Stargate Clinic PMA - Comprehensive Intake & Membership Agreement

Full Name: _____

Date of Birth: _____

Phone: _____

Email Address: _____

Today's Date: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Relationship: _____

Primary Wellness Goals: _____

Known Allergies: _____

Relevant Medical or Surgical History: _____

Current Medications & Supplements: _____

Please check all that apply:

[] I am currently pregnant

[] I am currently nursing

[] I am undergoing cancer treatment

[] I have a pacemaker or electronic implant

[] I have epilepsy or a seizure disorder

[] I am on anticoagulants

[] I have an autoimmune disorder

[] I am taking pain or psychiatric medications

[] I acknowledge therapies are not FDA evaluated

[] I understand results may vary and no guarantees are made

[] I grant permission for testimonial/image use

[] I DO NOT grant permission for testimonial/image use

[] I understand I am joining a Private Membership Association

Member Declaration & Signature

By signing below, I agree to participate in Stargate Clinic PMA services as a voluntary member, and I acknowledge and accept the terms outlined above regarding the nature of the services and their legal and insurance distinctions.

Signature: _____ Date: _____

Printed Name: _____