NEW PATIENT INFORMATION

In order to receive the best possible results, it is important to read and understand the following information:

- Some cases may require treating preliminary items that are contained within a substance, such as vitamins, minerals, phenolics and/or sugars. For example, sugar may need to be addressed before proceeding with alcohol, grains or fruit.
- After addressing any preliminary items, patients may choose what order remaining substances are treated.
- It is possible to treat numerous items in one session if they are all part of the same family. For example, all dairy products (milk, cheese and yogurt) and calcium may be treated together. But dairy and wheat, or tomatoes and pollens may not be addressed in the same session. The treatment will not be successful.
- We cannot guarantee how many sessions each substance will require to reduce the symptoms associated with that item.
- When addressing a condition, instead of a single substance or family of substances, multiple items may be contributing to the symptoms. Therefore such conditions may require multiple sessions to relieve the symptoms of the condition.

Please adhere to the following guidelines:

- As a courtesy to our other patients who may have strong sensitivities, please do not smoke or wear perfume or fragrances prior to coming in to the clinic.
- Do not eat or chew gum during the session.

Office Policies

- The clinic has a 24-hour cancellation policy. Late cancellations or no-shows will incur a charge of ________.
- Please arrive 10 minutes prior to your appointment time. Late arrivals may be rescheduled and will incur a charge of ________.
- Payment is due at the time services are rendered.

Initial Assessment for:
Patient's Name ____

	Food Phenolics		Corn		Pollens		
	Eggs		Yeast Mix		Trees		
	Chicken		Caffeine		Grasses / Weeds		
	Protein		Coffee Mix		Flowers		
	Calcium		Chocolate		Plants		
	Milk / Dairy		Soy		Plant Phenolics		
	Vitamin C		Glutamates		Molds / Mildews		
	B-Complex		Amines		Fungus / Sinus Fungus		
	Vitamin A		Salicylates		Dust / Dust Mites		
	Iron		Artificial Preservatives		Cats		
	Mineral Mix		Artificial Colors		Dogs		
	Sugar Mix		Artificial Flavors		Cockroaches		
	Salt Mix		Acids				
	Grain / Wheat Mix		Enzymes				

PATIENT INFORMATION

Last Name________________________ First Name ________________ Date _________________________

Address ____ Zip Code __________

Telephone Home ______________ Work ____________________ Cellular ________________________

Email Address:____

Age _______________ DOB _________ Occupation ____

Who to reach in case of an emergency ____

How did you hear about our clinic? ____

Are you currently receiving health care? Please circle: Y N

If yes, name of physician:____

Condition being treated: ____

What are your most important health concerns?

1 ____

2 ____

3 ____

Please list tested or suspected allergies and related symptoms:

Foods ____

Seasonal ____

Drug / other ____

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

____

Daily Dosage ____

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)?____________________________

Do you smoke? Please circle: Y N

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the items listed on the New Patient Information form.

Signature ____ **Date** ____________

(If under the age of 16, must be signed by Parent or Legal Guardian.)

WAIVER AND RELEASE

I ______________________ (the "Undersigned"), hereby consent to treatment at
(INSERT CLINIC NAME AND ADDRESS)

I understand that such procedures are non-invasive.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results in the reduction of symptoms. The clinic cannot guarantee that new reactions will not develop in the future. While the treatment can address many symptoms associated with allergies and sensitivities some cases do not respond to the treatment.

I also understand that the only known risk factor with the treatment of symptoms associated with allergies or sensitivities, including immunotherapy, is the possibility of increased sensitivity. I assume all responsibility for unpredictable reactions which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention.

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

☐ **No, I do not have any life threatening allergies.**

☐ Yes, I have the following allergies that may cause anaphylaxis:

____

____

____

I agree to pay the clinic the standard fee for any and all treatments administered.

IN WITNESS THEREOF, the undersigned executed the Agreement as of

DATE ______________________________

______________________________ ______________________________
Signature of Undersigned Signature of Practitioner

____
Signature of Parent or Legal Guardian

Updated 11/2010