

# Trinity Holistic Wellness Center

Reference Number: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M/F Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Work/Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Email: (Please print) \_\_\_\_\_

Marital Status: Single/Married/Separated/Divorced/Widowed Co-Habitat? Y / N Length of Relationship \_\_\_\_\_

Significant Other's (SO) name: \_\_\_\_\_ SO Age: \_\_\_\_\_ SO Sex: Male / Female

How did you hear about us: \_\_\_\_\_

What brings you in today? \_\_\_\_\_

Describe the issue(s): \_\_\_\_\_

## PARENT(S) GUARDIAN OF MINOR

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Work: \_\_\_\_\_ Home: \_\_\_\_\_

## EMERGENCY CONTACT – Who should we contact in case of emergency?

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Work: \_\_\_\_\_ Home: \_\_\_\_\_

## MISCELLANEOUS INFORMATION

Do you have a belief in God or a Supreme Intelligence? Y / N

Is it okay to talk about God or a Supreme Being (no preaching) Y / N

Do you practice your faith regularly? Y / N

Do you pray or meditate often? Y / N

What faith do you consider yourself: \_\_\_\_\_

Describe your Emotional – Spiritual Status: \_\_\_\_\_

Please Initial Each:

\_\_\_\_\_ I understand that if I am more than 10 minutes late, I may need to reschedule my appointment.

\_\_\_\_\_ 24 Hours notice is required to reschedule any appointment. If this notice is not given,  
a missed appointment charge of \$25.00 will be assessed on your account. Your Next appointment  
will require a 50% deposit.

\_\_\_\_\_ Treatment options presented to me require my compliance for best results.

\_\_\_\_\_ Results with any treatment may vary among individuals.

\_\_\_\_\_ Package Pricing is non-refundable. Any credit on an account may be applied to another service.

\_\_\_\_\_ Stem Cell Therapy must be paid in full in advance, no refund given if stem cell therapy appointment is  
missed.

\_\_\_\_\_ Date: \_\_\_\_\_

Name

\_\_\_\_\_

Printed Name