NEW CLIENT APPLICATION

DIRECTIONS:

- Complete to the best of your ability and leave blank the items you cannot or do not want to answer (NOTE: The more information you give at the start, the better we can help you meet your goals).
- There are no right or wrong answers, and the questions of this application are meant to gage where you are currently in your wellness journey.

Name:

Phone Number:

Email:

Gender

Male ☐ Female ☐

Date of Birth:

What services are you requesting?

In-Person ☐ Online ☐

How did you hear about us?

New spaper

Occupation

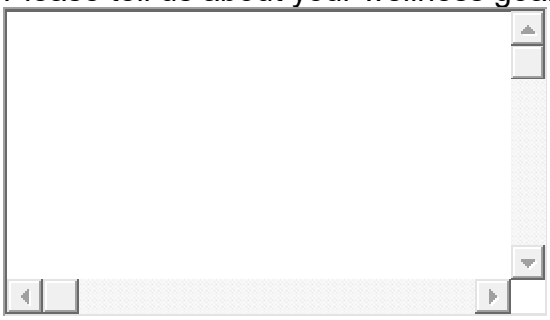
Hours of work per week:

Specific areas you are concerned about (Pick up to 3)

- [ ] Fitness
- [ ] Stress
- [ ] Weight Loss
- [ ] Confidence
- [ ] Strength
- [ ] Conditioning
- [ ] Flexibility
- [ ] Balance
- [ ] Stamina
- [ ] Nutrition
- [ ] Health Issues

Other:

Please tell us about your wellness goals/What you hope to accomplish with us.



How often do you participate in physical activity?

Never

When doing physical activity, for how long do you remain active?

N/A

At what intensity are you physically active? Choose your ability to talk during exercise.

N/A

What is the best way for us to communicate?

- [ ] In Person
- [ ] Phone/Video Call
- [ ] Text
- [ ] Facebook
- [ ] Email

Other:

Do you use social media?

- [ ] Facebook
- [ ] Twitter
- [ ] Instagram
- [ ] LinkedIn

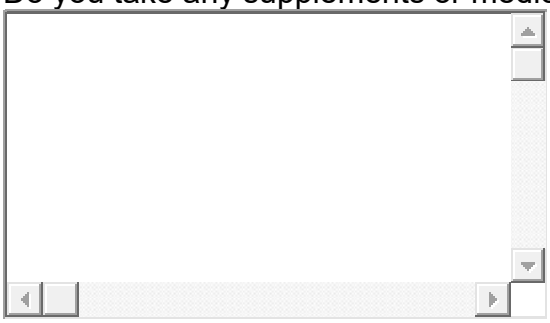
Other(s):

Personal Medical History: Please select if any of the following medical problems apply to you.

- [ ] Heart Disease/Heart Attack
- [ ] Diabetes
- [ ] Depression/Anxiety
- [ ] Bleeding/Clotting Problem
- [ ] High Cholesterol
- [ ] Seizures
- [ ] Cancer (Malignancy)
- [ ] Thyroid Problem
- [ ] OBGYN Problem
- [ ] High Blood pressure
- [ ] Hepatitis
- [ ] Allergies/Asthma

Other(s):

Do you take any supplements or medications? If so, please list:



Do you currently have, or have you had any injuries or illnesses in the last 6 months? If yes, what is/was your injury/illness? If yes, what is/was the date injury/illness started?

Are you currently getting treatment or healed/better? If you are getting or had treatment done, where and by whom?

Food Information: For the last three days, what have you eaten for each category?
Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

Anything you would like to share about your food habits?

DISCLAIMER:

I understand that this does not substitute for medical treatment. Plans are selected for individual therapeutic/wellness benefits. I understand that the Impact Coaches do not diagnose mental or physical illnesses nor prescribe treatment of disease. Even though this is not medical treatment, the Impact Coaches must be aware of existing physical conditions, I have stated any pertinent information.
I have fully disclosed any concerns to Impact Wellness Solutions and its staff. I understand that the plans used are but do waive and release any and all claims for damages I may have against Impact Wellness Solutions and its providers.
I agree to hold Impact Wellness Solutions and its providers harmless and indemnify it for any incidents(s) arise from my use of Impact Wellness Solutions and its provider's facilities, essential oils, advice or treatments.

☐ I Agree

PLEASE ELECTRONICALLY SIGN YOUR INITIALS AND PUT TODAY'S DATE ONCE YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE DISCLAIMER ABOVE (REQUIRED).

Signature: Date:

Thank you for taking the time to apply with us! We will get back to you as soon as possible to help you begin your health and wellness journey!

–Impact Wellness Solutions