Blue Orchid Clinic

We are pleased to welcome you to our practice.

Please take a few minutes to fill out these forms. If you do not know the answer to a question, please say I don't know or something similar.

These questions are here so that I may truly help you in all areas of your life.

We look forward to working with you to maintain a Healthy You.

Patient Information

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Sex: ☐M ☐F Age: _____ yrs. old Birthdate: ____/____/____

Relationship Status: _____ Their Name, if applicable: _____

Children's Name(s), if applicable: _____

Others living with you, including pets: _____

Employer & Occupation: _____

In case of Emergency, Notify

Name: _____

Relationship: _____ Contact #: _____

What Services Are You Interested In?

Check the box, with the service that you are interested in.

- ☐ Holistic Care
- ☐ Vitamin & Supplement care
- ☐ Nutrition
- ☐ Chemical Free Lifestyle
- ☐ Relaxation & Exercise
- ☐ Finding your Life's Purpose
- ☐ Personal Life Development
- ☐ Relationship Development
- ☐ Professional Life Development
- ☐ Financial Coaching
- ☐ Other: _____

Who may We Thank for Referring You?

Name/Source: _____

How Important is Your Health to You?

On a scale of 1-10; 1 being least important & 10 being your highest priority.

1 2 3 4 5 6 7 8 9 10

Medical History

Check the box, with the condition that you have.
Please use the space below to write any other conditions not listed.

- ☐ Anxiety
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Bowel/Bladder Problems
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Dizziness/Fainting
- ☐ Eczema
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches/Migraines
- ☐ Heart Attack/Stroke
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Immunity Problems
- ☐ Joint Problems
- ☐ Kidney Problems
- ☐ Liver/Gallbladder Problems
- ☐ Memory Loss/Forgetfulness
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Palpitations
- ☐ Pace Maker
- ☐ Ringing in the Ears
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Skin Conditions
- ☐ Surgical Implants
- ☐ Thyroid Condition
- ☐ Weight gain or loss

Do you participate in any of these activities?

☐ Alcohol ☐ Cannabis ☐ Smoke Cigarettes ☐ Vape ☐ Other:_____

How Much/Often:

Accidents & Surgeries

Please use the space below to write any previous accidents that required hospitalization or rehabilitation therapy, surgeries and any other hospitalization.

Family History

Please use the space below to write any pre-existing family conditions.

Allergies

What allergies or sensitivities do you have?

Current Medications & Supplements

Medications with mg per day	Supplements with mg (or g, iu, etc.) per day

More space on back if needed.

Beauty & Skincare Products

What are the name brands of the beauty, hygiene and skincare products that you currently use?

Cleaning Products

What are the name brands of the cleaning (kitchen, bath, etc.) and laundry products that you currently use?

Organic Food

Do you currently use organic, whole food, or all natural food products? If so, how often?

Exercise Routine

What type of exercise do you currently partake in? How often?

Relaxation Routine

What type of relaxation or stress relief do you currently partake in? How often?

Financial Overview

What is the state of your finances? How is your money being spent every month?

If you would like help with this section, please write "would like to do a budget" and we will devote a session to your finances.

Life Coaching

Is there any other area of your life that you need help with? Relationships, Professional, etc.?

Additional Notes

Please use this space to add anything else not already covered
or to continue a topic if not enough room was provided above.

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Blue Orchid Clinic and its Health Professional(s), to help determine an appropriate holistic treatment plan.
If there are any changes in my medical status, I will inform the Clinic or Health Professional(s).

X_____	X_____	_____
Print Name	Sign Name	Date

Confidentiality Agreement

It is understood and agreed to that the below identified discloser of confidential information may provide certain information that is and must be kept confidential. To ensure the protection of such information, and to preserve any confidentiality necessary under patent and/or trade secret laws, it is agreed that:
The Confidential Information to be disclosed can be described as and includes:

- All personal information regarding the Wellness Members health, family, work, wealth, etc. shall never be talked about or shared to anyone by the Wellness Professional or Blue Orchid Clinic.
- Information can be shared only in third person format. (Example: I, Wellness Professional, have helped someone in a similar situation by getting them on St John's Wort for depression and got them off there prescription medication.)

X_____	X_____	_____
Print Name	Sign Name	Date

Office Use Only

DO NOT sign until payment, for future consults/sessions, has been agreed upon by both parties

Payment Agreement Notes

Based on income, the agreement for pricing on consults/sessions will be listed below.
And any other notes needed

$_____ Follow-Up for Holistic Coaching
$_____ Follow-Up for Personal Life Coaching
$_____ Follow-Up for Professional Life Coaching
$_____ Follow-Up for Financial Coaching

_____
_____
_____
_____

X_____ X_____ _____
Print Name Sign Name Date

Payment Authorization

I understand all charges and accept the responsibility of those charges.
$5 payment is due at the time of booking an appointment. Total agreed upon above will be taken at the time of appointment, minus the $5 booking fee. Payment can be made in cash or by using PayPal. Note: PayPal is free, if transfer is made online. We do have a card reader on-premises, however, there is an additional fixed fee added on depending on charges.

X_____ X_____ _____
Print Name Sign Name Date

Privacy Policy

This notice describes how medical information about you may be used and disclosed, as well as how to get access to this information. Please review this information carefully.

Blue Orchid Holistic Wellness Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. All employees have signed a confidentiality agreement.

EMERGENCIES

We may disclose your health information to notify or assist in notifying emergency responders, in the event of an emergency. We will also notify your emergency contact provided on your new patient information form.

PUBLIC HEALTH

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

We may disclose your health information in the course of any administrative or judicial proceeding.

MARKETING

We may contact you for marketing purposes and fund raising purposes.

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Blue Orchid Holistic Wellness Clinic is not required to agree to the restriction that you requested.
You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
You have the right to inspect and copy your health information.
You have a right to request that Blue Orchid Holistic Wellness Clinic amend your protected health information. Please be advised, however, that Blue Orchid Holistic Wellness Clinic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
You have a right to a paper copy of this Privacy Policy at any time, upon request.

CHANGES TO THIS NOTICE OF PRIVACY POLICY

Blue Orchid Holistic Wellness Clinic reserves the right to amend this Privacy Policy at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Blue Orchid Holistic Wellness Clinic is required by law to comply with this notice or the last current one signed by the patient on file.

This notice is effective as of the date listed below.
I have read the Privacy Policy and understand my rights contained in the notice. By way of my signature, I provide Blue Orchid Holistic Wellness Clinic with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Policy.

X_____	**X**_____	_____
Print Name	Sign Name	Date