New Client Registration Form

Last name:_________________________________ First name:_________________________________

DOB:__________Age:______Gender(sex):______Email:____

Address:_____________________________________City:_________________State:______Zip:_________

Phone: (H)____________________ (C):____________________(W)______________________________

Employment: ______________________________________

How did you hear about us? ____________________________

What would you like to achieve in your visit with us?____

____

____

What are your 3 top health goals?

1. ____
2. ____
3. ____

General Information

Height: _________ Weight: ________ Weight 6 months ago: __________ Weight 1 year ago:___________

Highest adult weight: ______________ Desired weight: _____________ Blood Type:_________________

History of eating disorder: □Yes □ No If yes, please explain: _________________________________

____

Medical History (ie. Surgeries with dates, childhood and adult diseases): ____________________________

____

____

Allergies: ____

Recent labs (if known): ____

Family History (if known): ____

____

Women(check all that apply): □Regular Periods □Painful Periods □PMS □Post- Menopausal □Fertility

Comments: ____

Medications and Nutritional Supplements

Medications: ______________________________

____

Vitamins/Minerals: ______________________________

____

Herbs/Botanicals:______________________________

____

Other : ______________________________

Digestive Health

Do you experience : upset stomach bloating burping gas nausea heartburn acid reflux rectal itching (please circle or specify)______________________________

Bowel Movement frequency: how often ___________ per day __________ per week

Consistency: Hard Soft Watery Formed

Do you experience constipation or diarrhea? Please circle or specify______________________________

Do you have blood or mucous in the stool? Please circle or specify______________________________

Rate your digestive function: □ Good □ Fair □ Poor

Comments:______________________________

Food Profile

How many meals do you eat a day? : (please circle) One Two Three Four or more

How much water do you drink per day? (Please circle) None 8-24oz 24-64oz 64oz or more

Coffee (Number of cups per day): ________________ Soda (Number of cans per day):__________________

Tea: (Specify type and number of cups per day)______________________________

Food Allergies or Intolerances: □Yes □No

Comments: ______________________________

____

Percentage of food cooked at home: □90-100% □75+ □<50%

When eating out, where do you eat out and what do you order? ______________________________

____

Food Cravings: ______________________________

List personal "barriers/challenges" to eating well: ______________________________

____

Typical Day

Please list the foods consumed during each meal, the time of the meal and if you usually skip a particular meal,

Breakfast: ______	Lunch:_____________	Evening Meal____	Snacks AM or PM	Typical Beverages

Lifestyle

What do you do to nourish yourself (funhobbies,relaxation):____

Life Stressors: ____

Any healing arts/therapies that you partake on a regular basis :_______________________________________

Marital Status:______________________________ Spouse Name:_____________________________________

Children (names and ages): ____

Sleep: □8+ hours □6-8 hours □<6 hours

Do you wake refreshed? ______________________________

Do you have problems: □ falling asleep □staying asleep □waking up in the middle of the night □waking up in the middle of the night and can't fall back asleep

Energy level : (Please circle your average daily energy level)

(Lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest level)

Stress level: (Please circle your average daily energy level)

(Lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress)

How do you cope with stress? ____

Exercise/Movement Activities (please list): ____

____

How often?: __________ x per day __________per week __________per month

Rarely exercise due to: ____

Personal Habits

Please specify current or past usage of these substances and how much:

Tobacco:____

Alcohol: ____

Caffeine:____

Recreational Drugs:____

RELEASE STATEMENT

I know Michelle Sanderbeck has not, does not, or will attempt to treat, prevent, cure, or relieve a human disease, aliment, defect, complaint, or other condition, whether physical or mental, by attendance or by a device, diagnostic test or other means, or to offer, undertake, attempt to do so, or to hold oneself out as able to do any of these acts.

I know Michelle Sanderbeck is a Doctor of Naturopathy, Certified Natural Health Professional, Quantum Wellness Coach, Loomis Digestive Health Specialist and is proficient in biofeedback. Her sole purpose is to work stressors of the body and to educate as to the historical use of food, minerals, vitamins, enzymes and herbs.

I understand that any suggested minerals, vitamins, enzymes, and herbs are sold as food and nutritional products only. They are not sold for the prevention, cure, treatment, or mitigation of disease.

I understand I am responsible for my own health, healing and wellbeing. I understand that I have the ability to heal myself. I further understand that natural healing is not a substitute for adequate medical care and I intend to remain under the care of my primary medical provider.

I understand that I MUST COMMIT MY OWN PERSONAL EFFORTS to the services provided, and that the success of any program in which I enter will depend on a large degree to my understanding, determination and perseverance.

I understand my identity and any information about me, whether I share it with Michelle Sanderbeck or she discovers it on her own will be held in the strictest of confidence, except when released by me in writing or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time, I also give Michelle Sanderbeck permission in writing to contact my primary care practioner or specialist with regard to the training provided and the results I obtain. I have the right to withdraw this permission anytime.

I acknowledge that my signature indicates that I have read, understand and agree with all of the above statements.

Signature:____ Date:______________

How did you hear about us? ____
Would you like to be informed about upcoming events at Be Well Western Carolina, LLC? (If yes)

Please provide your email address below.
Email: ____

Be Well Western Carolina, LLC
29 Forga Plaza Loop Waynesville, NC 28786
828.734.7702 | www.bewellwc.com

Consent to Heal

I acknowledge that I am responsible for my own health and well-being. I understand that physical, mental, and emotional healing is a collaboration between myself and healthcare provider. Healing does not merely happen to me. Healing is something that I do. I consent to do my part in this collaboration. I understand that Michelle Sanderbeck ND works with the whole person.

I understand that this agreement is for myself and for others in my life. I happily consent, on all parts and on all levels of who I am to heal. I acknowledge that this consent requires that I increase some positive behaviors and decrease negative behaviors.

- I consent to minimize complaining, blaming, irony and sarcasm because I know that they contribute to illness and make it harder to get well.
- I consent to maximize praise and gratitude by expressing these towards myself and others as I understand that this will help me get well.
- I consent to minimize all obsessive worrying and concern about anything at all, including my health problems, because this can make it more difficult for me to get well.
- I consent to acknowledge and rejoice in all improvement in my health.
- I consent to acknowledge all fear of getting well and any gains I get from staying sick so that I can release what hinders my ability to get well.
- I consent to minimize and eliminate all behavior that undermines or sabotages my healing.
- I realize that I deserve to be well.

Signature:____ **Date:**______________

Financial Policies

Payment: Payment for office appointments, supplements and lab tests are due in full at the time of service and/or purchase. For payment we accept cash, check, Visa, Mastercard or American Express. Your insurance companies may reimburse for naturopathic care. Please check your individual coverage to find out more about your benefits and limitations. We do not take insurance or bill insurance in our office.

*Telephone calls greater than 20 minutes are payable at standard office rates.

Delinquent Accounts: If a check is returned due to insufficient funds, there will be a $30 charge added to your account.

Cancellations and No Shows: We require a minimum 24-hour cancellation notice. Charges up to the full visit fee apply to all non-emergency cancellations with less than 24 hours notice.

Supplements: During the course of care, we may recommend certain natural remedies. You have the option of purchasing these supplements at our office or outside the clinic. Payment for supplements is always due at the time of service. Supplements are nonrefundable unless they are unopened and returned within 30 days of purchase.

I understand that I am financially responsible for all charges and agree to abide by this financial policy.

Client/Guardian Signature:___________________________________ Date:_____________

Be Well Western Carolina Education Association

29 Forga Plaza Loop
Waynesville, NC 28786
828.734.7702
michelle@bewellwc.com

Application to Become a Member

I, ____, hereby apply to become a Member of this private education and information sharing association. I include in my membership the members of my family and dependents herein listed on this application.

1. I understand Association is a private education association formed under the First, Fourth, Fifth, Ninth, Tenth and Fourteenth Amendments to the U.S. Constitution and Section Two of the 1982 Canadian Charter of Rights and Freedoms to grant me, my family and my dependents all the rights and protections set forth therein anywhere in the United States and Canada.

2. I understand and assert my right to freedom of expression both spoken and written and the right to freedom of assembly guaranteed to me, my family and my dependents under the First Amendment to the United States Constitution; and under Section Two of the 1982 Canadian Charter of Rights and Freedoms.

3. I understand and assert my right to privacy and the inalienable human right of self-determination and all of the other freedoms guaranteed to me, my family and dependents under the Fourth and Ninth Amendments to the United States Constitution; and under Section Two of the referenced 1982 Canadian Charter.

4. I understand and assert my right for me, my family and my dependents to all of the freedoms and rights not specifically granted to the federal government nor prohibited to the state governments by the Constitution as stipulated in the Tenth Amendment to the United States Constitution; and under Section Two of the referenced 1982 Canadian Charter.

5. I understand and assert all of my civil rights, including the rights of due process and equal protection under the law, guaranteed by the Fifth and Fourteenth

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Initial ______

Amendments to the United States Constitution, and the referenced 1982 Canadian Charter which guarantees these rights to me, my family and my dependents.

6. I hereby invoke my right against self-incrimination for the opinions voiced in any media by myself, my family and my dependents as guaranteed in the First and Fifth Amendments to the United States Constitution, and the referenced 1982 Canadian Charter, on the basis that our opinions are thus protected and may change from time to time.

7. I understand it is my responsibility to maintain strict confidentiality of all communications between me and other Association members. I also understand it is my responsibility to maintain the confidentiality of all communications of an Association member I hear or inadvertently overhear at any time. I further understand that anything I say or write is communicated under the umbrella of this Association and is, and will be held absolutely confidential.

8. I acknowledge and understand the Association coaches are trained and qualified to competently coach, discuss, educate, empower, explain, facilitate, instruct, mentor, supervise, teach, train and tutor me, my family and dependents to make my own decisions regarding my own health, natural therapies, nutrition and wellness of my family and dependents; to demonstrate sills and techniques, and to examine, quiz and test us over knowledge, skills and techniques to empower each other to make all of our own life decisions.

9. I understand I am responsible for the results my decisions have on me, my family and my dependents; and I hold Association and all members of Association harmless for all harm I may cause myself or others because of my decisions; and I take full responsibility for any harm that may be caused to me, my family and dependents as a result of my own decisions.

10. I understand Association has a nondiscrimination policy and does not allow any discrimination of any kind based on age, birthplace, condition, creed, disability, disease, disorder, education, employment, family, family heritage, gender, health issues, heritage, illness, language, livelihood, mental capacity, nationality, opinions, personality quirks, place of residence, race, skin color or any other known or observable difference between people.

11. I understand that this application includes me, my family, dependents and pets for all coaching services requested or approved by me, including: coaching, demonstrating, discussing, educating, examining for knowledge, explaining, facilitating, instructing, mentoring, questioning, supervising, teaching, testing, training and tutoring any of us to empower us to make our own decisions regarding our own health, lives, nutrition, therapies and wellness and that of our dependents and pets.

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Initial ______

12. I declare that I have read and understand this application and am qualified to make this decision to join Association to experience the services offered and learn how to improve and manage my own health, nutrition, therapies and wellness, and that of my family and my dependents.

I confidentially apply to join Association herein disclosed, under Section Two of the Canadian Charter of Rights and Freedoms and the Bill of Rights in the US Constitution. I hereby claim sanctuary under these rights and freedoms, and in token hereof sign this application without prejudice.

_____day of ___________________,20_____.

Signature: ____

Member's Printed Name:____

Complete Address: ____

____

____

Best Phone Contact: ____

Other Phone Contact: ____

Best E-mail Contact: ____

Other E-mail Contact: ____

List of my family members, dependents and pets to be included in my membership:

____

____

____

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