



ATLANTIS SALUD

combining ancient wisdom

with 21st century

natural therapies

Hello, and thank you for making contact,

Find below **Client information form**. This information you provide is complete confidence and will be used internally and with other medical staff we consult with to help with your program and recovery.

You will also receive an email. From us regarding **DROPBOX**.

Dropbox is a file hosting service operated by the American company *Dropbox, Inc.*, For you and me, it means we can have one location, that you can securely place documents, images, and all your reports. What you place in this folder you save on your computer or use online, we can see. What we place in this folder, you can see. It is that simple, it's a shared location for all documents, images, and your program.

Once the below form is completed, we should schedule a new consultation. Using WhatsApp +593993919977 please write or TEXT to that number and request a time or call the office directly.

Consultations are **Tuesday and Thursday in the afternoon**.

Anytime if you need a quick question answered. Write in **WhatsApp**.

Evenings for group family consultations and monthly program review **SKYPE**

At our facilities, early morning we are doing IV therapies, most afternoons after 2 pm we can sit down and have a chat. But Tuesday and Thursday we do not have face to face appointments, so we can help those at home.

Please supply the following with this form.

Blood tests

Scan reports

Details of any food allergies

Expected dates of reports you have ordered?

Details of past traditional and Natural; or Alternative therapies you have done, and if and what side effects good or bad that you experienced.

Regards,

The Atlantis Team

<https://www.atlantis-health-retreat.com/>

In Confidence
Atlantis Health ReTreat S.A.

Your Name _____

Age _____ **Today's Date** _____

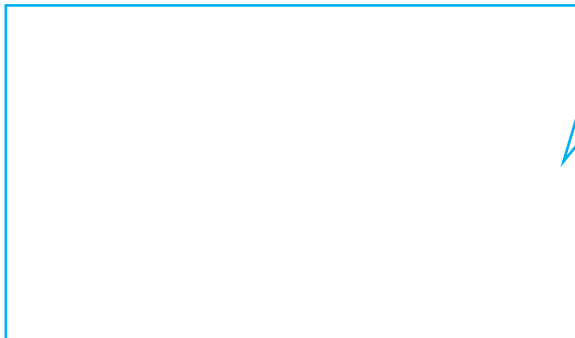
Reason for first making contact _____

Person at Atlantis who has spoken with you? _____



Please insert a current photo here

Please place a copy of ID or Passport here
This is required for our accounting program
And to not charge you sales tax if we are supplying products or services to countries outside of Ecuador.



Male Client History and Membership Form

Date: / / 2020

Member No:

Main Contact Person:

..... Email.....

Client Needing Help Details:

Date of Birth: / / Age ID #.....

Email Address:

Home address

..... State: Postcode:

Telephone Client.....

Telephone Partner/friend:

Family Emergency Contact.....

Occupation:.....

How did you hear about us?

Friend Seminar Advertising Another practitioner Internet

Give details.....

I consider myself: Fit Reasonably Fit Reasonably Unfit Unfit

Personal History:

.....
.....

Any Surgeries?

.....
.....

Family History:

.....
.....

General Medical History

Blood Group: A, B, AB, O (Please indicate + or – if known)

How many children do you have?

Primary Health Complaint (Health Challenge 1):

.....
.....
.....

First Noticed:

Known Cause:

Have you had any surgery? If so, what kind and when:

.....

Previous Tests:

Previous Treatment:

Efficiency of Treatment:

Expected Outcome According to your Doctor:

.....

Are you taking any prescription and/or non-prescription medication?

If so, please list the drug and its purpose:

.....

.....

Are you presently under the care of a doctor?

If so, for what illness or purpose:

.....

List details of supporting reports placed in DROPBOX

- 1)
- 2)
- 3)
- 4)
- 5)



General Medical History

Do you have allergies to any of the following?

Herbs Foods Pollens Vitamins Medicines Other

If so, please list and include your reaction:

.....

Do you smoke? Yes, No Passive Quit When?.....

How often?/day

Do you consume alcoholic beverages? Yes No glasses/week

Are you currently on a specific diet? Yes No

Detail:

This diet is for what purpose?

.....

.....

Please detail below any nutritional supplementation you may be taking and why:

.....

.....

How do you rate the level of stress in your life right now? High Medium Low

Detail:

.....

.....

How do you rate your energy level throughout the day:

Morning: High Medium Low

Noon: High Medium Low

Night: High Medium Low



List your 5 Health Challenges- complaints

Below is space available for you to list your health challenges in the order of the most to the least intrusive.

For example, Health Challenge 1: This is your primary complaint
 Health Challenge 2: Sharp pain in right shoulder
 Health Challenge 3: Constipation
 Health Challenge 4: Lower back pain
 Health Challenge 5: Rash on left leg

The next step is to rate the intensity of each of the challenges on a scale of 1 to 10. 1 meaning it does not concern you, 5 meaning you put up with it but you would like it gone, and 10 meaning it prevents you from doing certain things and you urgently need to address this challenge.

HHealth Challenge 1: (this is your primary health challenge from the previous page)

.....

Detail:

.....

Rating: 0 1 2 3 4 5 6 7 8 9 10

HHealth Challenge 2:

Detail:

.....

Rating: 0 1 2 3 4 5 6 7 8 9 10

HHealth Challenge 3:

Detail:

.....

Rating: 0 1 2 3 4 5 6 7 8 9 10

HHealth Challenge 4:

Detail:

.....

Rating: 0 1 2 3 4 5 6 7 8 9 10

HHealth Challenge 5:

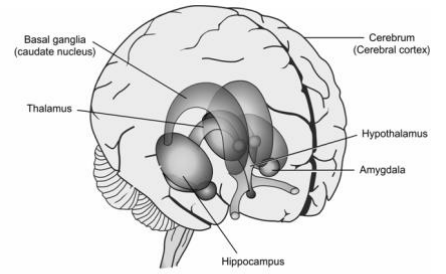
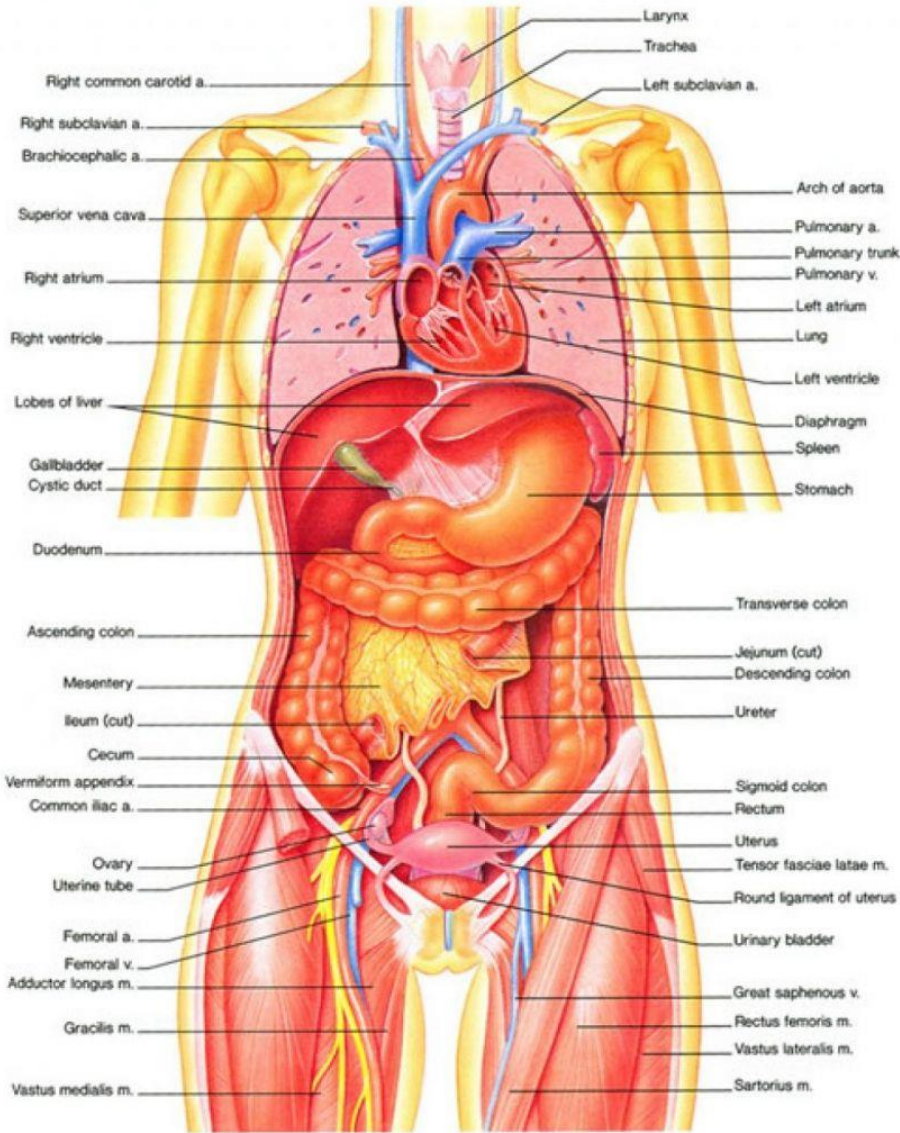
Detail:

.....

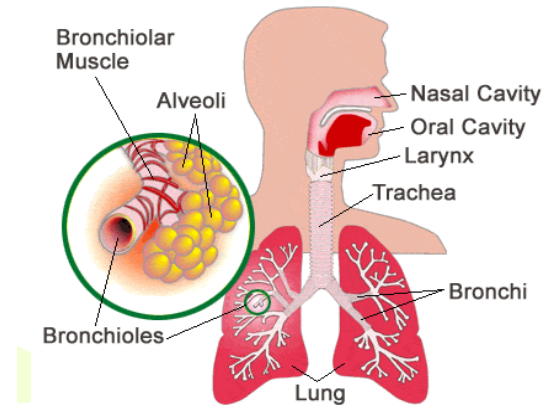
Rating: 0 1 2 3 4 5 6 7 8 9 10



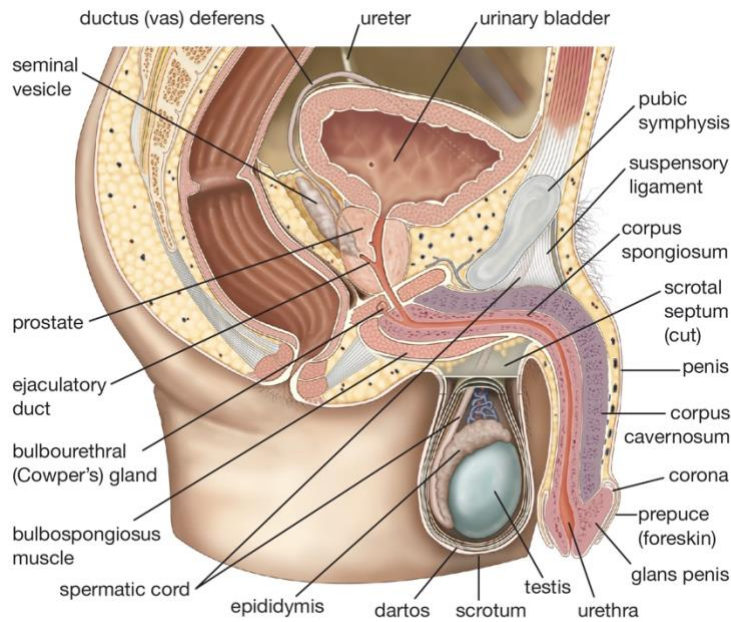
In Confidence
Location of Health Issues, this is important.



Inner structure of the human brain, including the limbic system.



IS

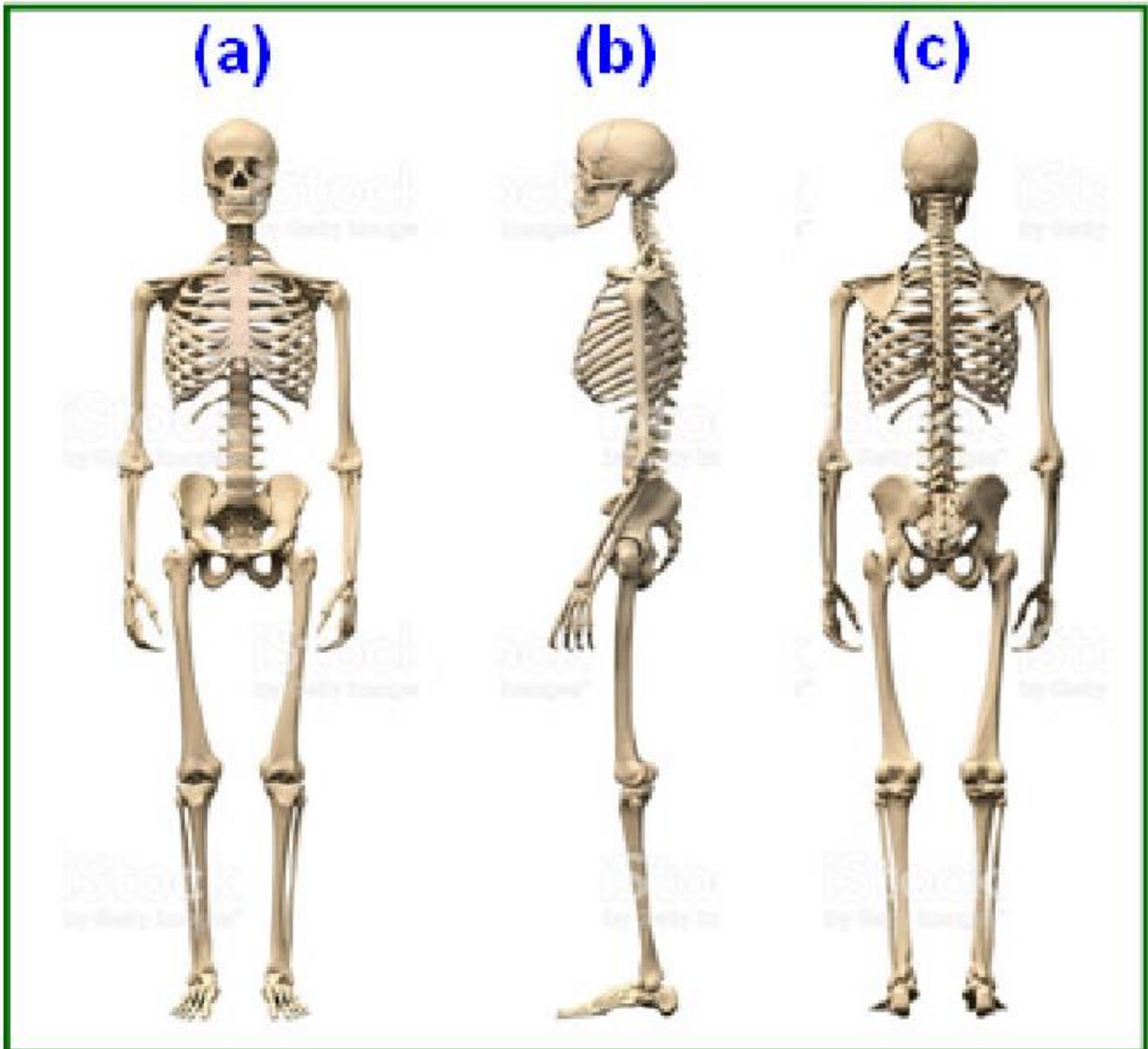


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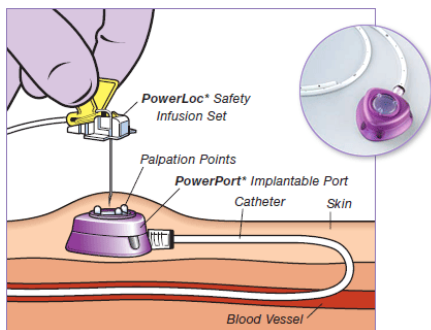
skeleton (Bone Issue's)

Primary: Please indicate as 1
Secondary: Please indicate as 2
Other: Please indicate as 3
Other: Please indicate as 4
Description:
Other: Please indicate as 5

Description:
Description:
Description:
Description:
Description:



Do you have a PORT? Y. - N



In Confidence

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No

Payment Details: At Atlantis, cash payments up to \$100 are possible in the office. All other payments are by arrangement or by **International Bank Money Order**. Please confirm the required payment details before you make the payment.

To Ecuador

BANK in Ecuador (USD is our currency.)

- Name of the bank: BANCO DEL PACIFICO
- Checking Account #: 07902069
- Address of the bank: P. Icaza 200 y Pichincha
Guayaquil-Ecuador
- Swift Code: PACIECEG
- Phone: +593 43731500

Beneficiary,

- Company Tax/RUC No: 0992918950001
- Name: Atlantis Salud Spa S.A.
- Address: Av. Malecón y Atahualpa, Edificio Punta Pacifico
Local 1-2
Chipipe-Salinas
SANTA ELENA 241550
Phone: +593 995135303 Karina Administration Director

PATIENT DISCLOSURE

I understand that any Reports generated from my images or discussion is intended for use by trained Atlantis care providers to assist in evaluation, diagnosis and or treatment. I further understand that any reports or programs or systems provided are not intended to be used by individuals for self-evaluation or self-diagnosis.

I understand that any reports by Atlantis or other staff will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the Thermo graphic findings discussed in the Report or bloods tests taken. You agree and accept our Disclaimer, terms and conditions detailed on the website.

By signing below, I certify that I have read and understand the statements above and consent to the above evaluation and recommended programs. I understand that I will be sent another form to fill in and an invoice. This invoice is only payable if I choose to become a member of The Atlantis System.

Signature.....Today's Date:

Witness.....Today's Date:

CONFIDENTIAL

FAX or/and Email WARNING: This fax and accompanying documents are for use of addressee only. Any review/use is STRICTLY PROHIBITED
If received in error, please notify us immediately & call.
USA-Canada Toll Free +1 1-877-891-1368