Personal Health and Consent Form

Name _____ Phone ( ) _____ DOB _____

Street Address _____

City _____ State _____ Zip _____ Occupation _____

E-mail: _____

In case of emergency: _____ Phone ( ) _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, please also inform your Natural Practitioner.

__ Yes __ No Do you frequently suffer from stress?
__ Yes __ No Do you have diabetes?
__ Yes __ No Do you experience frequent headaches?
__ Yes __ No Are you pregnant?
__ Yes __ No Do you suffer from arthritis?
__ Yes __ No Are you wearing contact lenses?
__ Yes __ No Are you wearing dentures?
__ Yes __ No Do you have high blood pressure?
__ Yes __ No Are you taking high blood pressure medication?
__ Yes __ No Do you suffer from epilepsy or seizures?
__ Yes __ No Do you suffer from joint swelling?
__ Yes __ No Do you have varicose veins?
__ Yes __ No Do you have any contagious diseases?
__ Yes __ No Do you have osteoporosis?
__ Yes __ No Do you have any allergies?

__ Yes __ No Do you bruise easily?
__ Yes __ No Any broken bones in the past two years?
__ Yes __ No Any injuries in the past two years?
__ Yes __ No Do you have cardiac or circulatory problems?
__ Yes __ No Do you suffer from back pain?
__ Yes __ No Do you have numbness or stabbing pains?
__ Yes __ No Are you sensitive to touch or pressure?
__ Yes __ No Have you ever had surgery? Explain below.
__ Yes __ No Other medical condition, or are you taking any medications I should know about?
__ Yes __ No Do you have tension or soreness?

If Yes, please specify _____

_____

Other Comments _____

_____

I understand that it is my sole responsibility to be in charge of my own personal health and that I have answered the above questions honestly. I understand that I have sought out the services of a Minister and that the services to be provided are focused in Natural Healing and are of a Spiritual Nature. Having requested the services of an Officer of the Church, I understand that such services constitute for the New Haven Native American Church. Medicine Man or Woman, as a Person under the Law, as an Ecclesiastic Body in General, and as a Church Entire, the very establishment and practice of their Religion. I will make it my personal responsibility before any services shall be performed, to understand the kind and nature of the service to be provided and the level of competence of the person providing such service. I understand there are limits to the confidentiality that the Minister can provide. I understand this limits of confidentiality are due to breaches in electronic transmissions, subpoena or other dictates of Law, theft of records, and other such extenuating circumstances. Also any audio or visual recordings automatically brings the risk of violation of Confidentiality therefore if any service is to be recorded, I will be informed of the use of any such devices. I also agree to keep the Minister/Natural Practitioner updated to any changes in my medical profile. If I experience any pain, discomfort, emotional stress, or other unusual condition during any service, I will immediately inform the Minister. I have been adequately informed of all services, competence of the Minister, limits of confidentiality, and herby do give my consent for such services to be preformed.

Client Signature _____ Date_____

Practitioner Signature _____ Date_____

Consent to Treatment of Minor: By my signature below, I hereby authorize the Minister/Natural Practitioner to minister to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____Date _____