A NEW (Daly) BEGINNING

Wellness Application

Please return form to representative or email to ANewDalyBeginning@gmail.com

All information contained in this questionnaire is strictly confidential and will become part of your medical record.

Name: _____ **Today's Date:** _____

Address: _____ **Date of Birth:** _____

City: _____ **State:** _____ **Zip Code:** _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

E-mail Address: _____

Home Phone: _____ **Cell Phone:** _____

Occupation: _____ **Are You Currently Working?** _____

Annual Household Income: _____ **Emergency Contact:** _____

Emergency Contact Relationship: _____ **Emergency Contact Phone:** _____

PERSONAL HEALTH HISTORY

Type of Cancer: _____ **Date of Diagnosis:** _____

Any Surgeries: _____ **Date of Surgery:** _____

Allergies: _____

Skin Concerns: _____

Massage Concerns: _____

How the patient program works:

Client participants must fill out a Wellness Application and have the Medical Release Form completed and signed by a medical professional. Once approved, the client will be scheduled for their 1st appointment. When scheduled, the patient will be e-mailed the full Medical Intake Form and Medical Release. The 1st appointment will be a ½ hour history intake, and a ½ hour treatment. At the intake the Medical Intake Form is discussed between the client and an Oncology trained Esthetician or Oncology trained Massage Therapist depending on the service being received. If the client is receiving a skincare treatment, sample products are given at the end of the service for home use. The client is then entitled to 2 more complimentary treatments. They can choose between a skincare treatment or massage. An educational session on varied numbers of important topics regarding their treatments is included. Participants are encouraged to continue with reduced cost treatments when complimentary ones have ended.

Confirmation

I confirm that I understand all the guidelines terms and services of ***A New Daly Beginning, Inc***.
I have entered all information above in truthful and honest answers providing information to the best of my ability.

Patient Signature _____ **Date** _____