ESSENCE OF EXCELLENCE
YOU ARE THE ROYALTY OF YOUR HEALTH

JAPONICA WALKER, BA, CNC, CPT, CHS
RELEASE AND CONSENT FORM

FIRST NAME: _____ **LAST NAME:** _____

STREET: _____**CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE: _____ **EMAIL:** _____

DATE OF BIRTH: _____ **GENDER:** _____ **HEIGHT:** _____ **WEIGHT:** _____

ASSUMPTION OF RISK, WAIVER OF LIABILITY, INDEMNIFICATION AND HOLD HARMLESS ACCEPTANCE

I, _____, ACKNOWLEDGE THAT:

1. **I HAVE BEEN INFORMED OF THE NEED OF MEDICAL APPROVAL BEFORE JOINING IN THE TOTAL HEALTH AND WELLNESS PROGRAM DESIGNED FOR ME, WHICH INCLUDES BUT NOT LIMITED TO: MIND, BODY, SPIRIT, NUTRITIONAL, SUPPLEMENTATION, AND FITNESS/TRAINING PROGRAM AND PROGRAM AND ANY OTHER RECOMMENDATION THAT WILL AID IN BRINGING IN MY WHOLE PERSON INTO BALANCE. I UNDERSTAND THIS A NATUROPATHIC DOCTOR IS NOT A LICENSED MEDICAL DOCTOR**
2. **I AGREE THAT ANY INFORMATION, INSTRUCTIONS, OR ADVICE OBTAINED MAY NOT BE USED FOR A SUBSTITUTE FOR MY DOCTOR'S ADVICE OR TREATMENT**
3. **I AGREE TO RELEASE AND DISCHARGE ANY AND ALL RESPONSIBILITIES OR LIABILITIES FROM INJURY ARISING FROM MY PARTICIPATION IN ANY RECOMMENDED PROGRAM.**
4. **I UNDERSTAND THAT RESULTS ARE INDIVIDUAL AND MAY VARY.**

SIGNATURE _____ **DATE** _____

SIGNATURE OF GUARDIAN,
IF UNDER 18: _____ **DATE** _____

MEDICAL HISTORY
PLEASE CHECK THE ONE(S) THAT APPLY TO YOU

○ CONSTIPATION ○ HIGH BLOOD PRESSURE ○ DIABETES ○ PREGNANT ○ INSOMNIA ○ CANCER ○ BULIMIA ○ GASTRIC SURGERY	○ DIARRHEA ○ LOW BLOOD PRESSURE ○ MENOPAUSE ○ ANOREXIA ○ FOOD ALLERGIES ○ HEART DISEASE ○ SEIZURES ○ SKIN PROBLEMS	○ DEPRESSION ○ MIGRAINES ○ THYROID ISSUES ○ INCONTINENCE ○ GALL BLADDER ISSUES ○ SLEEP APNEA ○ OTHER: _____
MEDICATIONS:	**ALLERGIES:**	**VITAMINS/MINERALS/HERBS:**