GEOPATHIC STRESS

# ERADICATOR

12 Grovetree rd. Toronto, ON M9V 2Y2

## Health History Form

An accurate health history is important to ensure that it is safe for you to receive any treatment. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Signature _____ Date _____

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Name:_____ Telephone:_____

Address:_____

Date of birth:_____ Weight:_____ Height:_____

Occupation:_____ E mail: _____

Where did you first hear about Eradicator?_____

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**Health History: Please check the conditions that you are currently experiencing, or have experienced often in the past.**

current previous

### Head/Neck

o - o headaches
type_____
o - o vision problems
o - o contact lenses
o - o earaches

### Respiratory

o - o chronic cough
o - o shortness of breath
o - o smoking
o - o breathing problems
type_____

### Cardiovascular

o - o high blood pressure
o - o low blood pressure
o - o poor circulation
o - o heart disease
o - o stroke
o - o varicose veins
o - o cholesterol

### Other medical conditions?

_____
_____
_____
_____

current previous

### Skin

o - o skin conditions
o - o type_____
o - o bruise easily

### Other Conditions

o - o difficult digestion
o - o constipation
o - o liver_____
o - o gall bladder_____
o - o kidney_____
o - o bladder _____
o - o diabetes, onset _____
o - o sinus
o - o allergies _____
o - o insomnia
o - o cancer_____
o - o arthritis
affected areas _____

### Infections

| | current-previous |
|---|---|
| herpes | o - o |
| hepatitis | o - o |
| plantar warts | o - o |
| TB | o - o |
| HIV, AIDS | o - o |
| other _____ | |

current previous

### Muscle pain/stiffness

o - o neck
o - o lower back
o - o upper back
o - o shoulders
o - o leg: left/right
o - o knee: left/right
o - o other _____

### Woman

o - o menstrual problems
o - o caesarian section or other
o - o gynecological surgery _____
_____
o - o pregnant: due date_____
children: number_____
o - o menopausal problems_____
_____

### Surgery

Type_____
Date_____
Current symptoms
_____
_____

### Injury

Type_____
Date_____
Current symptoms
_____
_____

### Medical Doctor

Name_____
Phone_____
Date of last visit
_____

### Current Medications

| Name | For what condition? |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

# Statement of acknowledgement

1. That you understand that the practitioners in this clinic are not Medical doctors, that we use non-invasive, natural methods of assessment and treatment of body dysfunctions.
2. That you understand that the methods utilized in this clinic, may not be an accepted by standard (allopathic) medicine.
3. That you are not an agent of any private or governmental agency attempting to gather information without stating your intentions.
4. That you are accepting or rejecting this care of your own free will.
5. That you understand that the ultimate responsibility for your health care is your own and that we are here to support you in this. We reserve the right to discontinue our services where it is apparent that your expectations and what we provide is not in agreement.
6. That you understand that fees are payable at the time of the appointment by you.
7. 24 hour notice is required for appointment cancellation, otherwise you will be responsible for the full fee. Any special financial arrangement may be made with your practitioner.

**Limitation of Liability**

In consideration of the acceptance of this Application/Agreement and the services to be rendered by Eradicator and the facilities to be made available to you, you (and your heirs, executors, administrators, successors and assigns) hereby release, waive and forever discharge Eradicator and its employees, officers, directors, shareholders, agents, representatives, successors and assigns of and from all claims, demands, damages, costs, expenses, actions and causes of action, whether in law or equity (collectively, "claims") in respect of death, injury, loss or damage to person or property however caused, arising or to arise by reason of the negligence of Eradicator or during the Applicant's attendance at the facilities operated by Eradicator, and notwithstanding that any such claims may have been contributed to or occasioned by the negligence of any of the aforesaid.

This Waiver and Release of liability includes, without limitation, injuries which may occur as a result of (a) the Applicant's use of any equipment or facilities which may malfunction or break; (b) improper maintenance by Eradicator of any equipment or facilities; (c) negligent instruction or supervision by Eradicator; (d) the Applicant following any program of diet and/or remedy and/or equipment on the recommendation of Eradicator or any of the aforesaid; and (e) the Applicant slipping and falling while on the premises of Eradicator 12 Grovetree rd. The Applicant hereby waives any right that the Applicant may have to bring a legal action to assert a claim against Eradicator for the negligence of Eradicator.

The Applicant hereby acknowledges that she/he has carefully read this Waiver and Release and fully understands that it is a release of liability. The Applicant further undertakes to hold and save harmless and agree to the above release, waiver and indemnity.

I,_____ have read, understood and acknowledge the above statements.

Signature _____ Date _____