Peridot Health and Wellness Center

Client Information **Please fill out **ALL** fields below

Last:_____First:_____Middle intial_____

Address:_____

City_____State____Zip_____

Home Phone:_____CellPhone_____

Email_____Age_____ Birth Date_____

Sex _____Female _____ Male_____

Client Employer_____Occupation_____

Emergency Contact Name:_____

Relationship to Client:_____CellPhone_____

Peridot Health and Wellness Center has a **24-hour cancellation policy** for all Services, if a cancellation within the 24 hours occurs you will be a courtesy reminder. If multiple cancellations occur you will be charged a $**25 cancellation fee**.

Health Information

*Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Reason For Visit_____

Preferred Pharmacy_____

Do you have or have you had any of the following(Circle for each and provide explanation below if Yes)

Aid/HIV____	Chest Pain_____	Hay Fever/Allegeries_____
Anxiety Disorder_____	Cancer_____	Headaches/Migraines_____
Arthritis_____	Deep Vein Thrombosis___	Hematologic/Blood Disease____
Asthma_____	Neck Problems_____	High Cholesterol_____
Rheumatoid Arthritis____	Infectious Disease____	Kidney/Bladder/Bowel Prob _____
Bleeding Disorder_____	Depression_____	Pacemaker/defibrilator_____
Sinus Problems/Infections__	Diabetes_____	Pulmonary Disease_____
Hepatitis/Liver Problems____	Epilepsy/Seizures_____	Physical Restrictions_____
High Blood Pressure_____	Eye/Vision Problems_____	Thyroid Disease_____
Cardiac Disease_____	Fibromyalgia_____	Tuberculosis_____

Are you **Pregnant** or **Breastfeeding** Y or N

List any other serious illnesses and/or accidents, or explanations from list above:_____
_____
_____

List all **MEDICATIONS** you are currently taking or **HAVE TAKEN IN THE LAST MONTH.** Please include the name, dosage, and frequency.

_____
_____

List all **VITAMINS/MINERALS/SUPPLEMENTS** you are currently taking or **HAVE TAKEN IN THE LAST MONTH.** Please include the name, dosage, And frequency._____
_____

List All A**llergies** (including Latex, antibiotics, topical ointments/creams, and over the counter meds)._____

I pledge with my signature the information provided on this document is accurate and complete to the best of my knowledge.

Signature_____ Date_____

Email: _____