

First Name:	Last Name:	Date of Birth:
Prefer to be Called:	Marital Status (Circle): Single Married Partnered Widowed Separated	Age:
Street Address:	City:	State: Zip:
Preferred Phone (Circle): home work cell	Alternate Phone: home work cell	May we leave a message on your preferred phone? <input type="radio"/> Yes <input type="radio"/> No
Employer:	Occupation:	SS#
Emergency Contact Name:	Preferred email:	Primary Care Physician:
Emergency Phone(s):		
List any drug allergies:	Preferred Pharmacy:	List any food allergies:

What is your main reason for your visit today?

Which Services Interest You:

- | | | |
|--|---|--|
| <input type="radio"/> acupuncture | <input type="radio"/> energy medicine | <input type="radio"/> men's health |
| <input type="radio"/> aromatherapy | <input type="radio"/> emotional freedom technique | <input type="radio"/> nutritional testing |
| <input type="radio"/> Biofeedback | <input type="radio"/> frequency specific microcurrent | <input type="radio"/> metabolic blueprint |
| <input type="radio"/> bio-identical hormones | <input type="radio"/> functional medicine | <input type="radio"/> nutrition counseling |
| <input type="radio"/> Bowen technique | <input type="radio"/> food allergies testing | <input type="radio"/> organization |
| <input type="radio"/> Chiropractic | <input type="radio"/> health coaching | <input type="radio"/> rapid eye technology |
| <input type="radio"/> craniosacral therapy | <input type="radio"/> Healing Touch™ | <input type="radio"/> Reiki |
| <input type="radio"/> counseling/therapy | <input type="radio"/> HeartMath™ | <input type="radio"/> walk & talk therapy |
| <input type="radio"/> detox program | <input type="radio"/> life coaching | <input type="radio"/> wellness |
| <input type="radio"/> energy medicine | <input type="radio"/> massage | <input type="radio"/> weight loss |
- Would you like to receive our newsletter?** Yes No *(we will never sell your name)*

Cancellation & Re-Scheduling Policy

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

Please know that all cancellations and/or rescheduling requests must be made at least two business days prior to the date of your appointment. If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be "missed" and charged for the full session fee. Thank you for your understanding.

() I understand and accept this policy

Your Signature

Today's Date

Records and Privacy Policy: We will not release your records to anyone without your written consent. Because this is an integrated practice with multiple practitioners, we may facilitate care by having only one record per client. Coordinated care by your chosen practitioners will always be done with respect for your personal privacy and confidentiality.

() I understand and accept this policy

NAME: _____

DOB: _____

Name: _____

DOB: _____

<p>How Well Do You Sleep? How Long Do You Sleep?</p>	<p>Daily Stress Level (Please Rate) <input type="radio"/> High <input type="radio"/> Moderately High <input type="radio"/> Average <input type="radio"/> None</p>	<p>Daily Energy Level (Please Rate) <input type="radio"/> Excellent <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor</p>																								
<p>Do You Exercise? What Type? How Often Per Week? For How Long?</p>	<p>How Important is Religion/Spirituality to You and Your Family's Life? <input type="radio"/> Extremely Important <input type="radio"/> Somewhat Important <input type="radio"/> Not At All Important</p>	<p>Do You Drink Alcohol? How Much Per Week? Do you Flush with Alcohol Intake?</p>																								
<p>Do You Use Recreational Drugs? How Much Per Week?</p>	<p>Do You Smoke? How Much Per Day? For How Many Years?</p>	<p>Where have you lived and traveled?</p>																								
<p>Previous Surgery and Dates: <input type="radio"/> Appendectomy Date: _____ <input type="radio"/> Hysterectomy Date: _____ <input type="radio"/> Tonsils/Adenoids Date: _____ <input type="radio"/> Breast biopsy Date: _____ <input type="radio"/> Back surgery Date: _____ <input type="radio"/> Knee surgery Date: _____ <input type="radio"/> Oral surgery Date: _____ <input type="radio"/> Cesarean Section Date: _____ <input type="radio"/> Tubal Ligation/Vasectomy Date: _____ <input type="radio"/> Other: _____ Date: _____ <input type="radio"/> Other: _____ Date: _____ <input type="radio"/> Other: _____ Date: _____</p> <p>Previous Injuries and Dates: <input type="radio"/> Head Injury _____ <input type="radio"/> Neck injury _____ <input type="radio"/> Back injury _____ <input type="radio"/> Bones Broken: _____</p> <p>Previous Car or Tramatic Injury: <input type="radio"/> Head Injury _____ <input type="radio"/> Neck injury _____ <input type="radio"/> Back injury _____ <input type="radio"/> Bones Broken: _____</p>	<p>Have You Been Diagnosed With: <input type="radio"/> Anemia <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Bronchitis <input type="radio"/> Cancer type: _____ <input type="radio"/> Diabetes <input type="radio"/> Epilepsy <input type="radio"/> Gallstones <input type="radio"/> Gout <input type="radio"/> Heart Attack <input type="radio"/> Heart Failure <input type="radio"/> Heart Valve Problems <input type="radio"/> Hepatitis (Liver problem) <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol or Triglycerides <input type="radio"/> Irritable Bowel or Colitis <input type="radio"/> Kidney Stones <input type="radio"/> Mononucleosis <input type="radio"/> Plantar Fasciitis <input type="radio"/> Pneumonia <input type="radio"/> Rheumatic Fever <input type="radio"/> Sleep Apnea <input type="radio"/> Stroke <input type="radio"/> Thyroid Problems</p>	<p>Do You Have or Wear: <input type="radio"/> Glasses <input type="radio"/> Contact lenses <input type="radio"/> Hearing Aid(s) <input type="radio"/> Dentures <input type="radio"/> Pacemaker <input type="radio"/> Artificial knee(s) <input type="radio"/> Artificial hip(s) <input type="radio"/> Other:</p> <p>How Often Have You Taken Antibiotics?</p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><u><5 times</u></td> <td style="text-align: center;"><u>>5times</u></td> </tr> <tr> <td>Infancy/Childhood</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Teen</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Adult</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table> <p>How Often Have You Taken a Course of Oral Steroids?</p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><u><5 times</u></td> <td style="text-align: center;"><u>>5times</u></td> </tr> <tr> <td>Infancy/Childhood</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Teen</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Adult</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>		<u><5 times</u>	<u>>5times</u>	Infancy/Childhood	<input type="radio"/>	<input type="radio"/>	Teen	<input type="radio"/>	<input type="radio"/>	Adult	<input type="radio"/>	<input type="radio"/>		<u><5 times</u>	<u>>5times</u>	Infancy/Childhood	<input type="radio"/>	<input type="radio"/>	Teen	<input type="radio"/>	<input type="radio"/>	Adult	<input type="radio"/>	<input type="radio"/>
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Adult	<input type="radio"/>	<input type="radio"/>																								

Any Other Hospitalizations and Dates:

NAME: _____

DOB: _____

Please describe your personal health history:

Family History: Please briefly describe any problems affecting your family below. If deceased, provide cause of death and their approximate age.

Mother – _____

Father – _____

Mother's Mother - _____

Mother's Father – _____

Father's Mother – _____

Father's Father – _____

Sibling(s) – _____

Spouse/Significant Other – _____

Child/Children – _____

Mother's Siblings – _____

Father's Siblings - _____

Ob-Gyn History (*Women Only*)

Are your periods regular? _____

Are your periods painful and/or symptomatic? _____

Have your periods changed recently? _____

Number of pregnancies total: _____

Number of miscarriages: _____

Number of abortions: _____

Current method of contraception: _____

Date of last pap smear: _____

Date of last mammogram/thermogram: _____

NAME: _____

DOB: _____

Digestive Health

Do you have gas, bloating or heartburn? _____

Has your digestion changed recently? _____

If so, in what way? _____

How often do you have bowel movements?

more than 3 times a day

1-3 times a day

4-6 times a week

1-3 times a week

Which if any of these features describe your bowel movements?

soft

hard

float

sink

offensive odor

blood visible

difficult to pass

watery

With whom do you live?

How well have things been going for you?

	Very Well	Fair	Poor	Very Poor	Does Not Apply
With your attitude					
In your job					
At school					
In your social life					
With your close friends					
With your spouse					
With your boyfriend/girlfriend					
With your parents					
With your children					
With sex					

Have you or your family recently experienced any major life changes? If yes, please explain.

NAME: _____

DOB: _____

Review of Symptoms: Please check if these symptoms occur presently or have occurred in the past 6 months. Note if the symptom is not applicable (n/a), mild, moderate or severe and add comments if indicated.

CATEGORY	SYMPTOM	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	COMMENTS
GENERAL	Cold hands/feet	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Cold intolerance	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Daytime sleepiness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty falling asleep	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Waking early	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fatigue	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Flushing	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Heat intolerance	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Night waking	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Nightmares	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	No dream recall	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Distorted sense of smell	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Distorted sense of taste	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Ear ringing/buzzing	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Eye crusting	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Eye pain	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Headache/migraines	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Hearing loss	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
Vision problems	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
MUSCLE	Calf cramps	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Chest tightness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Foot cramps	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Joint deformity	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Joint pain	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Joint redness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Joint stiffness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Muscle pain/spasms	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Muscle twitches: eyes	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Muscle twitch: arms/legs?	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Muscle weakness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Tendonitis	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Tension headaches	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	TMJ	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
MOOD	Anxiety	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Depression	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty concentrating	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty with balance	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty with thinking	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficult with followthrough	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	

NAME: _____

DOB: _____

CATEGORY	SYMPTOM	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	COMMENTS
MOOD	Difficulty with judgment	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty with speech	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty with memory	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Dizziness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fainting/light headed	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fearfulness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Irritability	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Numbness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Phobias	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Paranoia	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Seizures	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Suicidal thoughts	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Eating	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Bulimia	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Can't gain weight	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Can't lose weight	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Carbohydrate craving	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Poor appetite	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Salt craving	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
DIGESTION	Bleeding gums	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Bloating in abdomen	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Blood/mucous in stool	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Burping/flatulence	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Canker sores	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Cold sores	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Constipation	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Diarrhea	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty swallowing	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Dry mouth	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Foods repeat(reflux)	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Heartburn	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Hemorrhoids	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Liver disease/jaundice	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Nausea	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Periodontal (gum) disease	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Strong stool odor	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Undigested food in stools	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vomiting	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
SKIN	Acne on face	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Athlete's foot	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Bumps - back upper arm	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Cellulite	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	

NAME: _____

DOB: _____

CATEGORY	SYMPTOM	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	COMMENT
SKIN	Dark circles under eyes	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Easy bruising	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Eczema	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Herpes	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Hives	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Oily skin	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Psoriasis	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Rash	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Shingles	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Skin cancer	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Strong body odor	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vitiligo	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Dryness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Enlarged lymph nodes	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fingernails bitten	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fingernails brittle	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fungus fingernails/toenails	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	White spots fingernails	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
RESPIRATORY	Sleep Apnea	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Nose bleeds	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Post nasal drip	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Sinus infections	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Snoring	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Breathlessness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
HEART	Heart attack	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Heart murmur	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	High blood pressure	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Irregular pulse	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Mitral valve prolapse	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Palpitations	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Phlebitis/blood clots	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Swollen ankles/feet	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Varicose veins	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Infection	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
URINARY	Kidney disease	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Kidney stone	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Leaking/incontinence	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Pain/burning	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Urgency	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Prostate infection	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
MALES	Discharge from penis	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Ejaculation problem	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	

NAME: _____

DOB: _____

CATEGORY	SYMPTOM	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	COMMENT
MALES	Genital pain	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Lumps in testicles	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Low libido (sex drive)	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Breast lumps	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
FEMALES	Breast tenderness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Ovarian cyst	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Low libido (sex drive)	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Endometriosis	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fibroids	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Infertility	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vaginal discharge	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vaginal odor	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vaginal itch	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vaginal pain	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	PMS symptoms	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Menstrual cramps	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Heavy periods	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Irregular periods	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	No periods	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
Spotting between periods	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		

What percentage of the food you eat is home cooked? _____ %

Please list what you usually eat for:

Breakfast

Mid Morning Snack

Lunch

Afternoon Snack

Dinner

Desserts

Have you found certain foods do not “agree with you” or cause symptoms? If so, please identify the food and symptom you have.

NAME: _____

DOB: _____

EMOTIONS

_____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression

Total: _____

OTHER

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

Total: _____

GRAND TOTAL: _____

NAME: _____

DOB: _____

**RISKS AND BENEFITS OF INTEGRATIVE MEDICINE PROCEDURES UTILIZED AT
LIVING WELL DALLAS, LLC.
Legal Waivers and Liabilities**

I am exploring the possibility of utilizing Complementary and Alternative Therapies at Living Well Dallas, Inc. ("LWD") in conjunction with conventional medical care. I have provided to LWD all medical information relevant to my health status.

I acknowledge that I understand the services provided at LWD are for therapeutic purposes only and not for purposes of diagnosis. In certain cases lab test may be offered in order for my LWD physicians and providers to better evaluate the functional status of my body in order to better provide integrative therapeutic options. I understand that: (1) if a symptom persists, I should see my regular or non-LWD physician(s) regarding traditional diagnosis and treatment options; and (2) I should continue to see my regular or non-LWD physician(s) for conventional testing and screen purposes.

I have had the opportunity to review educational materials regarding integrative medicine procedures available at LWD and the risks and benefits of the procedures identified on the next page. I am aware that the practice of integrative medicine is not an exact science and I acknowledge that no guarantees have been made to me regarding integrative medicine procedures. I understand the integrative medicine procedures and the expected results, risks, complications and discomforts that may result from such procedures, and that such procedures may aggravate existing conditions or pain, or may lead to new complaints I have no further questions regarding the integrative medicine procedures or options available to me.

I hereby authorize any health care provider to release to LWD or any of its designees for treatment, administrative (including applications/claims evaluation), analytical and/or research purposes, any records and information pertaining to my medical history or services rendered. I hereby authorize LWD to release medical information to other healthcare providers as might be necessary to provide for continuity of care. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon.

With respect to any records and information concerning treatment of drug and alcohol abuse, drug related conditions, alcoholism, psychological/psychiatric diagnosis, hepatitis, tuberculosis, HIV test results and/or diagnosis of AIDS or Aids related condition, if applicable, I hereby authorize any health care provider to release to LWD or any of its designees, for treatment, administrative (including application/claims evaluation), analytical and/or research purposes. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon.

LWD offers a variety of health-related products to serve patients' immediate needs. All of the products offered for sale by LWD have been scientifically tested by their manufacturers and independently reviewed for quality by others who are qualified to do so. If you would like to know more about the risk, benefits and limits of knowledge relating to the products sold at LWD, please ask us and we will provide you with easy-to-read materials about them. LWD makes every effort to provide the products it sells to patients as cost-effectively as possible. LWD acts as a retailer for the manufacturers of the health-related products that it sells. All health-related products sold by LWD are sold at an industry-accepted markup. If you would like a list of the manufacturers with which LWD has a financial arrangement, please ask us and we will provide it to you. LWD has made arrangements so that it can provide health-related products in-office or on-line through the internet as a convenience to our patients. However, if you prefer to purchase these products (or other similar products) elsewhere, please let us know and we will provide you with information on where they are available.

I HAVE CAREFULLY READ THIS ACKNOWLEDGEMENT AND RELEASE, INCLUDING THE NEXT PAGE. I FULLY UNDERSTAND ITS CONTENTS AND I HAVE SIGNED IT OF MY OWN FREE WILL.

SIGNATURE: _____ WITNESSED: _____

Please select the type of service from the list of services on the following pages. Read the Informed Consent and sign your initials under the column labeled "Initials" next to the consent statement.

NAME: _____

DOB: _____

Nutrition

1) Nutritional and Dietary Changes

a. Nutrition is a rapidly evolving science. Nutritional interventions may affect your current medication schedule and symptoms. Positive nutritional changes have a positive effect on your health but do not absolutely guarantee of either avoiding or developing disease. Nutritional interventions may help to better evaluate your health status.

2) Nutritional Supplements

a. Supplements and nutritional supplements may interfere with prescribed medications. It is important that a physician is aware of what combinations of medications and supplements you are taking.

3) Nutrigenomic and Functional Nutritional and Medical Assessments

a. Nutrigenomic assessment is a rapidly evolving science. It is an indicator of potential risk of disease development, but not an absolute guarantee of either avoiding or developing disease. Functional medicine assessments may help to better evaluate your health status. However, neither of these assessments should preclude nor substitute for traditional medical care.

Initials	Informed Consent
	<p style="text-align: center;">Consent for Nutrition Services</p> <p>I am attending this nutritional consultation and working with Betty Murray, CN, HHC, RYT and or nutrition professionals at Living Well Dallas of my own volition. We recommends that you inform your medical doctor of any and all dietary changes which you make as a result of her recommendations.</p> <p>I understand that Betty Murray is a Certified Nutritionist and Certified Holistic Health Counselor with private licensure and the health coaches under her supervision are privately licensed, are trained to help guide clients in improving their health through dietary and lifestyle changes. Betty Murray LWD Health Coaches are not a medical doctors or registered dieticians and does not diagnose or treat disease. I take full responsibility for my health and for the decisions regarding my diet that I make as a result of the recommendations made. Any dietary supplements and nutritional recommendations are suggestions and whether or not I act on these suggestions is as a result of my own volition.</p> <p>I hereby release and discharge Betty Murray and LWD, Inc. from any and all claims that I or my family or heirs, have or may have, now or in the future. I have read and understood all of the above, and agree to proceed under these conditions. I understand that the above is meant to have legal significance and be legally binding.</p>

Acupuncture

4) Acupuncture

a. Description and theory: Acupuncture is an ancient Oriental medical technique where fine needles are inserted into the skin at specific anatomic sites for therapeutic purposes. Practitioners may further stimulate the needles with manual stimulation, heat (moxibustion) or electromagnetic stimulation in order to promote natural healing and promote function. Acupuncturists attempt to improve the flow of energy (also called "chi" or "ki") through the body by unblocking areas where it is stagnant and also redirecting it to areas of the body in which it is lacking.

b. Possible Risks and Side Effects of Acupuncture: these include discomfort, exacerbation of pain, dizziness, and fainting due to transient low blood pressure, infections, bleeding, bruising, underlying organ injuries, and failure to remove needles.

Initials	Informed Consent
	Consent for Services

NAME: _____

DOB: _____

Chiropractic

5) Chiropractic/Osteopathy

- a. Description and theory: These therapies are concerned with the relationship of the structures of the body to its function. Both rely heavily on hands-on procedures using touch (palpation) to assess areas of dysfunction. Our therapist may use techniques in order to correct this dysfunction. These include high velocity thrust or manipulation as well as various other more gentle techniques.
- b. Possible Risks and Side Effects of Manipulative Techniques: these are rare but include exacerbation of pain, bone injury, nerve injuries, paralysis and arterial or blood supply problems.

Initials	Informed Consent
	<p style="text-align: center;">Consent for Services</p> <p>I, _____, do hereby authorize this Chiropractic Clinic and its Doctors, associates, assistants, and interns to perform upon me examination and diagnostic procedures arising from any current or presently unforeseen conditions, which the Chiropractic Clinic, Doctors, associates, assistants, or interns may consider necessary or advisable in the course of my health care.</p> <p>I understand and agree this Chiropractic Clinic, Doctors, associates, assistants, and interns have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctors of the Chiropractic Clinic can determine whether to accept me as a patient.</p>

Massage

6) Massage and Rolfing (or Structural Integration)

- a. Description and theory: Massage is the scientific manipulation of the soft tissue of the body to normalize those tissues. Rolfing or structural integration involves a much deeper type of massage, where pressure is applied with a hand or elbow. Its aim is to free up the connective tissue between the muscles.
- b. Possible Risks and Side Effects of Massage and Rolfing are rare. These include stiffness, bruising and pain.

Initials	Informed Consent
	<p style="text-align: center;">Consent for Services</p> <p>I have read and I fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist, and update this form before receiving additional massages. The massage treatment given here is for the sole purpose of stress reduction, relief from tension or spasm and to increase circulation and energy flow.</p> <p>The Massage Therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder. Nor does the Massage Therapist do spinal manipulations. Massage Therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you may have.</p> <p>It is the Client's (your) responsibility to explain and discuss all physical conditions with the Massage Therapist so that they may do their job. Your Massage Therapist is an independent professional and is solely responsible for your treatment.</p>

NAME: _____

DOB: _____

Energy Therapy

- 7) Energy Medicine (also called Biofield therapeutics, Healing Touch, Therapeutic Touch, Reiki, etc.)
- a. Description and theory: Energy Medicine practitioners are trained to work on the human electromagnetic field that exists in and around the human body. They do this by placing their hands either directly or very near the body.
 - b. Possible Risks and Side Effects of Energy Medicine – none know.
- 8) Clothing for Treatment
- a. Your therapist or physician may ask you to disrobe and put on a gown in preparation for your treatment. If you feel uncomfortable in any way, or would prefer a chaperone present, please notify your therapist.

Initials	Informed Consent
	<p style="text-align: center;">Consent for Services</p> <p>I understand that Bethlyn Gerard, Suzan Jonz-Perez and Living Well Dallas are researchers and an educators and as such provides Rapid Eye Technolgy, Body Talk, Emotional Freedom Technique, Healing Touch and, Reiki, Voice Bio sessions providing energy enhancement using various forms of biofeedback and touch. As an individual interested in learning about stress reduction, enhancing brain and memory function, improving immunity and sleep, increasing range of motion and decreasing pain, I have solicited these services in good faith, exercising my free will which allows me to select what I understand to be beneficial to my health. I fully understand that Bethlyn Gerard and Suzan Jonz-Perez do not profess to be and is not an allopathic physician (MD), nor do they offer drugs, surgery, or chemical stimulants. I am also fully aware that they do not diagnose, treat or otherwise prescribe disease conditions or illnesses nor do they profess to provide or perform any act that would constitute the practice of medicine for which a license is required. I release Bethlyn Gerard or Suzan Jonz-Perez to do biofeedback, soft tissue manipulation, Healing Touch, EFT, Body Talk and other wellness consultation and stress reduction protocols applicable to my health status. I have had the opportunity to ask questions with regard to the described procedures and I hereby affirm: These sessions are for my personal education and information. I am not here for medical diagnostic or treatment procedures. I hereby release and discharge Bethlyn Gerard and Living Well Dallas, Inc. from any and all claims that I or my family or heirs have or may have now or in the future. By signing below, I acknowledge that I have read and understand all parts of this waiver.</p>

NAME: _____

DOB: _____

Licensed Counseling

9) Counseling

a. There is a very small chance that talk therapy or counseling can cause a flare up of underlying mental illness. Please notify your therapist if you have a history of mental illness.

Initials	Informed Consent
	<p style="text-align: center;">Consent for Services</p> <p>CLIENT RIGHTS AND RESPONSIBILITIES: I am pleased that you have selected me as your counselor. This document is designed to inform you about my background and qualifications as a therapist to ensure that you understand our professional relationship as well as your rights and responsibilities</p> <p>METHOD OF TREATMENT: I see therapy as a special and unique relationship between client and therapist. It is important that I meet you, the client, where you are at--meaning, that what works for one client may not work for another. Therefore, therapy will be tailored to meet your individual needs. I also believe that early experiences, in part, help shape the kind of people we are today. This means that as the client, you may spend some time talking about your family of origin and past issues. I am also interested in what you expect from and what you hope to achieve from therapy. I feel that this goal setting is an important part of therapy, as it allows both you and I to see and feel what progress is made during the counseling process.</p> <p>EFFECTS OF COUNSELING: There is always a risk of psychological side effects from psychotherapy. Sometimes symptoms worsen before they get better. Often therapy brings up painful emotions. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.</p> <p>LENGTH OF TREATMENT: Length of treatment is very difficult to predict. Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful.</p> <p>OUR RELATIONSHIP: Although you will be sharing personal things during the course of therapy, the tie between us is professional rather than personal. It is important to keep this relationship clear, so spending time with you socially or accepting phone calls from you at my home is inappropriate. Sexual intimacy between a therapist and a client is <u>always</u> inappropriate and illegal. If this has happened to you in the past, you should file a complaint with the appropriate licensing agency.</p> <p>YOUR RIGHT TO PRIVACY: I will not share the things you tell me without your written permission and I will respect your privacy within the parameters. However, I may be forced to reveal our communications if:</p> <ul style="list-style-type: none">• I suspect child or elder abuse.• I feel that there is a threat that you will harm yourself or others.• You become unable to take care of yourself and additional help is needed.• There is a licensure board inquiry• Legal matters are involved. <p>It is important in the field of psychotherapy to consult with other professionals about difficult cases. Therefore, it is possible that I will discuss your case with other therapists for the purpose of gaining information or insight about your situation. If this occurs, your name will not be revealed during these discussions.</p>

NAME: _____

DOB: _____

Life Coaching

10) Life Coaching

a. There is a very small chance that talking about life issues may cause a flare up of underlying mental illness. Please notify your therapist if you have a history of mental illness.

Initials	Informed Consent
	Consent for Services

Professional Organizing

Initials	Informed Consent
	Consent for Services

NAME: _____

DOB: _____

How to Prepare for Your Functional Medicine and Functional Nutrition Visits

Welcome to the practice of Functional Medicine. This may be a new experience for you so let us briefly introduce you to this type of medicine. This is about creating or restoring health by addressing the underlying causes of health problems. The basic principles of Functional Medicine are grounded in the concept that our bodies know how to create health if we restore the balance and harmony to our body, mind and spirit. We look at the body as a whole and at each person as a uniquely different "ecosystem". To create real change in your health generally requires profound change in how you look after yourself.

There is a lot of information we collect to help us make your health program and this requires a number of things. We ask you to consider your health in ways and in details you may not have done in the past. This a completely different approach to healthcare and cannot succeed without your ongoing participation.

There are homework assignments given at each visit or conference and an important series of questionnaires to complete before each and every visit (*Vitamin & Supplement sheet, Medication sheet and Medical Symptoms Questionnaire (MSQ)*). We are always available to help you with your health program.

On your first visit plan to have a detailed conversation about your specific goals for your health and to review your past health in detail. This appointment is approximately 1.5 full hours and will include a physical exam. For women we ask that you **do not wear makeup or nail polish to this appointment. For all patients, please do not wear any fragrances to your appointment [this includes perfumes, cologne, personal care products with scent, etc.] because a number of our patients are highly sensitive to all chemicals.**

Please bring the original bottles of all of your medication, supplements and any protein powders, fibers, etc. that you currently take. If you have previous test results please bring a copy of these tests to the appointment that you plan to leave with us.

At the conclusion of this appointment we will decide what additional testing we may need to complete your health plan and also discuss what your path along this journey might look like. We will provide you with the appropriate test paperwork, kits and instructions. Some kits are for you to take home and do at home. These come with postage-paid labels. You will ship these directly to the individual laboratories from your home or office. When the test results are completed, we receive your results in time for your next scheduled appointment. If your results are not completed, we will call you in advance of your appointment and reschedule.

Since this is a completely different approach to healthcare, you may be asked to think about your health and pay attention to your health and stay involved in the process of creating health. In order for our approach to work we need your full cooperation with a number of things on an ongoing basis.

These include the following:

1. You are responsible to schedule your follow-up appointments. After each appointment we will provide you with a written homework assignment. It is your responsibility to review this and let us know if you need assistance. The homework will outline the next steps you are to take in working on your health that you and your provider worked through on your visit and will indicate when your next appointment should occur.
2. You may need to keep an ongoing and current "Health Calendar" on which you record several things (Dr. Mack requires a health calendar):
 - a. **Any changes** you make in your supplements or medications. This includes starting or stopping anything as well as a change in dose, number of capsules, etc.
 - b. Any changes in how you feel, either improved or not.
 - c. Any major events, such as the flu or vacation.
 - d. There may be additional items we ask you to record over the course of time such as your exercise routine, bowel movements, hours of sleep, headaches, etc. The assignment is kept to what is currently relevant for your health plan, so if we ask you to monitor it please make this a priority.
3. We require you to prepare in advance for your follow up appointments. This includes completing the "**patient appointment forms**" sent in an appointment reminder email by our office staff before your appointment. Please set aside plenty of time to fill it out in advance of your appointment. On this form you will be asked to list the details of your current supplements and medications – these may have changed since your last appointment, and answer a new medical symptom questionnaire.
4. At the beginning of each appointment we will review the progress you have made on the previous homework assignment so plan to have this available.

NAME: _____

DOB: _____

5. In preparation for follow up visits, it is vital that you complete all the paperwork and return this to us at least 24 hours in advance of any phone consultation or bring it with you for your in-person visit.
6. If we do not know what you are taking or how much of your previous homework you have completed, it will limit the progress we can make during the appointment. **You must complete these forms in advance of your appointment to bring with you or send before your telephone consult.**
7. **Do not make any changes in your supplement protocol or diet without consulting with us first please.** Many patients have set their progress back by listening to advice that is well intended but wrong for them!
8. If you have a medical emergency, you should go through the usual emergency management channels.
9. We are available every weekday in the office from 9:00 AM to 6:00 PM central Monday through Thursday and 9:00 to 1:00pm on Friday. Dr. Mack is available from 10:30-6:00pm on Tuesdays. You may contact us by telephone or email. Generally your questions will be answered within 24-48 hours. However, please bear in mind that this is a unique practice where our providers are always ones who respond to your needs and questions.
10. We do not provide primary-care services. All of our medical and complementary services are adjunctive to your primary care team. There is no "on call" doctor that will be answering emergency calls. Emergencies should be called into 911 or directed to your primary care physician. We thank you in advance for your patience and understanding.

Functional Medicine is a unique opportunity to either improve or restore your health. It teaches you to become better informed about both basic and cutting edge science you can use to maintain your health throughout your life. Our goal is to help you move through this process and help you accomplish what you have put on your health wish list.

Email Questions Policy

Due to the highly popular demand of email questions and to the often lengthy research and response requirements, our office will be following the policy outlined below for email and phone inquiries between office visits.

Email is very efficient for you and for us, especially if we can be prompt in replies and save you time in the car and away from work and family. Handling incoming email questions and between visit communications is a great value for you and for us; we would like to nurture it without getting buried by it.

This is a way for you to have short questions answered in between your regular appointments to keep you moving forward on your health goals. Email questions for simple clarifications on your last visit homework and are considered usual and complimentary if they can be reviewed and answered by our office staff and do not require additional research and time by the provider.

Status updates and questions that require responses outside of the previous visit instructions and require time by the provider to research, review your chart and respond constitute a new encounter. Short question emails that would take no more than 15 minutes to answer including research time by the provider are reasonable for email encounters. And email encounters are a good way to get your questions answered.

If your question is very lengthy or there are several questions that may take well over 15-minutes to answer, the most prudent and economical choice would be a short telephone 30-minute consult or a short 30-minute in-office consult instead as it will provide additional time for discussion that is beyond what is effective in email format.

Here's how it works:

1. You determine you have a question that cannot wait until your next scheduled appointment or you have a status update that has arose that will require input, time and more than a few sentence response from your provider.
2. Open an email and address it to ty.daily@livingwelldallas.com
3. You will put "**patient question for _____ (your provider, i.e. Dr. Mack)**" at the beginning of the **subject line** of your email. This will move your question to the top of the incoming email list.

NAME: _____

DOB: _____

4. Our providers (doctors and nutritionist) will take care of such emails at the top of their daily agenda and all email inquiries will be answer within 48 hours.
5. In the body of the email, write your message including the questions you want answered.
6. Your provider (doctor or nutritionist) will start their stopwatch when they open your email and stop it when they have answered your questions, pasted the exchange into your medical record, and completed any other chores that are needed (call the pharmacy, order any additional lab test, or consulted with any other health care provider).
7. Your account number will be kept on file and charged for the total number of minutes spent. The number of minutes will be noted at the top of the email response as \$/per minute – Provider_Name.
8. You will be emailed a receipt separately. The charges will be coded like a phone consultation for insurance purposes.

The adoption of new technology such as email and web services has allowed us to become more responsive and available to you without getting in the car. Becoming more efficient and precise with our services allows us to provide better overall services to you. Thank you for your understanding in this matter.

Explanation of fees:

- Our physician fees are \$500 per hour for office visits, telephone consultations, and email consultation responses. You will be provided with a receipt document that explains the nature of the charges and the medical diagnosis for those of you submitting these to insurance carriers.
- Our Nutritionist fees are \$125 per hour for established patients office visits, telephone consultations, and email consultation responses.
- In many cases, lab test fees are paid directly to the lab performing the testing based on your insurance company coverage of tests. If your insurance will not process the labs for you, we may often can pass along discounted practitioner pricing for your testing. In those cases, lab tests are paid to our office and we give you a receipt to submit for insurance reimbursement.

In health,

Betty Murray
Founder Living Well Dallas, Inc.
cc. Dr. Claudia Harsh, Dr. Suzanne Mack, Dr. Guy Francis