Wellness Guest Pre-Arrival Form

Private and Confidential

Please take a bit of your time to fill in the wellness pre-arrival form in details so that our Wellness Consultant can fully understand your health and lifestyle in order for us to design the best program suitable for you.

Client Details

First Name: _____ Family Name: _____

Program name: _____

Start Date: _____ End Date: _____

Hotel Name (for Outside Guest): _____ Room Number: _____

Date of Birth: _____ Age: _____

Occupation: _____

Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Widow □ Divorced

Number of children (if any): _____ person

Address: _____

Postcode: _____ Country: _____

Email: _____ Mobile: _____

Personal Health Assessment: -

Please indicate if you have had, or are currently experiencing, any of the following conditions:

	Alcoholism		Allergy/hay fever		Alzheimer's disease		Asthma
	Back problems		Auto-immune disease		Blood clots-legs		Bone injury
	Cancer		Blood pressure problem		Cholesterol, elevated		Depression
	Diabetes		Circulatory problem		Dental problem		Drug addiction
	Eating disorder		Eyes, ears, nose, throat problem		Food intolerance		Epilepsy
	Emphysema		Gastritis		Genetic disorder		Glaucoma
	Gout		Heart disease		Chronic Infection		Heart murmur
	Joint disease		Joint injury (Sprain)		Lung problem		Varicose veins
	Mental illness		Kidney/bladder disease		Obesity		Osteoporosis
	Stroke		Migraine/ headache		Ulcer		HIV/AIDS
	Skin problem		Muscle injury (Strain)		Thyroid disorder		Fractures
	PCOS		Inflammatory Bowel Disease		Hepatitis A/B/C		Hemorrhoids
	Fibroids		Irritable Bowel Syndrome		Abdominal surgery		Heart attack
	Seizures		Heart valve problems		Pacemaker		

	Heart surgery		Congestive heart failure		Acute stomach pain
	Liver dysfunction/liver test abnormality				Digestive tract bleeding
	Uncontrolled high blood pressure (over 150mm Hg)				Anal fistulas/fissures
	Pregnancy/ lactation/ Recent childbirth				

Date of last physical exam: _____

Exam result:

□ Normal

□ Abnormal

List of current health problems for which you are being treated:

1._____

2._____

3._____

4._____

5._____

Current medication:

Medication	Dose

Nutritional supplements	Dose

Major hospitalisations, surgeries, injuries: Please list all procedures, complications (if any) and dates:

	Year	Operation, illness, injury	Outcomes
Physical			

Mental & Emotional			
Other			

Menstrual cycle (ladies): Regular Irregular Absent Other _____

Health Habits:

□ Tobacco

_____ cigarettes □ per day □ per week

_____ cigars □ per day □ per week

□ Alcohol

Beer _____ glasses □ per day □ per week

Wine _____ glasses □ per day □ per week

Liquor _____ glasses □ per day □ per week

□ Caffeine

Coffee _____ glasses □ per day □ per week

Tea _____ glasses □ per day □ per week

Soda with caffeine _____ glasses □ per day □ per week

□ Water _____ glasses or _____ litres □ per day □ per week

□ Exercise _____ time per week, _____ minutes each time, type of exercise _____

□ Sleep

7 hour or more □

6 hour or less □

Difficulties falling asleep □

Waking up middle of the night □

□ Diet

Balanced (3 meals/day) □

Healthy □

Relatively healthy □

Unhealthy □

Confidentiality:

ABSOLUTE SANCTUARY agrees to keep and maintain in full confidence and shall not use or disclose to any persons any of the information furnished by you to ABSOLUTE SANCTUARY in this form ("Confidential Information"). Without your

written consent, ABSOLUTE SANCTUARY will not disclose any Confidential Information to any person, except for disclosure (i) pursuant to requirements of law, rules or regulations, a court order, or as a result of legal obligations imposed upon medical practitioners, and/or (ii) to ABSOLUTE SANCTUARY's staff, employees, agents, directors, affiliates, subsidiaries, consultants, shareholders and/or representatives who have a need to know such Confidential Information for the purpose of the services rendered to you.

Disclaimer:

I confirm that the information I have given above is true and correct in all material respects. I understand and accept that during any detox program it is normal for a person to experience a "healing crisis" which can include nausea, headaches, skin outbreaks, light headedness, fatigue and other minor symptoms and that the more toxic my body is the stronger such symptoms may be.

I acknowledge that:

(a) Ultimately the well being of my body and mind are my own responsibility and the decision to sign up for this detox program is mine alone.
(b) Absolute Sanctuary makes no claim to cure or diagnose illness or ailments but that a detox program may be helpful to promote wellbeing and healthy living; and
(c) The practitioners at Absolute Sanctuary are trained and qualified in their fields, but are not medical professionals.
(d) Absolute Sanctuary is not a medical or rehabilitation facility and makes no claim to help cure addictions, medical ailments.
(e) Absolute Sanctuary has its right to refuse any guest for its program without refund if they are medically unfit or contra-indicate for the programs.

In case that the information provided by me in this form is untrue and/or incorrect and/or incomplete, I hereby hold harmless Absolute Sanctuary, its officers and its employees from any liabilities & responsibilities whatsoever and I will have no claims whatsoever and will not take any legal or other action against Absolute Sanctuary, its officers and its employees in relation to my participation in the detox program and treatments provided to me.

CLIENT:

Signed: _____ Date: _____

Full Name: _____