LIVING WELL DALLAS | 14330 MIDWAY RD, SUITE 121, DALLAS, TX 75244 | 972-930-0260

First Name:	Last Name:	Date of Birth:
Prefer to be Called:	Marital Status (Circle): Single Married Partnered Widowed Separated	Age:
Street Address:	City:	State: Zip:
Preferred Phone (Circle): home work cell	Alternate Phone: home work cell	May we leave a message on your preferred phone? ○Yes ○No
Employer:	Occupation:	SS#
Emergency Contact Name: Emergency Phone(s):	Preferred email:	Primary Care Physician:
List any drug allergies:	Preferred Pharmacy:	List any food allergies:

What is your main reason for your visit today?

Which Services Interest You:

- ○ acupuncture
- ○ aromatherapy
- ○ Biofeedback
- ○ bio-identical hormones
- ○ Bowen technique
- ○ Chiropractic
- ○ craniosacral therapy
- ○ counseling/therapy
- ○ detox program
- ○ energy medicine
- ○ energy medicine
- ○ emotional freedom technique
- ○ frequency specific microcurrent
- ○ functional medicine
- ○ food allergies testing
- ○ health coaching
- ○ Healing Touch™
- ○ HeartMath™
- ○ life coaching
- ○ massage
- ○ men's health
- ○ nutritional testing
- ○ metabolic blueprint
- ○ nutrition counseling
- ○ organization
- ○ rapid eye technology
- ○ Reiki
- ○ walk & talk therapy
- ○ wellness
- ○ weight loss

Would you like to receive our newsletter? ○**Yes** ○**No** *(we will never sell your name)*

Cancellation & Re-Scheduling Policy

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

Please know that all cancellations and/or rescheduling requests must be made at least two business days prior to the date of your appointment. If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be "missed" and charged for the full session fee. Thank you for your understanding.

( ) **I understand and accept this policy**

_____ _____

Your Signature **Today's Date**

Records and Privacy Policy: We will not release your records to anyone without your written consent. Because this is an integrated practice with multiple practitioners, we may facilitate care by having only one record per client. Coordinated care by your chosen practitioners will always be done with respect for your personal privacy and confidentiality.

( ) **I understand and accept this policy**

_____ _____

Your Signature **Today's Date**

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:health & wellness center:

Please list the siblings in your family, including yourself, in birth order. Please include half and step siblings.

1._____ 4._____

2._____ 5._____

3._____ 6._____

Please list your children, in birth order. Please include any adopted children, or pregnancies lost prior to birth.

1._____ 4._____

2._____ 5._____

3._____ 6._____

Your mother's name: _____Living? _____

Your father's name: _____Living? _____

What term to do prefer to use in reference to God? _____

Please list any major diseases that you or anyone in your mother's or father's direct line have experienced:

Self:

Mother's Line:

Father's Line:

List any cravings, fears, phobias, or habits that have become bothersome:

Please list any major traumas that you have experienced in your lifetime and the age at which you experienced them. Remember to include anything that had a strong emotional response at the time, even if it seems insignificant now.

What are the top three issues that you would like to address?

1. _____

2. _____

3. _____

** On the back, list other healing modalities that you have experienced, your approximate age at the time, and a brief note on your result/response to that modality.**

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:health & wellness center:

Rapid Eye Technology Legal Waiver

I am attending Rapid Eye sessions and working with Suzan Jonz-Perez, MRET, of my own volition. I understand that Suzan Jonz-Perez, MRET, the person facilitating these sessions, is a Master Rapid Eye Technician and is not a counselor or physician. I take full responsibility for my health and for the decisions that I make as a result of Suzan Jonz-Perez' recommendations.

I understand that Suzan Jonz-Perez, MRET, is a certified Master Rapid Eye technologist trained to use the Rapid Eye techniques to facilitate stress reduction and personal growth. I take responsibility of updating Suzan Jonz-Perez of all known medical or mental conditions I am now, or may later become aware of; and it has been made clear to me that said sessions are not a substitute for medical examinations and/or diagnosis by physicians.

I hereby release and discharge Suzan Jonz-Perez and Living Well Dallas, Inc. from any and all claims that I or my family or heirs, have or may have, now or in the future. I have read and understood all of the above, and agree to proceed under these conditions.

I understand that the above is meant to have legal significance and be legally binding.

_____

Print your full name

_____

Sign your full name

_____

Today's date

06/07

LIVING WELL
health & wellness center
14330 Midway Rd | Bldg 1, Suite 121 | Dallas, TX 75244
Ph# 972.930.0260 | Fax# 972.559.3648

Rapid Eye Technology
Pricing and Packages

Single Session
$175

12 sessions in 4 months Package
$450/month ($150 per session, $1800 total)

12 Sessions in 6 months
$320/month ($160 per session, $1920 total)

6 sessions over 2 or 3 days
$900 ($150 per session)

Suzan is available every Wednesday and Friday for individual sessions. Please contact Suzan for questions regarding which plan will best meet your needs.

972.768.9892
suzan@livingwelldallas.com

** We offer Care Credit as an interest-free option to pay for your health and wellness services obtained at Living Well Dallas.

Prices good through 12/31/11