PATH OF LIFE HEALING CENTER
Presents DETOX RESET RETREAT

BRINGING PREVENTIVE, RESTORATIVE, AND SUSTAINABLE
HEALTH SOLUTIONS TO THE WHOLE PERSON.
GUEST LIFESTYLE ASSESSMENT APPLICATION FORM

CONFIDENTIAL

Please Note: The information received during this program and/or any services, or any future programs or interactions, and/or any services, is for general education and community service, and is not intended to supply specific medical care or advice. No medical care, treatment, or diagnosis is provided during this program, and/or services. It is advisable to consult with one's personal health care provider before implementing any lifestyle changes.

I release Path of Life Healing Center, or associated persons, facilities, and/or organizations from any and all liability. Participation in this program indicates acceptance of all these and additional terms found in our Liability Release Waiver.

Please Choose Your Stay:

For Best Results:	_____ Participate in the Ten-Day Program (Detox, Reset, Revitalize)
Next Best:	_____ Participate in the Seven-Day Program (Detox & Reset)
No Time to Get Away:	_____ Participate one day at a time on a Daily Healthy Pass

Signature: _____ Date: _____

Please email the completed form to **vkalu@pathoflifehealing.com**
On the email subject line indicate: **Detox Retreat – Add Your Name**

GENERAL INFORMATION:

Name: _____

Address: _____

Phone: Main (____) _____

Email Address: _____

Optional:

Religious Affiliation (if any): _____ Length of affiliation? _____

Age: _____ Birthdate: _____ Gender: Male: ____ Female____ Prefer not to say: ____

Marital Status (circle one): Single, Separated, Married, Divorced Widowed

Weight: _____lbs. Height: _____

Emergency Contact Name: _____

Cell and Email: _____

List any health concerns you have (physical, mental, social, or spiritual): _____

_____

_____

What specific condition/s would you like this program to address? _____

_____

_____

When did you last consult a physician? _____

Are you currently being treated for any ailments? Yes /No If yes, which ones? _____

_____

Please list any surgery that you have had (include date/s): _____

_____

_____

What diseases have you been diagnosed with? (please list all): _____

_____

_____

Do you have any family history of disease? If so, please list all. _____

_____

_____

Do you have any skin or feet issues such as athlete's feet, eczema, ring worm, etc… _____

Are you vaccinated? _____ The type? _____ How many boosters did you receive? _____

Do you have any children? If so, what ages? _____ Are they healthy? _____

Blood Pressure: _____ / _____ Sodium: _____ Hemoglobin A1c: _____

Glucose: _____ Postprandial (2 hours after meal): _____

Cholesterol: _____ HDL: _____ LDL: _____ Triglycerides: _____

Sedimentation Rate: _____ C-Reactive Protein: _____

List any values on your labs that are out of range: _____

_____

_____

Are you presently experiencing any of the following: (please circle)		
□ Dizziness	□ Numbness	□ Bad body odor / □ Bad Breath
□ Fainting	□ Clammy skin	□ Excessive sweating
□ Nausea	□ Cold hands or feet	□ Hair loss
□ Pain: Where _____	□ Constipation	□ Fever
□ Heart palpitations	□ Diarrhea	□ Infections
□ Fatigue	□ Indigestion / Acid Reflux	□ Bleeding
□ Headaches	□ Cold / Flu	□ Weight loss
□ Memory loss	□ Blurred vision	□ Weight gain
□ Insomnia	□ Swelling anywhere	□ Sexual dysfunction
□ Difficulty breathing	□ Parasites / □ Worms / □ Mold	□ Anemia
□ Other:		

Please clearly list any food and environmental allergies, and/or allergies of any kind (please be specific). _____

_____

_____

Do you suffer from any of the following emotional / mental disorders? (please circle)

Depression: _____	Chronic Anxiety: _____	Bipolar: _____
Codependency: _____	Mania: _____	Schizophrenia: _____
Phobias: _____	OCD: _____	Neurosis: _____
Other:		

Are you experiencing any addictions or substance abuse? Yes / No (If yes, please list below):

_____

Are you currently suffering from any eating disorders? (please circle all that apply):
Anorexia Bulimia Binge Eating Other: _____

Please list all medications and / or pills, prescription or otherwise, you are currently taking (or have taken in the past 60 days): List usage, dosage and what they were/are prescribed for:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list all supplements and / or herbs that you are taking or have taken in the past 60 days (vitamins, minerals, nutritional drinks, etc.).

_____

_____

_____

_____