Natural Sources Wellness Center

320 Howard St.
Pritchett, CO. 81064
719-523-6611

CLINIC & LODGING APPLICATION

Today's Date:_____/_____/_____ Date Of Birth___/____/_____

How did you hear about us?____

Personal Information

Name:(Mr.,Mrs.,Ms.)___________________________________Nickname:__________________

Address:___________________________City_____________State________Zip_____________

Tel#(   )____________Bus#(____)__________Occupation______________________________________

Sex________Age______Height________Weight________Soc Security#______-______-______________

Spouse/Caretaker's Name____

Children's Name and Ages(if applicable)____
____

Does your family support your decision to attend Natural Sources Clinic?___________________________

In case of an emergency, please notify: Name____

Relationship______________ Tel#(   )____________ Alt#(   )__________________________

Health Treatment Profile

Current
Diagnosis____
____

Current Treatment Protocol____
____

If receiving Chemotherapy or radiation, date of last Treatment_____________________________

Are your blood count low?_______Have you had to have blood transfusions?________________

List ant medications(prescription or over-the-counter) you are taking and any side-effects you are experiencing____
____
____

List any food supplements, herbs, or other"natural" remedies you are taking ___________________________
____
____

On a scale of 1-10, how would you rate your current health status on a day-to-day basis?(10 being the best)_______

What are your most troublesome symptoms?____
____
____

List any previous hospitalizations, surgeries, or diagnoses for which you have received treatment
____
____
____

Have you ever given yourself enemas for the purpose of colon cleansing and detoxification?
____

Do you have difficulty climbing stairs ?____

Please check any of the following that apply to your situation and use additional paper to give details as necessary:

Allergies, food____	Colitis____	Hypoglycemia____	Pregnant____
Inhalant____	Constipation____	Irritable Bowel____	Smoker_____
Bacterial Infection____	Diabetes____	Kidney Disease____	Transplants____
Blood in Stool____	Heart Disease___	Lung Disease______	Viral Infection____
Blood in Urine____	Hemorrhoids____	Nausea____	Weight Gain_____
Broken Bones_____	Pain_____	Weight Loss____	
High Blood Pressure_____			

Do you have any other health challenges that concern you?_______________________________
____

Thank you for completing this application. It will be reviewed and a brief phone interview will be scheduled to address any concerns regarding your eligibility for the Clinic Program. We at Natural Sources look forward to being of help to you. If someone is planning to attend with you, they must fill out an application, There will be no exceptions.

I understand and agree to the above written terms of cancellation:

Signed:____ Date:______________________