state as a health care professional. However, all staff members are trained technicians and possess the proper training for administering sessions for clients. I recognize the possibility that this program may not prove successful or accomplish the results I expect or hope for. I understand that best results are obtained with a package program / protocol and membership.

I am fully informed that this approach to health differs from, and may not be recognized by, traditional medical standards. Clients should discuss any recommendations made by Mandira Wellness Center with their medical professional. As further inducement to Mandira Wellness Center to provide services for me, I hereby waive any claims and demands that I might now or hereafter have against Mandira Wellness Center or its owners or staff that may arise, or deemed to arise from participating in therapy programs at Mandira Wellness Center, and I hereby further release Mandira Wellness Center and its owners and consultants from any and all liability of whatsoever kind or nature arising out of or in any way relating to the therapy sessions I will receive at Mandira Wellness Center. Mandira Wellness Center does carry liability insurance as deemed necessary by the State of Florida and the leasing agent in which we are doing business on their property.

I understand that Mandira Wellness Center reserves the right to deny treatment if it is not deemed by Mandira Wellness Center to be in the best interest of the client(s) or staff.

It is understood that any therapy sessions, remedies, nutritional supplements, or treatment modalities are intended to enhance overall body performance and are not intended or implied to treat or “cure any specific illness.” It is understood that any suggestions regarding remedies and nutritional supplements are only Mandira Wellness Center best recommendation and are at no time to be considered a prescription.

Date: _____

Client Name (print): _____

Signature:_____

HARMONIC EGG
M I A M I

1501 SW 37 Avenue Miami ,Fl 33145 **www.harmoniceggmiami.com**

CONFIDENTIAL CLIENT APPLICATION

Client: _____ DOB: _____ Height:_____ Weight:_____

Telephone Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Address: _____ Email:_____

City: _____ State: _____ Zip Code:_____

Emergency Contact: _____ Relation: _____ Phone: (_____)_____

Relationship Status: ❑ Single ❑ Married ❑ Partner ❑ Separated ❑ Divorced ❑ Widow/Widower

Spouse/Partner Name: _____ # of children _____

Occupation: _____ Do you enjoy your job? ❑ Yes ❑ No

Primary Reason for seeing us: _____

Have others helped you with the problem: _____

What are your expectations after the sessions: _____

Who can we **thank** for your being here (who referred you): _____

Check conditions listed below which you have experienced: Use ☒ for over a year ago, fill in ■ for current.

METABOLISM
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ High/Low BP
- ☐ Blood sugar
- ☐ Thyroid

DENTAL
- ☐ Tooth Problems
- ☐ Root Canals
- ☐ Amalgam Fillings
- ☐ Difficulty chewing
- ☐ TMJ

CHEST
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Asthma

ALLERGIES
- ☐ Medications
- ☐ Chemicals
- ☐ Foods
- ☐ Plants

DIGESTION
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Gas/Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ History of Ulcers
- ☐ Colitis
- ☐ Liver Disease

SKIN
- ☐ Rash
- ☐ Eczema
- ☐ Dry Skin
- ☐ Acne
- ☐ Recent Botox
- ☐ Any recent substance or Injection under skin

EYES/EARS/MOUTH
- ☐ Headaches
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Blurred Vision
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Mouth Sores

FEMALE
- ☐ Pregnant
- ☐ Problems with periods
- ☐ Cancer
- ☐ Breast Tenderness
- ☐ Breast Implants
- ☐ Menopausal Symptoms

STRUCTURAL
- ☐ Arthritis
- ☐ Bursitis
- ☐ Osteoporosis
- ☐ Foot/Ankle Swelling
- ☐ Blood Clots/Phlebitis
- ☐ Varicose Veins
- ☐ Recent Surgery
- ☐ Neck Pain/Problems
- ☐ Back Pain/Problems
- ☐ Sciatica

IMMUNE
- ☐ Chronic Fatigue
- ☐ Fibromyalgia
- ☐ Yeast Infections
- ☐ Past viral infections
- ☐ Past Strep or Mono
- ☐ Epstein- Barr
- ☐ Lyme

MALE
- ☐ Prostate
- ☐ Cancer

URINARY
- ☐ Frequent Urination
- ☐ Difficulty starting Urination
- ☐ Urinary Incontinence

NEUROLOGIC
- ☐ Numbness or Tingling
- ☐ Weakness
- ☐ Insomnia
- ☐ Poor Balance

HARMONIC EGG
M I A M I

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CLIENT INTAKE

Describe any specific medical attention or assistance you will need while visiting our center (you must be able to get into the unit or bring a caregiver to help you).

_____

Will you be bringing a caregiver, nurse or spouse with you? _____

Please check the word that best describes your current state of health:

❑ Excellent ❑ Good ❑ Average ❑ Improving ❑ Declining ❑ Serious. ❑ Debilitated

What brings you joy? _____

Please check the most emotional draining relationship or relationship in your life:

❑ Your Partner ❑ Job ❑ Children ❑ Relationship with Yourself ❑ State of the World

Is your home environment peaceful or stressful most of the time? ❑ Peaceful ❑ Stressful

Do you have trouble concentrating, or '*brain fog*'? ❑ Yes ❑ No **Do you feel supported?** ❑ Yes ❑ No

What drives you, inspires you, gives you a sense of purpose:_____

_____

Please check the emotions that best reflect how you feel most of the time:

☐	Joy	☐	Sad	☐	Excited	☐	Optimistic
☐	Anger	☐	Depressed	☐	Passionate	☐	Terrified
☐	Resentment	☐	Hopeless	☐	Safe	☐	Anxious
☐	Peaceful	☐	Despair	☐	Calm	☐	Alone
☐	Happy	☐	Blissful	☐	Afraid	☐	Frustrated

Do you adhere to any particular diet? _____

How many hours of sleep do you get on average? _____

Do you drink filtered or purified water? ❑ Yes ❑ No

Describe your exercise/activity routine: _____

Are you sensitive to light / loud noise? ❑ Yes ❑ No **If Yes, please explain** _____

_____

Are you in fear regarding your health? _____

Regaining well-being requires a strong personal commitment. How ready are you to make the lifestyle changes, the diet changes and the attitude changes that may be necessary to good health?

❑ Ready ❑ Somewhat ❑ Not looking to make changes

☐ *I have read the above information and have filled out the form to the best of my knowledge. I understand that the questions on this form are being asked in order to better access my current circumstances and their relationship to my well-being. I further understand that I am voluntarily agreeing to have a relaxation therapy session and that no medical claims or promises of healing have been given.*

Signature: _____ Date:_____

MEDICATIONS CLIENT

Medications, Herbs, Supplements (list name, dose, and purpose)

NAME	DOSE	PURPOSE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

We recommend drinking 90 - 128 ounces of water daily starting on the day before your first session and for the days of integration**. Do you expect any difficulty with this?** ❑ Yes ❑ No
Explain: _____

How much do you use? ❑ Alcohol_____ ❑ Tobacco _____

❑ Coffee/Tea _____ ❑ Drugs/Marijuana _____

Injuries/Accidents? ❑ Yes ❑ No When & Describe _____

Traumatic life events leading to any illness: _____

_____

Toxic Exposures: _____

Describe other medical conditions that we should be aware of: _____

❑ Cancer ❑ Heart Problems ❑ Stroke ❑ Seizures ❑ Diabetes ❑ MS

Other: _____

Areas in body of complaint or tension: _____

_____

Surgeries with dates (include location of metal plates/rods/screws) _____

_____

Family medical history: ❑ Diabetes ❑ Heart Problems ❑ High BP ❑ Cancer ❑ Alzheimer's

Other:_____

Current Levels: (1=very low, 5=very high):

Pain ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 Explain: _____

Stress ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 Explain: _____

Energy ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 Explain: _____