Are You Ready...?

☐ Contact any doctors you need to get copies of previous labs from.
  - These can be faxed to us as well, at 425-823-8817.

☐ Get blood drawn (2 weeks prior to visit)- if you have not had basic blood work (CBC & CMP) in the last 4 months.
  - Confirm blood work is sent to CMC.

☐ Schedule panoramic x-ray- if you currently do not have one.
  - Get this your at your dentist- or at Northwest Radiography in Bellevue (425) 453-3440.

☐ Print & fill out paperwork.

☐ Fax or E-mail back to us at least 2 days prior to your appointment.

☐ All supplements and medications you are currently on- preferably one dose in individual baggies, labeled so you know what they are.

Time To Go? You Should Have:

☐ Filled out paperwork.

☐ Panoramic x-ray.

☐ Any extra labs you want the doctor to see.

☐ Plenty of time! Please arrive ½ before your scheduled appointment, and no eating or drinking ½ hour prior to arriving at the clinic.

☐ Bagged supplements
Directions to our Clinic

I-405 S toward Bellevue/Renton:
• Take Exit #20
• Right onto NE 124th Street
• Left onto 100th Ave NE (becomes 98th Ave NE)
• CMC is on your left (two-story peach building with parking in the back)

I-405 N toward Everett:
• Take Exit #20A
• Left onto NE 116th Street
• Right onto 98th Ave NE
• CMC is on your right (two-story tan building with parking in the back)

LOST? Please call our office for help.
Dr. Nazanin Kimiai, ND, L.AC,

Dr. Nazanin Kimiai has received her medical degree in naturopathic medicine, as well as Acupuncture and Oriental medicine from Bastyr University in Washington. She has done her undergraduate studies in the field of psychology at Seattle Pacific University in Seattle, Washington. She has completed advanced studies and an internship program in Acupuncture and Oriental medicine in four major hospitals in Mainland China. She has also been extensively trained and she has worked with Dr. Klinghardt MD, Ph.D., for over 15 years.

She is the founder of The Comprehensive Medical Center, an inter disciplinary clinic in Kirkland, Washington. Believing in the principle and the wide variety of the treatment modalities offered through her field. She has orchestrated a medical clinic that offers every patient, any possible treatment program integrating body, mind and spirit in healing within the naturopathic scope of practice.

Dr. Kimiai incorporates elements of many disciplines in her practice through understanding the process of health. She specialized in Oriental medicine, Homeopathy, Naturopathy, Neuraltherapy, Oxidative medicine, German Biological Medicine, and Homotoxicology with an extensive detox program for environmentally and/or chemically sensitive as well as chronically ill patients.

Dr. Kimiai is a/an:
- Doctorate of Naturopathic Medicine, licensed in the State of Washington
- Diplomate of National Council for Certification of Acupuncturists
- Acupuncture licensed, State of Washington
- Member of the Association of Naturopathic Physician, State of Washington
- Member of Acupuncture Association of Washington
- Member of Institute of Oxidative Medicine
- Member of American Academy of Environmental Medicine
- Member of ACAM
- Member of A4 (Anti-aging Medicine)
- Board certified physician anti-aging medicine
**COMPREHENSIVE MEDICAL CENTER**  
11656-98TH AVENUE NE  
KIRKLAND, WA 98034  
PHONE: 425-823-8818  FAX: 425-823-8817

**PERSONAL INFORMATION SHEET**

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<td>ADDRESS:</td>
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<td>STREET</td>
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<td>CITY</td>
<td>STATE</td>
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<tr>
<td>HOME PHONE #</td>
<td>(CELL)</td>
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<tr>
<td>EMAIL:</td>
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<td>MARITAL STATUS:</td>
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<td>DATE OF BIRTH:</td>
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<td>GUARANTOR OF THE ACCOUNT, IF OTHER THAN PATIENT:</td>
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<td>CREDIT CARD#</td>
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**EMERGENCY CONTACT INFORMATION:**

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**REASON FOR VISIT:**

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**AUTHORIZATION FOR TREATMENT**

The undersigned hereby authorizes the doctor to perform diagnostic tests deemed necessary for my care, to perform any and all forms of treatment, medication and therapy that are indicated and are in accordance with the Standards of Naturopathic Care. I understand that I will be responsible for payment for all services and fees rendered by Comprehensive Medical Center.

Patient's Signature:  
Date:  
Parent or Responsible Party:  
Relationship:  
COMPREHENSIVE MEDICAL CENTER
FINANCIAL RESPONSIBILITY AGREEMENT

Client Fees and Payment Policies of Comprehensive Medical Center

Full payment for all charges is required at the time of service. In special circumstances, the doctor may arrange differently. A minimum billing fee of $2.00 or 15% APR, whichever is greater, is added to any unpaid balance. Slight fee increases may occur in September of each year to accommodate increases in expenses. We are committed to providing economical, quality healthcare. Thank you for your patronage.

FIRST OFFICE VISIT
Dr. Kimiai first initial visit: $400.  

SOTTOPELLE:
Women: $500 initial visit, $350 for reinsertions.
Men: $500-$1000, determined after lab work.

PHONE CONSULTATIONS
Dr. Kimiai $6/minute. There is a minimum of 15 minutes charge. Please be advised that there is additional charge for the physician to review your chart and write a protocol. Please contact the front desk before scheduling any future appointments, as these prices are subject to change.

RETURN OFFICE VISIT
Dr. Kimiai $250 an hour, Dr. Allen $150 an hour. Please contact the front desk before scheduling any future appointments, as these prices are subject to change.

NON-SUFFICIENT FUNDS
We accept payment by check, cash, Visa, or MasterCard. Checks or credit cards payments denied for lack of funds will be charged a fee of $59.
CANCELATION CHARGE
We require 72-hour notice, during our normal business hours, for canceling or rescheduling a new patient visits, if you are coming for 1 day only and a 2 week notice if you are coming for 1 week. 24-hour notice must be given for the canceling or rescheduling of a return office visit. Half the cost of the scheduled visit will be charged for late cancellation notice. Full fee is charged when no notice is given.

Initial __________

INSURANCE
All charges incurred at our office are your responsibility and due at the time of service, regardless of any insurance coverage you may have. You will be provided a super bill at the time of service, which you may submit to your insurance company for reimbursement. If any and/or all of these super bills have to be reproduced at a later time there will be a fee to reproduce these forms. Our office does not process prior authorization requests; however, there will be a $35 minimum fee for special circumstances.

Initial __________

Please check with your insurance provider before scheduling appointments if you are planning on submitting your bill. Some services that we provide that are not covered by insurance, include, but are not limited to:

Infrared sauna  Colon Hydrotherapy
Constitutional Hydrotherapy  Hypothermia
IV Therapies  Sauna
Lymphatic Drainage

PURCHASE OF PHARMACY PRODUCTS
All pharmacy items must be paid for at the time of purchase.

Initial __________

PHARMACY PURCHASE RETURNS
Credit towards future purchases will be given for unopened items in perfect condition if returned within 10 days. Refrigerated items, herbal tinctures, homeopathic remedies, injectable remedies, injectable supplies, and products packaged in the clinic are final sale and cannot be returned.

Initial __________

I agree to make payment according to the policies of the Comprehensive Medical Center stated herein.

PATIENT NAME: ____________________________ (Print)

PATIENT SIGNATURE: ______________________ DATE: ______________
Informed Consent for Naturopathic Consultation

I, ___________________________ hereby authorize naturopathic assessment and consultation and certify that I understand the nature of this healthcare method, including the risks of possible adverse reactions and choices I may have about other approaches. I understand that the physicians at Comprehensive Medical Center (CMC) do not function as primary care physicians. I understand that CMC does not offer after hour services or provide any hospital-based services. If I have difficulty with any aspects of my care at CMC, I understand that I should call during business hours to discuss my concerns. Urgent symptoms or other health related emergencies will be brought to the attention of my primary care doctor or the nearest urgent care facility.

I hereby authorize the staff of CMC to leave detailed messages on the following phone number regarding medical questions or lab results:________________________.  Initial __________

I hereby authorize the staff of CMC to leave detailed messages on the following email address regarding medical questions or lab results:________________________.  Initial __________

I, ___________________________ hereby authorize the medical staff at CMC to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, PAP smears, thermography, laboratory, tissue biopsy.

Minor office procedures: e.g., neural therapy, therapeutic injections, wound dressing, ear cleansing.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections, IV therapies.

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body’s healing responses.

Pharmacology: naturopathic physicians in Washington state may prescribe legend drugs as defined under RCW 69.41.010 with the exception of Botulinum toxin. This includes IV administration of all substances within prescriptive authority.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

Psychological counseling

I recognize the potential risks and benefits of these procedures as described below:
Potential risks: allergic reactions to prescribed herbs and supplements; side effects of medications; aggravation of pre-existing symptoms; discomfort; pain; infection; burns; nausea; light headedness; inconvenience of lifestyle changes; injury from injections, venipuncture or procedures. Notify the medical staff at CMC if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of surgery; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression.

Notice to pregnant or lactating women: Please inform your physician immediately if you are pregnant, suspect you are pregnant, or if you are breastfeeding. Some of the therapies used could present a risk to the pregnancy or child.

With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been given to me by the medical staff at Comprehensive Medical Center regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

__________________________________________
Signature of Patient or Guardian

__________________________________________
Date

__________________________________________
Printed Name of Patient
We understand that your medical and health information is personal. Protecting our health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

When you receive care from us, we may use our health information for treating you, billing for services, and conducting our normal business known as health care operations. Examples of how we use your information include:

- **Treatment:** We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment.
- **Payment:** We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services provided to you to claim and obtain payment from our insurance company or Medicare.
- **Health Care Operations:** We use your health information to improve the quality of care, train staff, provide customer service, manage costs, conduct required business duties, and make plans to better serve our patients.

To use your health information for other than the above uses requires your signed authorization.

There are limited situations when we are permitted or required to disclose health information without your signed authorizations. These situations include:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drug problems with medical devices.
- To protect victims of abuse, neglect, or domestic violence.
- For health oversight activities such as investigations, audits, and inspections.
- For lawsuits and similar proceedings.
- When otherwise required by law.
- When requested by law enforcement as required by law or court order.
- To coroners, medical examiners, and funeral directors.
- To deduce and prevent a serious threat to public health and safety.
- For other limited situations, see the full copy of our Notice of Privacy Practices.

We are required by law to:

- Maintain the privacy of your health information.
- Provide this notice that describes the ways we may use and share your health information.
- Follow the terms of the notice currently in effect.
- We reserve the right to make changes to this notice at any time and make the new privacy practices effective with all information we maintain. You may request a copy of any notice from our Privacy Officer.

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restrictions.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances we may deny you access to some portion of your health information and you may request a review of the denial.
- Request amendments or additions to your health record.
- Request an accounting of certain disclosures of your health information made by us.

All the above requests must be made in writing through our Privacy Officer.
Notice of Privacy Practices
Patient Acknowledgement

Patient Name: ___________________ Date of Birth: ______________

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which the practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: ___________________ Date: ___________________

Relationship to patient (if signed by a personal representative of patient): ___________________
Policy for Patients that have Medicare Insurance

The policies at Comprehensive Medical Center; Dr. Nazanin Kimiai, ND, and Dr. Beck, ND, for Medicare patients are:

1. We do not bill Medicare.
2. We have our patients pay at the time of care.
3. We ask that our patients do not turn in our forms, receipts or claim forms to Medicare for reimbursement for the expenses charged in our clinic.

I __________________ have read the policy on Medical billing and claim forms. I intend to be tested and treated at the Comprehensive Medical Center by one of the above independent providers. I agree not to seek reimbursement now or at any time for the services rendered at the Comprehensive Medical Center.

Signature: ___________________________ Date: __________
LABORATORY CHARGES

The healthcare professionals at Comprehensive Medical Center do their utmost to ensure that you receive the best possible treatment for our condition. We will also spend as much time as is required for treatment of each patient. Because of the quality of care we are trying to give to our patients, we can schedule only a limited number of patients each day. In return, we are requesting that you show up for your appointments. Please refer to Sec. 7 of the Financial Responsibility Agreement setting forth our cancellation fees.

Some of the lab tests are the financial responsibility of the patient. We hope that this is not an inconvenience for you and appreciate your immediate response to the given laboratories. Please be aware of the specific laboratory name and address. We will assist you with any information that you may need to supply to them.

I am financially responsible for some of the laboratory payments that are required during my treatment with Dr. Kimiai or any other physicians at Comprehensive Medical Center. I have read, understand and agree to the terms outlined herein. I understand that I am charged by the procedure.

NAME:________________________ DATE:_______

SIGNATURE:________________________
# Pertinent Neural Therapy History

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Age</th>
<th>Date</th>
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**A. Please complete the following with the approximate age of occurrence:**

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>AGE</th>
<th>DENTAL INTERVENTION</th>
<th>AGE</th>
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</thead>
<tbody>
<tr>
<td>(Please list surgeries: e.g., tonsillectomy, appendectomy, etc.)</td>
<td></td>
<td>(Root canals &amp; extractions-please try to name &amp; number tooth-refer to dental chart on the back. Also age of first silver amalgam filling, braces, retainer, etc.)</td>
<td></td>
</tr>
<tr>
<td>TOXIC PROFESSION PAST PRESENT</td>
<td>AGE</td>
<td>LONG PERIODS ON PRESCRIPTION OR STREET DRUGS, OR ALCOHOL, OR CIGARETTES</td>
<td>AGE</td>
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<tr>
<td>(artist, graphic designer, dentist, dental assistant gas station worker, painter, industry, computer cleaning, etc.)</td>
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<tr>
<td>INJURIES/ACCIDENTS WITHOUT STITCHES</td>
<td>AGE</td>
<td>INJURIES/ACCIDENTS WITH STITCHES</td>
<td>AGE</td>
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<tr>
<td>MAJOR PSYCHOLOGICAL TRAUMA</td>
<td>AGE</td>
<td>TREATED FOR PARASITES AND/OR INFECTION?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**TOTAL CHILDMARKS:**

**TOTAL CHILDMARKS:**

**TOTAL CHILDMARKS:**

**TOTAL CHILDMARKS:**
Social History:
The following is important and will help the doctor determine how your lifestyle affects your health.
On an average day, how much?
Coffee ______ Alcohol per day/week (oz) ______
Tea? ______ Do you smoke? Y N How many per day? ______
Milk? ______ Do you use other tobacco products? Y N
Juice? ______ Do you use recreational drugs? Y N
Soda ______ Hours of sleep per night ______
Water ______

What did you have for your last:
  Breakfast: ____________________________________________
  ____________________________________________
  ____________________________________________

  Lunch: ____________________________________________  ____________________________________________
  ____________________________________________
  ____________________________________________

  Dinner: ____________________________________________

What do you snack on? ____________________________________________

Do you have an exercise program? Y N

Marital status: (circle one)
Married    Widow    Divorced    Single    Living with significant other

Employment:
Who is your employer? ____________________________________________
What activities do you do at work? ____________________________________________
Do you handle chemicals? ____________________________________________
Do you like your job? Y N    Don't know    How long at this job? ______

I live in a: House    Apartment    Trailer    Other:________
I have lived in this structure for ______ years/months
I have: (please circle) a SmartMeter    Wi-Fi    Use a Microwave

Please leave this section blank for the doctor.
Air quality airtight: y/n    heat oil/gas/electric/WBS plants:________
Water: city/well/distilled/filter:________
Pets:______________________________________________
Dust:______________________________________________
Spiritual/religious interests:________________________
Hobbies:__________________________________________
Family History:
If any blood relatives have had any of the following please circle.
- Diabetes
- Hypoglycemia
- Cancer
- Tuberculosis
- Glaucoma
- Seizures
- Mental illness
- Heart disease
- Allergies
- Kidney disease
- Bleeding disorders
- Sickle cell anemia
Approximate age is okay.

Parents:
Mother: Living/Deceased; age____ (please circle)
Notable conditions:

Father: Living/Deceased; age____ (please circle)
Notable conditions:

Fathers side:
Grandmother: Living/Deceased; age____ (please circle)
Notable conditions:

Grandfather: Living/Deceased; age____ (please circle)
Notable conditions:

Mothers side:
Grandmother: Living/Deceased; age____ (please circle)
Notable conditions:

Grandfather: Living/Deceased; age____ (please circle)
Notable conditions:

List brothers and sisters with ages and medical problems: L-Living D-Deceased

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List your children and ages including medical problems: M-Son F-Daughter

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C. Please use the numbered teeth below to indicate on the other side which teeth have had dental intervention. **ALSO**, please use the KEY to mark appropriately on the dental chart, and answer upper/lower, if appropriate.

**Use a mirror!**

(#1, 16, 17 & 32 are wisdom teeth)

**Dental Chart**

**KEY**
- Pulled teeth  
- Cavities filled  
- Crowns  
- Bridge  
- Root canals

- Dentures?  
- Braces?  
- Retainer or Night Guard?

**E. Finally, mark with an "X" where you have pain or dysfunction.**

D. Write your chief complaint(s) below and indicate the approximate age of onset.

<table>
<thead>
<tr>
<th>HEALTH COMPLAINT</th>
<th>AGE</th>
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(Over)
HEALTH APPRAISAL QUESTIONNAIRE

Name__________________________________________ Date________________

PART I

Circle any of the following medications you are taking:

* Antacids
* Antibiotic/Antifungal
* Antidepressants
* Antidiabetic/Insulin
* Aspirin/Tylenol
* Chemotherapy
* Cortisone/Anti-Inflammatories
* Heart Medications
* High Blood Pressure
* Hormones
* Laxatives
* Lithium
* Oral Contraceptives
* Radiation
* Recreational Drugs
  Specify________________________
* Relaxants/Sleeping Pills
* Thyroid
* Ulcer Medications
* Other________________________

Circle if you eat, drink or use:

* Alcohol
* Candy
* Carbonated Beverages
* Cigarettes
* Coffee
* Distilled water
* At fast food restaurants regularly
* Fried foods
* Luncheon meats
* Margarine
* Refined sugars
* Saccharine (Sweet 'n Low)
* Chew tobacco
* Vitamins and/or minerals
  (Please list)____________________

Circle if you:

* Diet often
* Do not exercise regularly
* Past or recent water drainage issue at home or place of work
* Salt food without tasting
* Are under excessive stress
* Are exposed to chemicals at work or home
* Are exposed to cigarette smoke
* Past or recent exposure to animals

INSTRUCTIONS: Circle the number that best describes the intensity of your symptoms. If you do not know the answer to the question, leave it blank. 0 = Symptom is not present     1 = Mild     2 = Moderate     3 = Severe

PART II

1. Burping
2. Fullness for extended time after meals
3. Bloating
4. Poor appetite
5. 0 1 2 3
6. 0 1 2 3
7. 0 1 2 3
8. 0 1 2 3
9. 0 1 2 3
10. 0 1 2 3
11. 0 1 2 3
12. 0 1 2 3
13. 0 1 2 3
14. 0 1 2 3
15. 0 1 2 3
16. 0 1 2 3
17. 0 1 2 3
18. 0 1 2 3
19. 0 1 2 3
20. 0 1 2 3
21. 0 1 2 3
22. Vaginal yeast infection
23. Toe and fingernail fungus
24. History of antibiotic use
25. Stomach upsets easily
26. 0 1 2 3
27. 0 1 2 3
28. 0 1 2 3
29. 0 1 2 3
30. 0 1 2 3
31. 0 1 2 3
32. 0 1 2 3
33. 0 1 2 3
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42. 0 1 2 3
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<th></th>
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<th>5. Abdominal Cramps</th>
<th>0 1 2 3</th>
<th>26. History of constipation</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6. Indigestion 1-3 hours after eating</td>
<td>0 1 2 3</td>
<td>27. Known food allergies</td>
<td>0 1 2 3</td>
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<td></td>
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<td>7. Fatigue after eating</td>
<td>0 1 2 3</td>
<td>28. Lack of interest in eating</td>
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<td></td>
<td></td>
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<td>8. Alternating constipation/diarrhea</td>
<td>0 1 2 3</td>
<td>29. Shiny stool</td>
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<td></td>
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<td>9. Diarrhea</td>
<td>0 1 2 3</td>
<td>30. Three or more large bowel movements daily</td>
<td>0 1 2 3</td>
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<td>10. Roughage and fiber causes constipation</td>
<td>0 1 2 3</td>
<td>31. Dry, flaky skin and/or dry brittle hair</td>
<td>0 1 2 3</td>
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<td></td>
<td>11. Mucous in stools</td>
<td>0 1 2 3</td>
<td>32. Pain in left side under rib cage</td>
<td>0 1 2 3</td>
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<td></td>
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<td></td>
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<td>12. Stool poorly formed</td>
<td>0 1 2 3</td>
<td>33. Acne</td>
<td>0 1 2 3</td>
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<td></td>
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<td></td>
<td>13. Stomach pains</td>
<td>0 1 2 3</td>
<td>34. Food allergies</td>
<td>0 1 2 3</td>
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<td></td>
<td></td>
<td></td>
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<td>14. Stomach pains just before and/or after meals</td>
<td>0 1 2 3</td>
<td>35. Difficulty gaining weight</td>
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<td>15. Dependency on antacids</td>
<td>0 1 2 3</td>
<td>36. Relief of symptoms by carbonated beverages</td>
<td>NO YES</td>
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<td>16. Chronic abdominal pain</td>
<td>0 1 2 3</td>
<td>37. Relief of stomach pains by drinking milk/cream</td>
<td>NO YES</td>
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<td>17. Butterfly sensations in stomach</td>
<td>0 1 2 3</td>
<td>38. History of ulcer or gastritis</td>
<td>NO YES</td>
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<td></td>
<td></td>
<td></td>
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<td>18. Difficulty belching</td>
<td>0 1 2 3</td>
<td>39. Current ulcer</td>
<td>NO YES</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>19. Stomach pain when emotionally upset</td>
<td>0 1 2 3</td>
<td>40. Black stool when not taking iron supplements</td>
<td>NO YES</td>
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<td></td>
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<td>20. Frequent and recurrent infections (colds)</td>
<td>0 1 2 3</td>
<td>41. Meat eater</td>
<td>NO YES</td>
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<td>21. Bladder and kidney infections</td>
<td>0 1 2 3</td>
<td>42. Rapidly failing vision</td>
<td>NO YES</td>
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**PART III**

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<th></th>
<th></th>
<th></th>
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<th>1. Intolerance to greasy foods</th>
<th>0 1 2 3</th>
<th>16. Depressed, apathetic</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Headaches after eating</td>
<td>0 1 2 3</td>
<td>17. Retain water</td>
<td>0 1 2 3</td>
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<td></td>
<td></td>
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<td>3. Light colored stool</td>
<td>0 1 2 3</td>
<td>18. Big toe painful</td>
<td>0 1 2 3</td>
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<td></td>
<td></td>
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<td>4. Foul smelling stool</td>
<td>0 1 2 3</td>
<td>19. Puffy, wrinkly skin</td>
<td>0 1 2 3</td>
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<td>5. Less than on bowel movement daily</td>
<td>0 1 2 3</td>
<td>20. Sugar causes irritability and mood swings</td>
<td>0 1 2 3</td>
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<td>6. Hard stool</td>
<td>0 1 2 3</td>
<td>21. Muscle pain or stiffness</td>
<td>0 1 2 3</td>
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<td>7. Sour taste in mouth</td>
<td>0 1 2 3</td>
<td>22. Red blood in stool</td>
<td>NO YES</td>
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<td></td>
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<td>8. Grey colored skin</td>
<td>0 1 2 3</td>
<td>23. High blood cholesterol</td>
<td>NO YES</td>
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<td></td>
<td></td>
<td></td>
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<td>9. Yellow in whites of eyes</td>
<td>0 1 2 3</td>
<td>24. Thinning or loss of outside portion of eyebrow</td>
<td>NO YES</td>
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<td></td>
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<td>10. Bad breath</td>
<td>0 1 2 3</td>
<td>25. Gain weight easily</td>
<td>NO YES</td>
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<td></td>
<td></td>
<td></td>
<td>11. Swollen eyes (bulging)</td>
<td>0 1 2 3</td>
<td>26. Anemia unaffected by iron</td>
<td>NO YES</td>
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<td></td>
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<td></td>
<td>12. Strong smelling urine</td>
<td>0 1 2 3</td>
<td>27. Axillary (armpit) temperature below 97.6 F</td>
<td>NO YES</td>
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<td></td>
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<td>13. Sensitive to the cold</td>
<td>0 1 2 3</td>
<td>28. Infertility</td>
<td>NO YES</td>
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<td></td>
<td></td>
<td></td>
<td>14. Cold hands and feet</td>
<td>0 1 2 3</td>
<td>29. Trouble waking up in the morning</td>
<td>0 1 2 3</td>
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<tr>
<td></td>
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<td></td>
<td>15. Excessive menstrual bleeding</td>
<td>0 1 2 3</td>
<td>24. Dark circles under the eyes</td>
<td>0 1 2 3</td>
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</table>

**PART IV**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th>1. Feel tired in the afternoon</th>
<th>0 1 2 3</th>
<th>25. Dizziness upon standing</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Itchy eyes</td>
<td>0 1 2 3</td>
<td>26. Lack of mental alertness</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Red or inflamed eyes</td>
<td>0 1 2 3</td>
<td>27. Headaches</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Low blood pressure</td>
<td>0 1 2 3</td>
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<td></td>
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</tbody>
</table>
5. Sensitive to exhaust fumes, smoke, smog, and petrochemicals 0 1 2 3
6. Cannot tolerate much exercise 0 1 2 3
7. Water retention 0 1 2 3
8. Eyes sensitive to bright light 0 1 2 3
9. Depression or rapid mood swings 0 1 2 3
10. Inflamed or bleeding gums 0 1 2 3
11. Running nose 0 1 2 3
12. Get boils or styes 0 1 2 3
13. Nose bleeds 0 1 2 3
14. Loss of smell 0 1 2 3
15. Throat infections 0 1 2 3
16. Cold sores, fever blisters 0 1 2 3
17. Loss of taste 0 1 2 3
18. Swollen joints 0 1 2 3
19. Certain foods make you sick, depressed, or jittery 0 1 2 3
20. Chronic pain 0 1 2 3
21. Mucous in throat 0 1 2 3
22. Post nasal drip 0 1 2 3
23. Discharge from eyes 0 1 2 3

**PART V**

1. Difficulty breathing at night 0 1 2 3
2. Chest pain while walking 0 1 2 3
3. Heaviness in legs 0 1 2 3
4. Calf muscles cramp while walking 0 1 2 3
5. Heart pounds easily 0 1 2 3
6. Feel jittery 0 1 2 3
7. Heart misses beats or has extra beats 0 1 2 3
8. Swelling of feet and ankles 0 1 2 3
9. Slurred speech 0 1 2 3
10. Headaches 0 1 2 3
11. Numbness in extremities 0 1 2 3
12. Pain when getting up in morning in back of head and neck 0 1 2 3
13. Heartburn after eating 0 1 2 3
14. Pain in left arm 0 1 2 3
15. Exhaust with minor exertion 0 1 2 3
16. Do you do aerobic exercise? NO YES
17. Have you ever exercised regularly? NO YES
18. Drink 5 or more cups of coffee daily NO YES
19. Severe cough NO YES
20. Has a doctor ever told you that you have heart trouble? NO YES
21. Poor concentration 0 1 2 3
22. Ringing in ears 0 1 2 3
23. Ear canal hair NO YES
24. Tingling and/or burning in hands or feet NO YES
25. Spider veins on nose and/or face NO YES
26. Vertigo 0 1 2 3
27. Blushing with no apparent cause 0 1 2 3
28. Is your blood pressure high? NO YES
PART VI
1. Loss of vision when standing suddenly 0 1 2 3
2. Crave sweets 0 1 2 3
3. Headaches relieved by eating sweets or alcohol 0 1 2 3
4. Feel shaky or jittery 0 1 2 3
5. Irritable if a meal is missed 0 1 2 3
6. Wake up in middle of night craving sweets 0 1 2 3
7. Feel tired or weak if a meal is missed 0 1 2 3
8. Night sweats 0 1 2 3
9. Increased thirst 0 1 2 3
10. Fatigue 0 1 2 3
11. Boils and leg sores 0 1 2 3
12. Need to drink coffee to get started 0 1 2 3
13. Feel faint 0 1 2 3
14. Poor concentration 0 1 2 3
15. Forgetful 0 1 2 3
16. Calmer after eating NO YES
17. Overweight 0 1 2 3
18. Feel energized from exercise 0 1 2 3
19. Failing eyesight 0 1 2 3
20. Sugar in urine 0 1 2 3
21. Family history of diabetes 0 1 2 3
22. Crave sweets, but eating sweets does not relieve craving NO YES

PART VII
1. Chronic cough 0 1 2 3
2. Coughing up blood 0 1 2 3
3. Coughing up phlegm 0 1 2 3
4. Pain around ribs 0 1 2 3
5. Shortness of breath 0 1 2 3
6. Rattling mucous when you breathe 0 1 2 3
7. Sensitive to smog 0 1 2 3
8. Infections settle in lungs 0 1 2 3
9. Live or work around people who smoke 0 1 2 3
10. Bronchitis NO YES
11. Exposed to chemicals and radiation NO YES
12. Smoker NO YES

PART VIII
1. Frequent urination 0 1 2 3
2. Frequent bladder infections 0 1 2 3
3. Rarely need to urinate 0 1 2 3
4. Urination when you cough or sneeze 0 1 2 3
5. Painful/burning when passing urine 0 1 2 3
6. Difficulty passing urine 0 1 2 3
7. Can’t hold urine 0 1 2 3
8. Rose colored (bloody) urine 0 1 2 3
9. Cloudy urine 0 1 2 3
10. Back of leg pains associate with dripping after urination 0 1 2 3
11. Frequent vaginal infections 0 1 2 3
12. Back pain in the kidney area 0 1 2 3
13. General water retention 0 1 2 3
14. History of kidney or bladder infections NO YES
15. Have used antibiotics to control urinary tract infections? NO YES

IF YES, WHEN DID YOU LAST USE THEM?
TREATMENT DURATION:

PART IX (MALES ONLY)
1. Difficulty urination 0 1 2 3
2. A sense of bladder fullness 0 1 2 3
8. Premature ejaculation 0 1 2 3
9. Wake up to urinate at night 0 1 2 3
3. Increased straining with smaller amounts of urine passed
4. Rose colored (bloody) urine
5. Pain or burning while urinating
6. Difficulty attaining and/or maintaining an erection
7. Low sexual drive

**PART X (FEMALES ONLY)**
1. Monthly weight gain
2. Headaches
3. Easily distracted
4. Anger
5. Bloating and swelling
6. Tender breasts
7. Nausea and/or vomiting
8. Low backache
9. Anxiety
10. Suicidal feeling
11. Leg cramps and tenderness
12. Asthma attacks
13. Vaginal itching
14. Over 15 years of age and not begun menstruation
15. Vaginal discharge
16. Low or no desire for sex
17. Unable to get pregnant
18. Dislike for intercourse
19. Missed periods
20. Have to lie down on 1st or 2nd day of period
21. Pelvic soreness
22. Light scanty blood flow
23. Pain and cramps without blood flow
24. Anxiety about menstrual cycle
25. Pain during period is progressively getting worse
26. Vaginal bumps and sores
27. Ovarian cysts
28. Pubic area sore
29. Uterine cysts
30. Pain in ovaries
31. Breast lumps
32. Breasts sore to touch
33. Mother used D.E.S. (hormones) while pregnant
34. Breasts painful
35. Recent pap smear positive
36. Family history of breast cancer
37. Birth control pills
38. Hot flashes
39. Dryness of skin, hair, and vagina
40. Night sweats
41. Painful intercourse
42. Vaginal pain
43. Insomnia
44. Vaginal itching
45. Osteoporosis (bone loss)
46. Heavy bleeding for 2 weeks to a month
47. Hysterectomy
48. Sweating throughout day

**PART XI**
1. Pain in fingers
2. Bones sore/painful
3. Cavities
4. Dripping after urination
5. Ejaculation causes pain
6. Pain/coldness in genital area
7. Infertile
8. Varicose veins on scrotum
9. Low sperm count

**Females Only**
10. Pain during period is progressively getting worse
11. Vaginal bumps and sores
12. Ovarian cysts
13. Pubic area sore
14. Uterine cysts
15. Pain in ovaries
16. Breast lumps
17. Breasts sore to touch
18. Mother used D.E.S. (hormones) while pregnant
19. Breasts painful
20. Recent pap smear positive
21. Family history of breast cancer
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23. Hot flashes
24. Dryness of skin, hair, and vagina
25. Night sweats
26. Painful intercourse
27. Vaginal pain
28. Insomnia
29. Vaginal itching
30. Osteoporosis (bone loss)
31. Heavy bleeding for 2 weeks to a month
32. Hysterectomy
33. Sweating throughout day
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<tbody>
<tr>
<td>4. Arthritis</td>
<td>0 1 2 3</td>
<td>15. Bone deformity</td>
<td>NO  YES</td>
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<tr>
<td>5. Drink carbonated beverages/soda (#/week)</td>
<td>0 1-3 4-7 7+</td>
<td>16. Told you have osteoporosis/osteomalacia</td>
<td>NO  YES</td>
<td></td>
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<tr>
<td>6. Use antacid (#/week)</td>
<td>0 1-3 4-7 7+</td>
<td>17. Herniated disc</td>
<td>NO  YES</td>
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<td>7. Stiff in morning</td>
<td>0 1 2 3</td>
<td>18. Recent bone fracture</td>
<td>NO  YES</td>
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<td></td>
<td></td>
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<tr>
<td>8. Pain in neck and/or shoulders</td>
<td>0 1 2 3</td>
<td>19. Stiff all over</td>
<td>0 1 2 3</td>
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<tr>
<td>9. Unable to sit straight</td>
<td>0 1 2 3</td>
<td>20. Back pain</td>
<td>0 1 2 3</td>
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</tr>
<tr>
<td>10. Swollen knees/elbows</td>
<td>0 1 2 3</td>
<td>21. Athletic injury</td>
<td>0 1 2 3</td>
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<tr>
<td>11. Bursitis</td>
<td>0 1 2 3</td>
<td>22. Tendonitis</td>
<td>0 1 2 3</td>
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**PART XII**

|   |   |   |   |   |
|---|---|---|---|
| 1. Head feels heavy | 0 1 2 3 | 7. Loss of grip strength | 0 1 2 3 |
| 2. Ringing/buzzing in ears | 0 1 2 3 | 8. Convulsions | NO  YES |
| 3. Trembling hands | 0 1 2 3 | 9. Accident prone | NO  YES |
| 4. Loss of feeling in hands and/or feet (toes) | 0 1 2 3 | 10. Loss of muscle tone | NO  YES |
| 5. Exhaustion on slightest effort | 0 1 2 3 | 11. Need for 10-12 hours sleep | NO  YES |
| 6. Limbs feel too heavy to hold up | 0 1 2 3 | 12. Have had shingles | NO  YES |

**PART XIII**

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<tbody>
<tr>
<td>1. Nightmares</td>
<td>0 1 2 3</td>
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<tr>
<td>2. Can’t fall asleep</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
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<tr>
<td>3. Intense dreams</td>
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IV Therapy for Asthma/Cardiovascular Disease/Other Health Problems -- Signature Form

Dr. _______________ treats a number of illnesses using IV therapy (parenteral therapy) with various nutrients or chelation therapy. This is because, for most patients with significant health problems, IV therapy has been shown in his practice to be effective in the long term, and because Dr. _______________ feels it is far safer than giving you powerful and potentially dangerous drugs which often have significant adverse side effects.

Parenteral therapy with nutrients or chelation therapy are not yet considered to be “traditional” therapy in this country. More and more physicians are finding the benefits from this approach, but it will take quite some time before it is considered the "standard" of care. For this reason -- because it is a non-traditional approach -- Dr. _______________ wants you to understand the risk verses benefit ratio of this important approach to helping solve your health problems.

IV therapy with nutrients must be considered "investigational" in this country and does not benefit all patients. Some of the IV nutrients in the form or dosage used by this office are not yet approved by the FDA. If you have asthma or another serious illness, IV therapy could even make you considerably worse after the first (or even the first few) treatment(s), so you must be aware of this eventuality. We generally ask our patients to commit to 3 treatments at a minimum, as it sometimes takes 3 treatments to see a significant effect. However, if satisfactory subjective or clinical results are not noted by the time the first 3 treatments are complete, we generally discontinue therapy and move on to another approach.

IV therapy is generally administered once or even twice weekly until you are able to go longer between treatments without loss of benefit. Generally speaking, should you note an improvement with IV therapy, you should find that the periods of improvement last longer and longer as time goes on. IV therapy with nutrients is often combined with other treatment modalities in this office, and it is hoped and somewhat expected that IV therapy can be discontinued without loss of benefit when the other treatment modalities take effect. Chelation therapy is usually administered long-term.

The general risks of IV or chelation therapy include, with decreasing frequency: fatigue; headache; worsening of symptoms after the first 1-3 treatments (lessening with each, if it happens); discomfort during the infusion; irritation of the vein, causing eventual closure of the vein; inflammation at the site of an IV (phlebitis); failure to achieve a substantial benefit; renal failure; death. All except the first 3 are extremely rare, and there has never been a reported death from IV therapy with any of the nutrients (or EDTA) used in our office unless used contrary to our explicit instructions (I include it here because it must be included in any disclaimer form).

By signing this form, you acknowledge that you understand all of the above information, and that you are consenting to parenteral therapy with nutrients with such knowledge.

Thanks very much.

Signed: ___________________________________________ Dated: ____________________

[Note: this is my form, not from J. Emord]
INFORMED CONSENT FOR MY EDIA OF ETA PI XI CHELATION THERAPY

I acknowledge my medical history and my understanding of the risks and side effects of the proposed procedure. I have been informed that this therapy may have certain medical procedures, including but not limited to:

- IV Therapy
- Plasma Exchange
- Chelation Therapy
- Vitamin Therapy
- Nutritional Therapy
- Oxygen Therapy
- Holistic Treatment
- Other Medical Procedures

I understand the potential side effects of this therapy, which may include:

- Fever
- Fatigue
- Nausea
- Headache
- Dizziness
- Skin rash
- Other Side Effects

I understand that there is no guarantee of success and that the therapy may need to be repeated. I also understand that the therapist may recommend additional treatments or therapies.

I agree to receive and follow all instructions provided by the therapist.

I have been informed of the potential risks and benefits of this therapy. I understand that there is no cure for my disease and that the therapy may not be effective. I agree to follow all instructions and to make all necessary arrangements for my treatment.

I understand that I may need to follow a healthy lifestyle to enhance the effectiveness of the therapy.

I understand that this therapy is not approved by the FDA for the treatment of my condition.

I agree to the terms and conditions of this consent form.

[Patient Name]
[Date]
[Signature]