BREATH
OF LIFE
wellness center

Welcome!

I want to personally congratulate you on your first step toward better health. It is my privilege to provide southwest Missouri with alternatives in natural health care. I was blessed to have parents that utilized alternative natural health care. There was no worry of side effects or addictions. By choosing alternative natural health care you are choosing to empower you, the individual, with comfort, confidence and knowledge to take control of your health and wellness. Throughout my education, I have learned that there are many ways to care for the body and I choose preventative care. We never know what future problems we avoid by taking preventative action. We are proud to care for your family from womb to tomb!

Thank you for your trust,

Dr. Nicole McCauley
Breath of Life Wellness Center

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TERMS OF ACCEPTANCE

Please Read Carefully

We encourage and support a shared decision making process regarding your health needs. As part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Wellness Care enables each individual to maximize his or her health. Health can only be maximized when the major cause of interference is removed and balance is obtained.

Health: A state of optimal physical, mental, social, and spiritual well-being, not merely the absence of disease or infirmity. Health will be maximized if all obstructions to it are removed.

Chiropractic: Chiropractic is based on the science that concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

Subluxation: An imbalance of health due to nervous system interference in the spinal column, cranium and/or contiguous structures of the body. The result is a lessening of the body's inborn "innate" ability to express life at maximum potential.

Adjustment: An adjustment is the special application of forces to facilitate the body's correction of subluxation. Our method of correction is by specific adjustments of the spine, contiguous structures and soft tissues. Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal of chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. We believe any named condition is merely a physical manifestation and not necessarily indicative of the underlying cause. Our only objective is to remove interference to the expression of your body's infinite wisdom, thus returning your body to balance. We do not offer to diagnose or treat any disease or condition. However, if during the course of examination, we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we give you the option to seek the service of a health care provider who specializes in symptom-based care.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-

rays), computerized electrodermal testing and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic care may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic care and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

The Vital (CEDSA) System provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the procedure is to disclose patterns of stress and to provide feedback to help in recommending a program to restore each system and meridian (energy pattern) to balance.

I understand that the Computerized Electrodermal Stress Analysis Survey does not provide a medical diagnosis, and that my testing technician may recommend further medical testing. If you suspect that you need further medical intervention, you should consult your physician.

I give my permission for the testing technician to evaluate me on the CSA System. I understand that by doing so THE TESTING TECHNICIAN IS NOT BECOMING MY PRIMARY CARE PHYSICIAN.
I understand that the testing technician will give me information about myself based on the evaluation and the testing technician will make recommendations to improve my health based on what is found.

Any decision to follow through with the program will be my own decision, and I will not hold the testing technician or Breath of Life responsible.

I have read the above paragraphs. I have been informed of the nature and purpose of chiropractic care, the

possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care. I understand the information provided. All questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize Dr. Nicole McCauley to proceed with Chiropractic Care.

Dated This Day _____ of _____ , 20_____

_____ _____
(Practice Member Signature) (Date)

_____ _____
(Doctor Signature) (Date)

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Parental Consent for Minor Practice Member

Patient Name _____

Patient Age _____ DOB _____

I am the parent, guardian, or personal representative of _____
(Please print name of minor / child)

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, which are deemed advisable by the doctor.

_____ _____
(Signature of Practice Member, Parent, Guardian or Personal Representative) (Date)

_____ _____
(Print Name of Practice Member, Parent, Guardian or Personal Representative) (Date)

I request that my child be able to maintain their chiropractic appointments without the presence of a parent/guardian when necessary. (This applies to children 14 years of age or older.)

_____ _____
(Signature of Practice Member, Parent, Guardian or Personal Representative) (Date)

_____ _____
(Witness Signature) (Date)

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NOTICE OF PRIVACY PRACTICES

Please Read Carefully

In the course of my care as a practice member at Breath of Life Wellness Center (BOL), my personal information may be used or disclosed in the following ways:

- My personal health information, including my clinical records, may be disclosed to another health care provider or hospital, should I choose concurrent care.
- My health care and billing records may be disclosed to another party, such as an insurance carrier or my employer, with my expressed written consent.
- my name, address, phone number, email address, and health care records may be used to contact me regarding appointment reminders, missed appointment notification, billing/collection efforts, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other related information that may be of interest to me.
- I give permission to leave a phone message on my answering machine or voice mail.
- I give permission to send a thank you letter including my name to the person referring me to this office.
- I give permission to use my name on a welcome board, referral board, and birthday board.
- I give permission to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to use any testimonials written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, or on their website or in ads in print media.
- By signing this form, I am giving BOL permission to use and disclose my PHI in accordance with the directives listed above.
- I have the right to inspect or copy, within boundaries, the protected health information to be used/ disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.
- I have the right to obtain a copy of the information that will use for these purposes. I also have the right to refuse authorization for BOL to contact me regarding these matters. My decision to refuse authorization will not affect the care I receive in any way.
- Under Federal Law, BOL is permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
- If BOL is providing health care services to you based on the orders of another health care provider.
- If BOL provides health care services to you in an emergency.
- If BOL required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with me, but BOL believes, in their professional judgment that I intend for BOL to provide care.
- If BOL is ordered to do so by the courts or another appropriate agency.

Any use or disclosure of my protected health information, other than as outlined above, will only be made with my express written authorization. BOL will normally provide information about my health to me in person at the time of my appointment.

BOL may also mail information to me regarding my health care or about the status of my account. If I would like to receive this information at an address other than my home or in a different format, I will advise BOL in writing of my preferences.

I have the right to inspect and copy my health information for seven years from the date the record was created, or as long as the information remains in the BOL office files. In addition, I have the right to request an amendment to my health information. Requests to inspect, copy, or amend my health related information should be provided to BOL in writing.

State and Federal Laws requires BOL to maintain the privacy of my patient file and the protected health information therein. BOL is also required to provide me with this notice of their privacy practices with respect to my health information.

Furthermore, BOL is required by law to abide by the terms of this notice while it is in effect. BOL reserves the right to alter or amend the terms of this privacy notice. If changes are made to BOL's privacy practices, I will be notified in writing as soon as possible following the changes. Any change in BOL's privacy practices will apply to all my health information on file.

Information used or disclosed based on this privacy notice may be subject to re-disclosure by the person to whom this office provides the information and may no longer be protected by the Federal Privacy Rule.

Under Federal Law BOL is required to ask for my permission to leave a message regarding confirming my appointment times and meetings and informing of products. The purpose of this use is to make a more pleasant, personable, efficient, and productive Wellness Center as well as further enhancing my access to quality health care.

If I choose not to authorize this information use, my decision will NOT affect my care in this office or my relationship with BOL's staff.

My signature indicates my authorization of this activity. This authorization will remain in effect for the duration of my care at BOL plus seven years or until revoked by me.

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy practices describes the types of uses and disclosures of my Protected Health information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this BOL. A copy of this notice is attached and I have been encouraged to read it and request a copy if I would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to BOL to use and/or disclose my PHI in accordance with the following:

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I have read and understand this patient Authorization to release Health Information and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

_____ _____

(Practice Member Signature) (Date)

_____

(Print Name)

_____ _____

(SSN) (DOB)

Parental Consent for Minor Practice Member

_____ _____

(Signature of Personal Representative) (Date)

_____

(Print Name of Parent or Personal Representative Name)

_____

(Print Name of Parent or Personal Representative Name)

_____

(Relationship to Minor Practice Member)

I may revoke this authorization at any time in writing. I will allow 2 weeks for this change to be completed.

Right to Revoke Authorization

I have the right to revoke this AUTHORIZATION, in writing, at any time. However, my written request to revoke this AUTHORIZATION is not effective to the extent that BOL has provided services or taken action in reliance on my authorization.

I may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of BOL. The written notice must contain the following information:

1. My printed name, SSN, address, and DOB
2. A clear statement of my intent to revoke this AUTHORIZATION
3. Date of my request
4. My signature

The revocation is not effective until it is received by the Privacy Official.

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This AUTHORIZATION is requested by BOL for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse this AUTHORIZATION, BOL will not refuse to provide care; however, I will be responsible for:

1. Payment in full at the time services are provided to me.
2. Scheduling my own appointments since BOL will be unable to contact me.
3. All contact with BOL regarding my care.
4. Additionally, any collection activity as permitted by law is not waived by refusal to sign the AUTHORIZATION.

This notice is effective as of **September 1, 2014**. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____

(Signature) (Date)

_____

(Print Name)

_____

(Alternate phone number where a message may be left)

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Personal Health History

Name _____

Home Phone _____

Address _____

Work Phone _____

Occupation _____

Email Address _____

Referred By _____

Date of Birth _____

WHAT WOULD YOU LIKE TO SEE BETTER OR IMPROVED IN YOUR HEALTH?

Check all that apply, and describe if checked.

Healthy Women

☐ Are you pregnant? (If yes, how many weeks?) _____

☐ Have you had a miscarriage or are you prone to miscarry? (If yes, when?) _____

☐ Is intercourse painful to you? (If yes, when?) _____

☐ Do you have diminished sexual desire? _____

☐ Do you have difficulty controlling your sexual desire? _____

☐ Have you had a hysterectomy? (If yes, when?) _____

☐ Do you have frequent yeast infections? (If yes, when?) _____

☐ Do you have problems with fertility? _____

☐ Do/did you experience morning sickness with pregnancy? (If yes, when?) _____

☐ Are you through or have symptoms of menopause? (If yes, when?) _____

☐ Do you have pre-menstrual syndrome? _____

☐ Do you retain fluid during your period? _____

☐ Do you have menstrual pain, cramps, or irregularities? _____

☐ Do you have abnormal feminine discharge? (If yes, when?) _____

☐ Do you have vaginal pain or discomfort? (If yes, when?) _____

☐ Have you been diagnosed with endometriosis? (If yes, when?) _____

☐ Do you have breast cysts or lumps? (If yes, which side?) _____

☐ Do you have mastitis? (If yes, which side?) _____

☐ Do you have tender or sore nipples? _____

☐ Do you frequently feel hot or perspire? _____

☐ Do you have any other female disorders? _____

Healthy Skin

☐ Do/did you have teenage or middle age acne? (If yes, where?) _____

☐ Is your skin generally healthy? _____

☐ Do you have premature aging and wrinkles? _____

☐ Do you have any abnormal skin growths or discolorations? (If yes, where?) _____

☐ Do you have athlete's foot? (If yes, which foot?) _____

☐ Do you have insect bite reactions or allergies? _____

☐ Are insects attracted to you? _____

☐ Do you scar easily? _____

☐ Do you have pain or discomfort in or around any scars? (If yes, where?) _____

☐ Do you have adhesions? (If yes, where?) _____

☐ Do you have excess body perspiration? (If yes, where?) _____

☐ Do you have excess body odor? _____

☐ Do you have reactions to poison ivy, oak or sumac? _____

☐ Do you have oily, dry, or itchy skin? (If yes, where?) _____

☐ Do you have eczema? (If yes, where?) _____

☐ Do you have psoriasis or cracking skin? (If yes, where?) _____

☐ Do you have cysts, warts, moles, liver spots, or fungal growths? (If yes, where?) _____

☐ Do you have rashes or vesicles (small blisters)? (If yes, where?) _____

☐ Do you have herpes or shingles? (If yes, how frequently do you experience outbreaks?) _____

☐ Do you have cold sores, fever blisters or canker sores? (If yes, when?) _____

☐ Are you troubled with boils? (If yes, when?) _____

☐ Do you get sores that are slow to heal? (If yes, where?) _____

☐ Are you troubled with corns? (If yes, which foot?) _____

☐ Do you have any other skin disorders? _____

Healthy Eyes

☐ Do you wear glasses or contacts? (If yes, how often?) _____

☐ Do you experience dry itchy, watery, or red eyes? (If yes, when?) _____

☐ Do you have eye discomfort associated with allergies? (If yes, when?) _____

☐ Do you or have you ever had pink eye? (If yes, which eye?) _____

☐ Do you have styes? (If yes, which eye?) _____

☐ Do you have cataracts? (If yes, which eye?)_____

☐ Do you have eye stress? (If yes, which eye?) _____

☐ Do you have macular degeneration? (If yes, which eye?) _____

☐ Do you have any other eye conditions? _____

Healthy Pain and Injuries

☐ Have you been diagnosed with Rheumatoid Arthritis? (If yes, where?) _____

☐ Have you been diagnosed with osteoarthritis? (If yes, where?) _____

☐ Does any part of your body experience numbness or tingling? (If yes, where?) _____

☐ Do you have back problems? (If yes, where?) _____

☐ Do you have a spinal curvature? (If yes, where?) _____

☐ Do you suffer from muscle cramps? (If yes, when?) _____

☐ Do you suffer from muscle spasms? (If yes, when?) _____

☐ Are your muscles frequently sore? (If yes, when?) _____

☐ Do you have muscle weakness? (If yes, when?) _____

☐ Are your joints stiff in the morning? _____

☐ Do you suffer from foot pain? (If yes, which foot, or both?) _____

☐ Have you been diagnosed with gout? (If yes, when?) _____

☐ Do you have headaches? (If yes, where?) _____

☐ Do you have migraine headaches? _____

☐ Do you have sciatica? (If yes, which side, or both?) _____

☐ Do you have teeth or gum problems? _____

☐ Do you have metal fillings? (If yes, silver, gold or both?) _____

☐ Do you have jaw problems? _____

☐ Do you bruise easily? _____

☐ Have you been diagnosed with neurological disease? (If yes, when?) _____

☐ Do you have any other pain or injuries? (If yes, where?) _____

Healthy Weight

☐ Are you overweight? (If yes, how much?) _____

☐ Are you underweight? (If yes, how much?) _____

☐ How often do you exercise? (If yes, when?) _____

☐ What type of exercise do you do? _____

☐ How many cups of water do you drink per day? _____

☐ Do you crave sweets? (If yes, when?) _____

☐ Do you have an excessive appetite? _____

☐ Do you have a poor appetite? _____

☐ Do you desire to vomit after eating? _____

☐ Do you have any obsessive diet habits? _____

☐ Do you have eating disorder? _____

☐ Do you eat when you are nervous? _____

☐ Do you have edema or retain water? (If yes, when?) _____

☐ Do you have any other weight disorders? _____

Healthy Mind and Emotions

☐ Do you or have you suffered from any emotional trauma? (If yes, when?) _____

☐ Do you have a fear of crowds or of going out of your house? _____

☐ Are you unusually jumpy? _____

☐ Do you suffer from nervousness? (If yes, when?) _____

☐ Are you claustrophobic? (If yes, when?) _____

☐ Do you have signs of depression? (If yes, when?) _____

☐ Do you portray signs of manic depression or personality shifts? (If yes, when?) _____

☐ Do you have feelings of grief of guilt? _____

☐ Do you have recurring fears or nightmares? _____

☐ Do you have any other phobias? (If yes, what?) _____

☐ Do you feel you are under considerable emotional stress? _____

☐ Do you have any obsessive behaviors? (If yes, when?) _____

☐ Have you been diagnosed with epilepsy? (If yes, when?) _____

☐ Do you suffer from poor concentration? (If yes, when?) _____

☐ Do you suffer from loss of memory? (If yes, when?) _____

☐ Do you suffer from confusion? (If yes, when?) _____

☐ Do you have any other mental or emotional disorders? _____

Healthy Control

☐ Do you smoke tobacco? (If yes, how many packs per day?) _____

☐ Do you chew tobacco? (If yes, how many tins per week?) _____

☐ Do you use recreational drugs? (If yes, what kind and how frequently?) _____

☐ Do you drink alcoholic beverages? (If yes, how much per day?) _____

☐ Do you crave stimulants? (If yes, when?) _____

☐ Do you have any other addictions? _____

☐ Do you wish to quit your addiction? _____

☐ Do you drink caffeinated beverages? (If yes, how much per day?)_____

Healthy Immune System

☐ Are you bothered with viruses at various times during the year? _____

☐ Do you have food allergies? (If yes, what foods?) _____

☐ Are you sensitive to chemicals? (If yes, on the skin, inhaled or both?) _____

☐ Are you oversensitive to the environment? (If yes, when?) _____

☐ Do you have recurring infections (viral, bacterial, or fungal)? _____

☐ Do you have colds or influenza often? (If yes, how frequent?) _____

☐ Do you cough frequently? (If yes, is it dry or productive?) _____

☐ Do you have frequent earaches or discharge? (If yes, which ear or both?) _____

☐ Do you have ringing in the ears or a loss of hearing? (If yes, which ear or both?) _____

☐ Have you been diagnosed with Lyme disease? (If yes, when?) _____

☐ Do you have frequent laryngitis or hoarseness? (If yes, when?) _____

☐ Do you have fevers frequently? (If yes, when?) _____

☐ Do you have frequent sinus infections? (If yes, when?) _____

☐ Do you have frequent sore throats? (If yes, when?) _____

☐ Are your glands often swollen? (If yes, where?) _____

☐ Are your tonsils often swollen? (If yes, when?) _____

☐ Do you have sinus headaches? (If yes, when?) _____

☐ Do you have yeast or fungal overgrowths? (If yes, where?) _____

☐ Do you or have you had thrush (Candida albicans)? (If yes, where?) _____

☐ Do you have any other immune disorders? (If yes, when?)_____

Healthy Digestion

☐ Do you have problems with constipation? (If yes, how frequently do you have bowel movements?)

_____

☐ Do you use laxatives? (If yes, how frequently?) _____

☐ Do you have diarrhea? (If yes, how frequently?) _____

☐ Do you have colitis? _____

☐ Have you been diagnosed with a gall bladder condition? (If yes, when?) _____

☐ Do you have gallstones? (If yes, when?) _____

☐ Do you have black stools? (If yes, how frequently?) _____

☐ Do you have red or bloody stools? (If yes, how frequently?) _____

☐ Do you have problems with heartburn? (If yes, how frequently?) _____

☐ Do you have problems with hemorrhoids? (If yes, how frequently?) _____

☐ Do you have problems with rectal fissures or polyps? _____

☐ Do you have indigestion? (If yes, how frequently?) _____

☐ Do you have problems with gas? (If yes, how frequently?) _____

☐ Do you have problems with bloating? (If yes, when?) _____

☐ Do you experience pain or tenderness in your abdomen? (If yes, when?) _____

☐ Have you ever had intestinal worms? (If yes, when?) _____

☐ Have you ever had an excessively itchy nose or rectum? (If yes, when?) _____

☐ Are you frequently nauseated? (If yes, how frequently?) _____

☐ Do you vomit frequently? (If yes, when?) _____

☐ Do you suffer from motion sickness? (If yes, when?) _____

☐ Have you been diagnosed with stomach ulcers? (If yes, when?) _____

☐ Do you have any other digestive disorders? _____

Healthy Urinary Tract

☐ Do you have frequent urination? (If yes, how frequently?) _____

☐ Do you ever lose control of your bladder? (If yes, how frequently?) _____

☐ Do you ever dribble urine when sneezing or laughing? _____

☐ Do you have painful urination? (If yes, how frequently?) _____

☐ Do you have difficulty starting your stream of urine? (If yes, how frequently?) _____

☐ Do you have frequent kidney or bladder infections? (If yes, how frequently?) _____

☐ Do you or have you ever had kidney stones? (If yes, when?) _____

☐ Do you have any other urinary tract disorders? _____

Healthy Circulation

☐ Do you have slurred speech? _____

☐ Do you have confusion? (If yes, when?) _____

☐ Have you been diagnosed with a heart condition? (If yes, when?) _____

☐ Do you have low blood pressure? _____

☐ Do you have high blood pressure? _____

☐ Do you have circulatory problems? _____

☐ Are you often dizzy? (If yes, when?) _____

☐ Do you get light headed when standing quickly? _____

☐ Do you have cold hands or feet? (If yes, how frequently?) _____

☐ Do you experience spells of rapid heartbeats? (If yes, how frequently?) _____

☐ Are you aware of your heart skipping beats? (If yes, how frequently?) _____

☐ Do you have nosebleeds? (If yes, how frequently?) _____

☐ Do you have varicose or spider veins? (If yes, where?) _____

☐ Have you been diagnosed with phlebitis? (If yes, when?) _____

☐ Do you have any other circulatory disorders? _____

Healthy Respiration

☐ Do you have hay fever or other allergies? _____

☐ Is your nose frequently stuffy? _____

☐ Have you been diagnosed with asthma? (If yes, when?) _____

☐ Have you been diagnosed with emphysema? (If yes, when?) _____

☐ Have you been diagnosed with bronchitis or pneumonia? (If yes, when?) _____

☐ Do you have chest pain or discomfort? (If yes, when?) _____

☐ Do you have post-nasal drip? (If yes, how frequently?) _____

☐ Do you spit up phlegm? (If yes, how frequently?) _____

☐ Do you snore frequently or loudly? _____

☐ Do you have any other respiratory disorders? _____

Healthy Detoxification

☐ Have you been diagnosed with any forms of cancer? (If yes, what form and where?)

_____

☐ Do you have any tumors or abnormal growths? (If yes, what form and where?) _____

☐ Have you been diagnosed with a liver condition? (If yes, when?) _____

☐ Have you ever had chemotherapy or radiation treatment? (If yes, when? Was it successful?) _____

☐ Do you have pain in the lower right portion of your abdomen? (If yes, when?) _____

☐ Have you worked or lived in any toxic environments? (If yes, where?) _____

☐ Do you have any other toxic conditions? _____

☐ Do you have old plumbing or paint in your home? _____

☐ Do you frequently consume seafood? (If yes, how frequently?) _____

☐ Do/did you live in an area with heavy outdoor pollution? (If yes, where and when?) _____

☐ Does breathing the air at work/home worsen your symptoms? _____

☐ Are you frequently in contact with household chemicals? (If yes, what brand?) _____

☐ Are you frequently in contact with topical cosmetics? (If yes, what brand?) _____

Healthy Allergy Correction

☐ Do you have allergies? (If yes, what?) _____

☐ Do you live or work in a moldy environment? (If yes, for how long?) _____

☐ Are you sensitive to fragrances or other odors? _____

Healthy Cancer Support

☐ Do/did any of your immediate family have cancer? _____

Supplements and Medications

Please list nutritional supplements you have tried with their results. Please specify if you are currently taking them.

_____

_____

Please list any prescription drugs you are currently taking, how long you have been taking them, and the conditions for which you are taking them:

_____

_____

_____

_____

Please list any prescription drugs you have taken in the past:

_____

_____

Please list any over the counter drugs you are currently taking, how long you have been taking them, and the conditions for which you are taking them:

_____

_____

Please list any over the counter drugs you have taken in the past:

_____

_____

Other

So we may provide you with the highest quality healthcare, please write any personal information you feel is important to your health and well-being:

_____

_____

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_____

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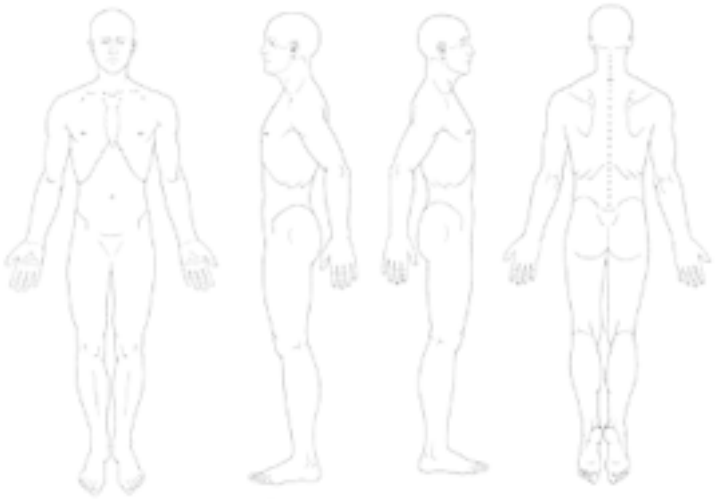
The major health problems of your immediate family will assist us in understanding your health pattern. Please report all diseases, sicknesses, reasons for hospitalization, cause, and age of death (if applicable):

Name	Relationship	Living?	Health Problems
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

Pain Locations and Descriptions



Legend

PP = Pain
NN = Numbness
TT = Tightness
BB = Burning
CC = Cramping

The information I have provided is accurate and true to the best of my knowledge.

_____ _____

(Signature) (Date)

Thank you for completing this questionnaire. We look forward to serving you!