

PATIENT INFORMATION

Please print clearly

Last Name _____ First Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above) _____

Home Phone (____) ____ - _____ Cell/Work Phone (____) ____ - _____

E-mail address (for internal use only): _____

Referred by: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Please circle the options that apply to you. If you answer Yes to any questions, please answer the question(s) that follows.

Gender: Male / Female

Marital Status: Single / Married / Divorced / Widowed

Overall Health: Excellent / Good / Fair / Poor / Other: _____

Do you smoke, consume coffee, or alcohol? Yes / No

If yes, please indicate the activity or activities that you do _____

If yes, please indicate the amount per week _____

Do you exercise periodically? Yes / No

If yes, please indicate the type of exercise _____

Do you sleep an average of 6-8 hours of sleep? Yes / No

Do you enjoy your work? Yes / No

How stressful is your average day? Very / Somewhat / Not at all

Please answer the following questions. Please write clearly

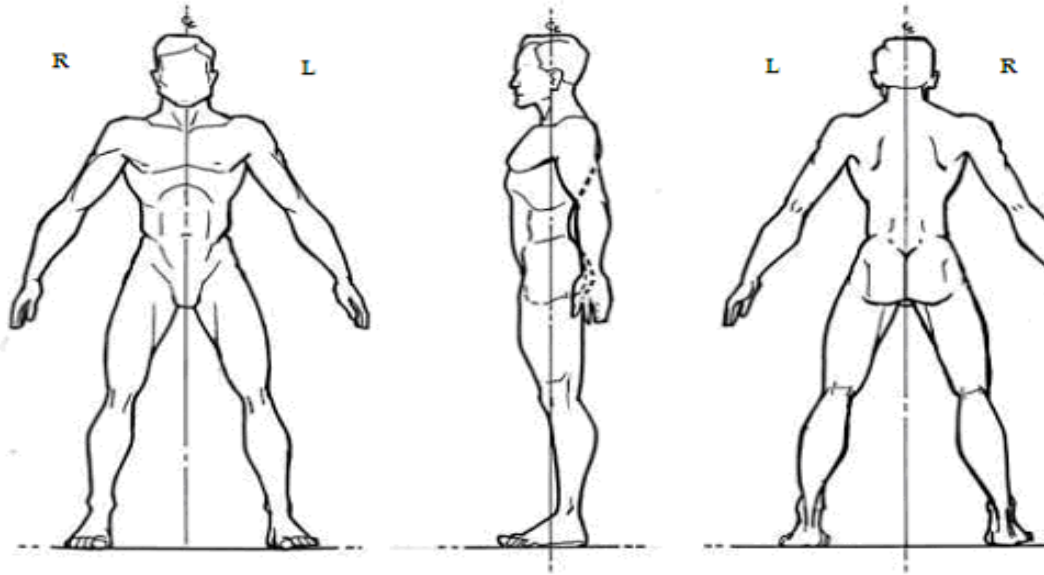
Describe your diet on a typical day: _____

Chief Complaint (Reason You are Here): _____

Brief Medical History (Past and current illnesses): _____

Past Surgeries (Please include dates): _____

Pain/ discomforts/Where are they in your body? (Please circle from the following areas):



Please indicate dosage and frequency of current Medications/Supplements/Treatments/Therapies

What are your top three expectations that you would like to achieve at our office?

PLEASE READ BEFORE SIGNING:

I specifically authorize the consultant or nutritional health practitioner (“NHP”) to use a muscle testing health analysis and to develop a natural, complementary health improvement program for me, which may include traditional chiropractic treatments (e.g. spine manipulation), acupuncture, therapeutic massages (including traditional Chinese techniques), dietary guidelines, herbal teas, or nutritional supplements in order to assist me in improving my health, and **not** for the treatment, or “cure” of any disease including, but not limited to, conditions of cancer, autoimmune deficiency syndrome (AIDS), systematic lupus erythematosus (SLE), bacterial infections, gastroesophageal reflux disease (GERD), or any other medical conditions.

I understand that the muscle testing system is a non-invasive, natural method of analyzing the body’s physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

No promise or guarantee has been made regarding the results of the Nutritional Program, but rather I understand that muscle testing is a means by which the body’s natural reflexes can be used as an aid to determining possible nutritional imbalances. I understand that the Nutritional Program has been developed to complement, aid, or supplement the guidelines of my primary care physician. Neither muscle testing, nor nutritional consultation is licensed by the state of California I promise that I will consult with

my primary care physician on an ongoing basis regarding the Nutritional Program. I agree that the doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I understand that I am to adhere to the guidelines of the Nutritional Program and that it has been fully laid out before me and discussed in detail. Although no promises or guarantees have been made, I understand that if I do not fully comply, that my failure to comply will greatly impact my results and success. **I agree to take full responsibility for asking questions, making follow-up visits, and informing the doctor of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during my care.**

I explicitly confirm that I have consulted and will continue to consult with my primary care physician regarding the Nutritional Program. In case of an emergency I promise to contact my primary care physician, or call 911 or the emergency telephone number in my area.

I authorize the doctor to discuss the details of my health and recommendations with the following person or people:

_____ (Your Initials) Please list: _____

_____ (Your Initials) Medical Practitioner: _____

I agree to cooperate and take an active role in my treatment under the Nutritional Program by maintaining a positive attitude regarding treatment, adding or maintaining an exercise program and a nutritious meal plan, continuing contact with and treatment from medical practitioners, communicating progress and side effects to the NHP handling my case. **I understand that I am to continue all medication and other treatment modalities as they have been prescribed to me unless otherwise directed by the medical doctor or primary care physician who prescribed them to me.**

I understand that I am financially responsible for all services rendered. Any disputes arising out of or relating to this agreement will be handled in arbitration and both parties will agree on an arbitrator from the American Arbitration Association. In the event of any dispute arising out of or relating to his agreement, I agree to pay all costs of collection, and reasonable attorney's fees. I agree that this agreement, all services, including, but not limited to, in-person consultations, phone consultations, testing, and analysis were rendered in California and all products were distributed in California. Venue will be in Los Angeles County, and California law, including California arbitration law, will apply. If any term of this agreement is unlawful, then that term will be severed, and the remainder of the agreement will be deemed valid and enforceable. I hereby authorize the doctor to release all information necessary to secure the payment of insurance benefits.

I have read, understand and agree to the terms and conditions above. I further agree that a photocopy of this agreement will be as valid as the original. This agreement applies to subsequent visits and consultations. I understand that there are no refunds for any services rendered.

Signature: _____ Date: _____

Print Name: _____