ThermaLife Registration Form

32 Johnson Drive Braselton Georgia 30517

(770)545-8590 office (706)824-0016 Fax

First Name_____ **Last Name**_____

DOB_____ **Age** _____ **Phone#** _____

Address_____

City_____ **State**_____ **Zip Code** _____

Email_____

Marital Status_____ **How did you hear about us?** _____

ThermaLife Release

I authorize the release of my medical records including diagnosis, records, reports, scans, and laboratory results to and from ThermaLife.

I understand that I am here to learn about food choices, lifestyle, and natural health practices, and that I will be offered information about food, nutritional supplements, herbs, therapies, imaging, and homeopathy, based on sound scientifically supported study. I have come of my own free will and acknowledge that a Board-Certified Naturopath with ThermaLife, LLC will offer assessments based on formal training in natural health, and holistic ministry.

I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnoses or treatment procedures. I am not on this visit, or any subsequent visit, as an agent for federal, state, or local agencies, or on a mission of entrapment or investigation.

The services performed here are at all times restricted to consultation on matters intended for the maintenance of the best possible state of natural health and stewardship of the body, and do not involve the diagnosing, treatment or prescribing of medications for disease.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature_____

Date_____/_____/_____

List any medical problems that other doctors have diagnosed:

List your prescribed drugs, over the counter drugs, and supplements:

General Health

Do you exercise? None_____ Occasionally_____ Regularly_____
Are you on a special diet? Yes_____ No_____ Type_____
Do you use caffeine? None_____ Coffee_____ Tea_____ Soda_____ Cups per day_____
Do you drink alcohol? Yes_____ No_____ How often? _____
Do **you use tobacco?** Yes_____ No_____ How often?_____
Is stress a major problem for you? Yes_____ No_____ Occasionally_____
Are you sexually active? Yes_____ No_____
Do you have any sexual concerns? Yes_____ No_____
Have you had an injection recently? Yes_____ No_____ **Where?** _____
Covid-19 Vaccine? _____ **How many?** _____
Have you had your gallbladder removed? Yes_____ No_____
Have you ever had a biopsy? Yes_____ No_____ Where? _____
Do you have dentures or dental implants? Yes_____ No_____
Do you wear glasses or contacts? Yes_____ No_____
Do you have pain? Where? _____
Any special concerns to address today? _____
_____

Women Only:

Date of last menstrual period? _____**On cycle today?** Yes_____ No_____
Do you still have your ovaries Yes_____ No_____
Do you still have your uterus? Yes_____ No_____
Do you have breast implants? Yes_____ No_____
Have you had a breast reduction? Yes_____ No_____