Health Questionnaire

Print name: _____ Age _____
First Last

Cell phone # _____ Alternate phone # _____

Email _____

What issues do you want to resolve? _____

_____

What is your medical diagnosis? _____

Any body parts surgically removed? _____ Did you get the COVID shot(s)? _____

CURRENT CHALLENGES

Abnormal Cells / Cancer	☐ YES ☐	Environmental Allergies	☐ YES ☐	Nerve Pain / Numbness	☐ YES ☐
Acne	☐ YES ☐	Epilepsy	☐ YES ☐	Not Sleeping Well	☐ YES ☐
Anxiety / Panic Attacks	☐ YES ☐	Fatigue	☐ YES ☐	Obesity	☐ YES ☐
Asthma / Bronchial	☐ YES ☐	Frequent Colds	☐ YES ☐	Pain	☐ YES ☐
Autoimmune Condition	☐ YES ☐	Hair Loss	☐ YES ☐	PMS	☐ YES ☐
Back Pain	☐ YES ☐	Headaches / Migraines	☐ YES ☐	Pregnant	☐ YES ☐
Bladder Issues	☐ YES ☐	Heart Issues	☐ YES ☐	Prostate issues	☐ YES ☐
Blood Sugar	☐ YES ☐	Heartburn	☐ YES ☐	Restless Legs	☐ YES ☐
Bone Loss	☐ YES ☐	High Blood Pressure	☐ YES ☐	Seasonal Allergies	☐ YES ☐
Bowel Issues	☐ YES ☐	Infertility	☐ YES ☐	Sinus Issues	☐ YES ☐
Breast Pain / Lump	☐ YES ☐	Joint Pain	☐ YES ☐	Skin Issues	☐ YES ☐
Breathing / Lung Issues	☐ YES ☐	Kidney Issues	☐ YES ☐	Teeth Problems	☐ YES ☐
Chest Pain	☐ YES ☐	Libido Issues	☐ YES ☐	Thyroid Issues	☐ YES ☐
Circulation Issues	☐ YES ☐	Liver Issues	☐ YES ☐	Tired / No energy	☐ YES ☐
Constipation / Diarrhea	☐ YES ☐	Medications	☐ YES ☐	Trauma/Emotional Pain	☐ YES ☐
Depression	☐ YES ☐	Memory	☐ YES ☐	Urinary Urgencies	☐ YES ☐
Digestion / Bloating	☐ YES ☐	Menopause	☐ YES ☐	Vertigo / Dizziness	☐ YES ☐
Emotional Issues	☐ YES ☐	Mood Swings	☐ YES ☐	Water Retention	☐ YES ☐

	Alcohol	Bowels Move	Eat Fish	Exercise	Sugar	Sweeteners	Fast Food	Cigarettes
# PER WK								

Diet is mostly: Meat, Vegetables, Fruits _____ or Carbs/Grains/Sweets & Junk Food _____

Do you usually get flu shots or vaccinations? _____ Known allergies? _____

Root canals? _____Mercury silver-colored amalgams? _____ Seeing other health professionals? _____

I understand that no doctor-patient relationship exists, but only a contract member-to-member Association relationship. I understand that no prescription or medication, or medical advice should be altered without consulting with my medical doctor. I agree to indemnify and hold harmless the Member Consultant and Getting Well Naturally Private Healthcare Membership Association from any and all claims and damages of every kind to myself or any person or property arising out of or attributed to the services provided or received.

Signature _____ Date: _____

Name _____ Date: _____

MEDICATIONS	Reason for taking it.	How long?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

SUPPLEMENTS you are CURRENTLY taking
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.

Are you pregnant? _____ Breastfeeding? _____ Do you have an electronic device in/on your body? _____

Are you experiencing pain? _____

Car accidents or another type? _____ When? _____

Do your health issues run in your family? _____ Do you feel like you need emotional or inner healing? _____

GETTING WELL NATURALLY - MEMBERSHIP CONTRACT
A Private Healthcare Membership Association
(That what we do and say is protected and private between us Members.)

I, _____, for membership fee paid in hand, do hereby apply for membership in Getting Well Naturally, a private membership organization. With the signing of this membership agreement, I/we accept the offer made to become a member of Getting Well Naturally and have read and agree with the following Declaration of Purpose from Article I of Getting Well Naturally's Articles of Association.

1. This Association of members hereby declares that our main objective is to protect our rights to freedom of choice regarding our health information and care, through maintaining our Constitutional rights.

2. As members, we affirm our belief that the Constitution of the United States is one of the best documents ever devised by man and the signer of the Declaration of Independence did so out of love for their country. We believe that the First Amendment of the Constitution of the United States of America guarantees our members the rights of free speech, petition, assembly, and the right to gather together for the lawful purpose of advising and helping one another in asserting our rights under the Federal and State Constitutions and Statutes. We strive to maintain and improve the civil rights, constitutional guarantees, freedom of choice in health care and political freedom of every member and citizen of the United States of America.

3. We declare the basic right of all our members to select spokesmen from our number who could be expected to give wisest counsel and advice concerning the need for physical and mental health care assistance and to select from our number those members who are the most skilled to assist and facilitate the actual performance and delivery of products, consultations, education, services and care.

4. We proclaim the freedom to choose and perform for ourselves the types of products, consultations, services and treatment methods and modalities that we think best for treating and preventing illness and disease of our minds and bodies and for achieving and maintaining optimum wellness. We proclaim and reserve the right to include options that include but are not limited to cutting edge treatment modalities and therapies practiced or used by any types of healers or therapists or practitioners the world over whether traditional or nontraditional, conventional or unconventional.

5. More specifically, the mission of our Association is to provide members with the highest level of quality education, products, services and care and the most effective methods of these products and modalities. We treat members and their health condition, and not merely the symptoms experienced. Our Association understands that wellness has many dimensions and strives every day to stay on the leading edge of new products and technology. The Association provides the most advanced products and technologies for assisting all aspects of a member's condition and/or health and provides the most effective means at an affordable fee. More specifically, the Association specializes in consultations, products, alternative modalities to support health and offers these products, instruments and services as alternates for service and benefits to members.

6. The Association will recognize any person (irrespective of race, color, or religion) who is in accordance with these principles and policies as a member, and will provide a medium through which its individual members may associate for actuating and bringing to fruition the purposes heretofore declared.

MEMORANDUM OF UNDERSTANDING

I understand that the fellow members of the Association that provide products, consultations, services and care, do so in the capacity of a fellow member and not in the capacity as a licensed health care provider. I further understand that within the association no doctor-patient relationship exists but only a contract member-member Association relationship. In addition, I have freely chosen to change my legal status as a public customer or client to a private member of the Association. I further understand that it is entirely my own responsibility to consider the advice and recommendations offered to me by my fellow members and to educate myself as to the efficacy, risks, and desirability of same and the acceptance of the offered or recommended therapy, treatment and care is my own carefully considered decision. Any request by me to a fellow member to assist me or provide me with the aforementioned therapy, treatment and care is my own free decision in an exercise of my rights and made by me for my benefit, and I agree to hold the Trustee(s), staff and other worker members and the Association harmless from any unintentional liability for the results of such care, except for harm that results from instances of a clear and present danger of substantive evil as determined by the Association, as stated and defined by the United States Supreme Court.

The Trustees and members have chosen William (Bill) Marvin Yeary as the person best qualified to perform services to members of the Association and entrust him to select other members to assist him in carrying out those services.

In addition, I understand that since the Association is protected by the First and Fourteenth Amendments to the U.S. Constitution, it is outside the jurisdiction and authority of Federal and State agencies and authorities concerning any and all complaints or grievances against the Association, any Trustee(s), members or other staff persons. All rights of

complaints or grievances will be settled by an Association Committee and will be waived by the member for the benefit of the Association and its members. Because the privacy and security of membership records maintained within the Association, which have been held to be inviolate by the U.S. Supreme Court, the undersigned member waives HIPPAA privacy rights and the complaint process. Any medical or healthcare records kept by the association will be strictly protected and **only** released upon written request of the member. I agree that violation of any waivers in this membership contract will result in a no contest legal proceeding against me.

I agree to join the Association, a private membership association under common law, whose members seek to help each other achieve better health and live longer with good quality of life.

I understand that the doctors, nurses and other providers who are fellow members of the Association are offering me advice, products, services and benefits that do not necessarily conform to conventional medical or health care.

As a member, I accept the goals of helping my body function better and choosing techniques that are both very safe and have a reasonably good chance to succeed, realizing that no diagnostic technique or treatment is foolproof. If I choose to forgo drugs, surgery, or radiation that has been recommended to me by others, I fully accept the risk that I might suffer serious consequences from that choice. Other aspects of informed consent will take place in my discussions with the providers and my fellow members of the Association.

My activities within the Association are a private matter that I refuse to share with the State Medical Board, the FDA, FTC, Medicare, Medicaid or my own insurance company without my expressed specific permission. All records and documents remain as property of the Association, even if I receive a copy of them. I fully agree not to file a lawsuit against a fellow member of the Association, unless that member has exposed me to a clear and present danger of substantive evil. I acknowledge that the members of the Association do not carry liability or malpractice insurance.

I enter into this agreement of my own free will or on behalf of my dependent without any pressure or promise of cure. I affirm that I do not represent any State or Federal agency whose purpose is to regulate and approve products. I have read and understood this document, and my questions have been answered fully to my satisfaction. I understand that I can withdraw from this agreement and terminate my membership in this association at any time. These pages and Article I of the Articles of Association of the Association consist of the entire agreement for my membership in the Association and they supersede any previous agreement.

I understand that the membership fee entitles me to receive those benefits declared by the Trustee(s) to be "general benefits" free of further charge. I agree to pay as levied those benefits that I receive that are declared by the Trustees to be "special assessments", per Fee Schedule.

I enclose the sum of $10.00 as consideration for my annual membership contract, said term beginning with the date of the signing of this contract, and by these presents do hereby certify, attest and warrant that I have carefully read the above and foregoing Getting Well Naturally's Contractual Application for Membership and I fully understand and agree with same.

IN WITNESS WHEREOF I set my hand this _____ day of _____, 20____.

_____

PRINTED NAME of Member (and name of legal guardian if applicant under 18 years)

_____

SIGNATURE of Member (and signature of legal guardian if applicant under 18 years)

_____

Street

_____

City **State** **Zip Code**

_____ _____

Home/Work/Cell #s **email address**

GETTING WELL NATURALLY

By: _____

Approved and accepted this _____ day of _____, 20____.

Disclaimer and Release of Liability

Getting Well Naturally Private Healthcare Membership Association and LifeCare Nutritionals LLC

Contraindications for electrotherapy instruments

Bemer, Zapper, Magnetic Pulsar, Ionic Foot Detox, Wellness Pro TENS Unit, GB4000 Frequency Generator, Zyto BioScanner, Chattanooga Intelect Transport Combo Ultrasound Unit

Please check all that apply.

I have on my body or inside my body:	**I am currently undergoing:**
☐ Pacemaker or defibrillator	☐ Pregnancy or breast feeding
☐ Electrical or battery implant	☐ Immunosuppressive therapy
☐ Prosthesis	☐ Bone marrow or stem cell transplantations
☐ Drug pump	☐ High fever or serious infection
☐ Hearing aid in my ear	☐ Severe cardiac rhythm disorder
☐ Brain stimulator	☐ Non-controlled seizure disorder (e.g., epilepsy)
☐ Muscle stimulator	☐ Hodgkin's disease
☐ Organ transplant	☐ Type 1 Diabetes
☐ Cancerous lesion	☐ Epilepsy
☐ Open wound	☐ Hemophilia (free bleeder)
☐ Metal implant or metal screws – Location(s) _____	☐ Chemotherapy or radiation
	☐ Post-surgical acute pain
Medications	**Magnetic Pulsar**
☐ Long-term use of corticoid agents	• Do not use over testicles or over the eyes
☐ Long-term use of coumarin derivates	**Zapper, Wellness Pro, GB4000, and Ultrasound Unit**
☐ Heartbeat regulating medication	• Do not use over heart or its arteries
☐ Medication, the absence of which would mentally or physically incapacitate you e.g., psychotic episodes or seizures	• Do not use over the carotid artery • Do not use over the back of brain • Do not touch eyes (below eyes on skin is okay) • Not directly over stints, pins, screws, metal implants • Not directly on the spine (okay on of each side)

The devices, equipment, services, and software offered do not diagnose, treat, remedy, cure, or prescribe treatments. I have indicated by marking the appropriate checkbox(s) of my health issues and conditions and medications that are listed above. I have read and understood the precautions and contraindications for use of the above devices. I release and hold harmless Bill Yeary, Getting Well Naturally Private Healthcare Membership Association, LifeCare Nutritionals LLC, and its employees.

None of the statements in BEMER marketing and in educational materials or on the Bemer web sites have been evaluated by the Food and Drug Administration (FDA). They are not intended to diagnose, treat, cure or prevent any disease. Furthermore, none of the statements should be construed as dispensing medical advice, making claims regarding the cure of diseases, nor can these products prevent or cure any disease state. BEMER products are in no way a substitute for medical care. You should consult a licensed health care professional before starting any health protocol or any health device such as BEMER, especially if you are pregnant or have any pre-existing injuries or medical conditions. You hereby release and hold BEMER USA and its parent, subsidiaries, affiliates, partners, officers, directors, agents, employees, contractors, service providers, or suppliers ("us") harmless from any and all claims, demands or causes of action of any nature and kind, known or unknown, which you or somebody on your behalf has or may in the future have against us relating directly or indirectly to your use of the BEMER products. Should this provision be found unenforceable under applicable law, the remaining provisions will remain in full effect. By signing below, you acknowledge that you have read, understood, and agree to all of the above.

Printed Name _____ Date _____Signature _____

July 2023