Wuji Wellness, LLC
480 456 1646

Personal Information

Date: _____

Name : _____ **Sex** : __ **M** __ **F**

Address: _____

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

Daytime Phone # :_____ **Evening Phone #**:_____

Cell Phone #:_____ **Email Address**:_____ _____

Date of Birth: _____ **Occupation**:_____ _____

Employer:
_____

Marital Status: ___ **Single** ___ **Married** ___ **Partnered, not married**

Children's Name and Ages : _____

_____

Name of Spouse/ Significant Other:_____ _____

Benefits you hope to attain from this service_____

Check all that apply:

___ Reduce Pain
___ Improve circulation of fluids & elimination
___ Normalize body functions
___ Improve sleep and quality of rest
___ Lower Anxiety
___ General Health
___ Mind-Body-Spirit- Balancing
___ Feel Better!
___ Prepare for surgery
___ Address special concern: _____
___ Release effects of trauma

Preferred Appointment Day and Time: _____

Primary Health Care Provider: _____

Provider's Address: _____

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

Telephone #: _____ **Extension**: _____

Permission to Consult with Primary Provider? ___ No ___ Yes _____(please initial if yes)

In case of Emergency, Please Notify:

Name: _____ **Telephone #**: _____

Relationship: _____ **Cell Phone #**:_____