Institute for Whole Body Wellness

Medical Thermal Imaging & Medical Colonics

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Friendswood, TX 77546
281-648-1026 Fax 281-648-2747
www.IWBW.org
Private Medical Membership Association

FIR Infrared Sauna

New Patient Information Forms

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State_____ ZIP_____

Shipping Address _____

_____

Home Phone (____) ____-_____ Work /Cell/Other Phone (____) ____-_____

e-mail address: _____

REFERRED BY:_____

Occupation _____ Employer_____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking:_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol_____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date:_____

_____

Past Accidents or injuries: _____

_____

Name: _____ Date_____

We do not diagnose.
We make no claims to cure any conditions.
We make no claims or imply any claims.
We do not claim that any supplemental material we may suggest will cure any condition.
We do not prescribe for, or treat diseases.

I understand the above statements. I understand that diet and nutrition are considered to be an inexact science, and the results obtained are not always constant or predictable. Medical Thermal Imaging is not a cure-all for any disease or infirmity.

I also understand that there is no guarantee of any results. Whether or not I participate in this program is my decision. I must make all decisions relative to my health.

I further understand that Joe Turcotte and Linda Turcotte ,and the staff, are not medical doctors in the so-called healing arts and are not attempting to portray themselves as, or conduct the activities of, a medical doctor.

If any representation has been made to me concerning any program or if I have any understanding about any program whose representations and/or understandings are contrary to any of the above statements, I will so indicate on the reverse side of this form.

Our work is limited to that of providing self-help education in natural health matters and the advocating of a healthy lifestyle. We ask you to affirm that you are not here seeking medical advice but rather seeking education advice, and not visiting on a mission of entrapment or as a representative of any state or local authority.

I understand that I am expected to meet on my scheduled appointment times. If, for any reason, I can not, I will reschedule at least 24 hours in advance. If I fail to reschedule at least 24 hours in advance my account will be charged for that visit.

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Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier?_____

_____

I have read and understand this document.

SIGNED:_____ DATE _____

Patient Name: **Date:**

1. **Chief Concerns:**

2. **Medications and/or Nutritional Supplements currently on:**

3. **Dietary Intake for 2 days before appointment:**

Breakfast:	**Breakfast:**
Snacks:	**Snacks:**
Lunch:	**Lunch:**
Snacks:	**Snacks:**
Dinner:	**Dinner:**
Snacks:	**Snacks:**