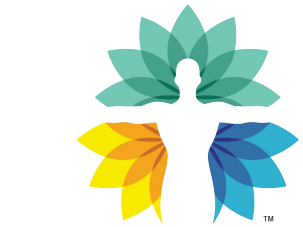

2 North Main Street
Payson, UT 84651
702-417-8522

Patient/Client/Friend Intake Form

First Name: _____ Email: _____(office use only)

Last Name: _____ Gender: Female ___ Male ___

Date of Birth: ___/___/___ Phone: _____

Social Security #: _____ Address: _____,State___Zip:_____

Height:_____ Weight:_____ Marital Status: _____

Spouse's Name:_____ Number of Children: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How Did You Here About Balanced Health?

From Another Healthcare Provider: _____ Family Member: _____

Friend: _____ Co-worker: _____

Social Media: _____ Advertising: _____

Health Insurance Information:

Provider: _____ Responsible Party: _____

ID # or Policy #: _____ Group: _____

Here at Balanced Health we work with you as a team to improve your health and human potential. We don't ask the typical health questions, we ask questions that are designed to get to the root of your health challenges or opportunities. We are grateful to partner with you in your health journey.

Please list the 5 most important health problems you would like help improving:

1. _____
2. _____
3. _____
4. _____
5. _____

Who is responsible for your health? _____

Do you really want to improve your health? _____

What are you willing to do to improve your health? _____

Do you love your life? _____

Do you love your work/job/home? _____

Do you feel you are fulfilling your life's purpose? _____

Do you feel like you are growing as a person? _____

What do you think might lie at the root of your health challenges?

_____

_____

What does your body need in order to heal? _____

_____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office.
I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

*** I agree with this statement of authorization: _____ sign & date.**