Health And Well Being History Form

Name:	Email:
Address:	City, State, Zip:
Home Phone:	Other Phone:
Cellular Phone:	Referred by:
Date:	Date of Birth:

PART 1.

* Please answer the following questions honestly and to the best of your ability.

BodyTalk

Describe the problem(s) for which you seek help. Please include dates when each problem occurred:

Past medical history (previous injuries, accidents, surgeries, etc. Please describe and include approximate dates:

List the medications (including over the counter) you are presently taking:

What daily activities are you finding difficult or are limited because of your above complaints:

Have you ever had this problem before, and if so when?

What are your goals from BodyTalk?

Please list any other kind of healthcare professional you are seeing for this/these problem(s):

Please list any medical tests you have had within the past year:

PART 2.

* Please mark the circle that best describes the frequency you experience the below conditions. **Leave blank if there is never a problem.**

1 Rarely (once a month or less)
2 Occasionally (less than once a week)
3 Frequently (more than once a week)
4 Constantly

DIGESTION

1 2 3 4 Loose stool or Diarrhea	1 2 3 4 Gas or belching	1 2 3 4 Blood in stool
1 2 3 4 Constipation	1 2 3 4 Stomach or intestinal pain	1 2 3 4 Black or dark stool
1 2 3 4 Poor digestion	1 2 3 4 Heartburn	1 2 3 4 Light colored stool
1 2 3 4 Parasites	1 2 3 4 Excessive appetite	1 2 3 4 Difficulty digesting oily food
1 2 3 4 Acid reflux	1 2 3 4 Poor appetite	yes no High cholesterol
1 2 3 4 Hiatal Hernia	1 2 3 4 Irritable bowels	yes no Gall stones
1 2 3 4 Nausea / vomiting	1 2 3 4 Hemorrohoids	

RESPIRATORY

1 2 3 4 Wet cough	1 2 3 4 Nasal problems	1 2 3 4 Other: _____
1 2 3 4 Dry cough	1 2 3 4 Poor sense of smell	yes no Pneumonia
1 2 3 4 Chest tightness	1 2 3 4 Sinus problems	yes no Asthma
1 2 3 4 Shortness of breath	1 2 3 4 Allergies	yes no Emphysema
1 2 3 4 Congestion	1 2 3 4 Hay fever	yes no Bronchitis
1 2 3 4 Wheezing	1 2 3 4 Catches colds easily	yes no Do you smoke? Number per day: _____

CARDIOVASCULAR

1 2 3 4 Hypertension	1 2 3 4 Restlessness	yes no Heart disease
1 2 3 4 Hypotension	1 2 3 4 Heart palpitation	yes no Phlebitis
1 2 3 4 Chest pain	1 2 3 4 Slow heart rate	1 2 3 4 Poor blood clotting
1 2 3 4 Dizziness	1 2 3 4 Poor circulation	yes no Heart attack How many times? ____
1 2 3 4 Easily bruised	1 2 3 4 Blood clots	yes no Stroke How many times? ____
1 2 3 4 Edema	1 2 3 4 Sweaty hands / feet	yes no Other: _____
1 2 3 4 Cold hands / feet	1 2 3 4 Anemia	

URINARY

1 2 3 4 Painful urination	1 2 3 4 Ear aches	yes no Low back pain
1 2 3 4 Incontinence	yes no Hearing impairment	yes no Knee problems
1 2 3 4 Difficulty with urination	yes no Kidney stones	yes no Other: _____
1 2 3 4 Ringing in ears	yes no Kidney infections	

NERVOUS SYSTEM

yes no Dyslexia	yes no Epilepsy	yes no Developmental or growth problems
yes no Learning disorder	yes no Head injury	yes no Nervous disorder? Type: _____
yes no Multiple Sclerosis	yes no Numbness, Where? _____	
yes no Muscular dystrophy	yes no Tingling, Where? _____	

MUSCLES / JOINTS

1 2 3 4 TMJ pain	1 2 3 4 Arm Weakness	yes no Rheumatoid Arthritis
1 2 3 4 Facial pain	1 2 3 4 Trunk Weakness	yes no Artificial joints
1 2 3 4 Loss of Balance	1 2 3 4 Difficulty walking	yes no Broken bones, fractures? _____ _____
1 2 3 4 Poor coordination	1 2 3 4 Joint swelling	
1 2 3 4 Leg Weakness	yes no Osteoarthritis	yes no Pins, etc? _____

MUSCLES / JOINTS (cont)

Mark the circle of painful areas, and indicate on which side: (R) right and / or (L) left

yes	no	Shoulder	R L	yes	no	Legs	R L	yes	no	Mid back	R L
yes	no	Arm	R L	yes	no	Knee	R L	yes	no	Low back	R L
yes	no	Elbow	R L	yes	no	Foot	R L	yes	no	Limited movement? Where? _____	
yes	no	Hands	R L	yes	no	Neck	R L				
yes	no	Hip	R L	yes	no	Upper back	R L				

OTHER

1 2 3 4	Insomnia	1 2 3 4	Fatigue	yes	no	Weight loss
1 2 3 4	Depression	1 2 3 4	Difficulty with speech	yes	no	Tuberculosis
1 2 3 4	Sleep too much, how long? _____	1 2 3 4	No thirst	yes	no	Thyroid problems
1 2 3 4	Shaky	1 2 3 4	Excessive thirst	yes	no	Fibromyalgia
1 2 3 4	Poor memory	1 2 3 4	Dry mouth	yes	no	Poor sense of smell
1 2 3 4	Difficulty paying attention	1 2 3 4	Pain at night	yes	no	Poor sense of taste
1 2 3 4	Anxiety	1 2 3 4	Headaches	yes	no	Cancer, Where? _____
1 2 3 4	Easily angered	1 2 3 4	Migraines	yes	no	Allergies? List: _____ _____
1 2 3 4	Obsessive tendencies in work relationships	1 2 3 4	Eye pain			
1 2 3 4	Difficulty making plans or decisions	1 2 3 4	Dry eyes	yes	no	Hepatitis? type: ____
1 2 3 4	Dizziness	1 2 3 4	Watery eyes	yes	no	Infectious disease: _____
1 2 3 4	Soft or brittle nails	1 2 3 4	Other eye problems? _____	yes	no	Herpes
1 2 3 4	Intolerance to temperature / weather changes	yes	no Dental problems	yes	no	Candida
1 2 3 4	Fever	yes	no Poor hearing	yes	no	Shingles
1 2 3 4	Chills	yes	no Difficulty swallowing	yes	no	Chemical dependency _____ _____
1 2 3 4	Nose bleeds	yes	no Diabetes			
1 2 3 4	Swollen glands	yes	no Weight gain	yes	no	Skin condition: ____ _____

MEN ONLY

1 2 3 4	Prostate problems	1 2 3 4	Impotence	yes	no	Infertility
1 2 3 4	Pain associated with genitals	1 2 3 4	Problems urinating	yes	no	Prostate cancer

WOMEN ONLY

1 2 3 4	Breast pain or tenderness	yes	no	Menopausal symptoms: _____	yes	no	Ovarian cysts
yes	no	Breast lumps	yes	no	Are your cycles regular? Length of cycle: _____	yes	no	Endometriosis
yes	no	Nipple discharge	yes	no	Painful menses with heavy or excessive flow	yes	no	PMS
yes	no	Menopause	yes	no	Painful intercourse	yes	no	Infertility

WELL BEING

* Please circle any of the following feelings you have experienced in the last few months.

Abused	Paranoid	Unable to grieve	Panic
Criticized	Overwhelmed	Apprehensive	Intolerant
Overworked	Muddled	Agitated	Uncertainty
Paralyzed	Persecuted	Uneasy	Aggravated
Depressed	Guilty	Distress	Annoyed
Rejected	Easily irritated	Fearful	Angry
Despair	Anxious	Impatient	Outraged
Helpless	Sad	Intimidated	Nervous
Hopeless	Grieving	Restless	Worried

* Please mark the circle that best describes the level of stress for the below listings.

My family stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My relationship stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My work stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My financial stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
My health stress is:	◯ None	◯ Minimal	◯ Moderate	◯ Severe
Other stress is _____:	◯ None	◯ Minimal	◯ Moderate	◯ Severe

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?

Do you exercise? And if so, what kind and how often?

How many hours a night do you sleep? _____ Is your sleep restful? _____If not, please explain: _____

PART 3.

* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.

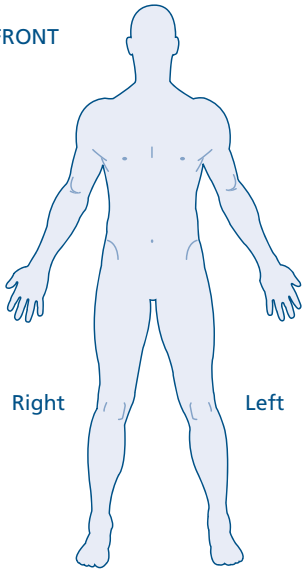
1. Slight awareness of discomfort.
2-3. Awareness of discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

1 2 3 4 5 6 ● 8 9 10 example: neck	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

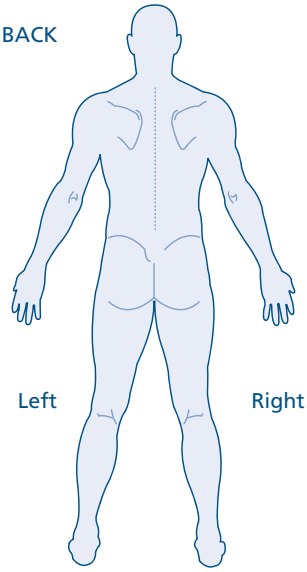
PART 4.

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.

FRONT



BACK



COMMENTS:

Practitioner's comments:

Client signature: Date:

Practitioner signature: Date:

Bali
HOLISTIC WELLNESS CENTER

Informed Consent:

I,_____(print name) understand that the BodyTalk/Body Intuitive session is an energy balancing system that facilitates the body's own innate wisdom for promoting physical, emotional and spiritual health by re-establishing communication within areas of the body. It is intended to enhance relaxation and to alert the body to possible energetic and/or emotional blocks that may create pain and disease. It is not a medical or nursing procedure, nor is it any manipulative therapy such as chiropractic, massage, or physical therapy. The participant understands that, it is safe, non-invasive and no diagnosis is given nor any medications prescribed.

The BodyTalk/Body Intuitive Systems do not conflict with any existing health care treatment modality and is complementary to each modality. It is not intended to create any physician-patient relationship or supplant any in-person medical consultation, examination, or treatment. Disregarding the advice from or discontinuing treatment by medical professionals is done based on the participant's own choice.

In addition, this activity may involve light physical contact. Contact may be in sensitive areas of the body, including but not exclusive to, the face, arms, chest, and groin area. The contact is part of the BodyTalk protocol. Any contact, whether part of the activity or accidental shall not give rise to any liability, either civil or criminal unless the contact is expressly unwanted or objectively unreasonable for the nature of the activity.

By signing below, the signor agrees that he or she has read the above disclaimer and wishes to participate in Body Talk / Body Intuitive Sessions

_____ _____

Name Date:

Primary Care Physician: _____

Referring Physician: _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand.

- *We do not treat symptoms or disease.*
- *An allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlining cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale**.*
- *Our procedures are safe and painless.*

ALLERGY RELATED QUESTIONS

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

☐ Infant (Age 0-2) ☐ Child Age (Age 3-5) ☐ Child (Age 6-12)
☐ Adolescent (Age13-18) ☐ Adult (age 19-25 ☐ Adult (Age 26-40)
☐ Adult (Age 41 and over)

PREVIOUS ALLERGY EVALUATION

Have you ever seen an allergist? ☐ Yes ☐ No
Have you had allergy skin testing? ☐ Yes ☐ No
Did you have any positive reaction? ☐ Yes ☐ No
If yes, please list positive allergens (including any medications)
_____
Have you ever received allergy injections? ☐ Yes ☐ No

WORK ENVIRONMENT

What is your occupation? _____
Are you exposed to chemicals or strong odors at work? _____
If yes, briefly explain _____
Are your symptoms worse while at work? _____
If yes, briefly explain
_____
ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW?
_____
_____

WHEN ARE YOUR SYMPTOMS WORSE

☐ Year round

☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
☐ July	☐ August	☐ September	☐ October	☐ November	☐ December

MEDICATIONS

Do you take any of the following medications on a regular basis?

☐ **Antihistamines** (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax Claritin, Allegra, Zyrtec, etc.)

☐ B**ronchodilators** (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc.}

☐ **Steroid inhalers** (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair etc.}

☐ **Nasal Steroids** (Beconase, Flonase, Nasacort, Rhinocort, etc.)

☐ **Medication that affect the immune system** (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc.)

☐ **Chemotherapy**

Please list any medications that you are currently taking:

_____

SMOKING – If you smoke please answer the following questions:

Number of cigarettes per day ____ A what age did you start? ___ Anyone smoke in your house? ___

FOOD RELATED SYMPTOMS

☐ Symptoms flare 5-60 minutes after meals	☐ Some foods are craved or addictive
☐ The smell or odor of some foods increases symptoms	☐ Some foods cause nasal symptoms
☐ Some foods cause swelling of the mouth or tongue	☐ Some foods cause rashes or hives
☐ Some foods causes upset stomach or vomiting	☐ Some foods cause diarrhea
☐ Symptoms occur with restaurant salad bars or Asian foods	☐ Some foods causes headaches
☐ Symptoms occur with any regularly eaten food	☐ Some foods cause asthma
☐ Preservatives, additives or food coloring increases symptoms	☐ No problem with foods

FOODS THAT CAUSES SYMPTOM FROM <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE

☐ Eggs	☐ Milk	☐ Beef	☐ Corn	☐ Wheat	☐ Soybean
☐ Peanut	☐ Pork	☐ Fish	☐ Shellfist	☐ Orange/citrus	☐ Potato
☐ Tomato	☐ Yeast	☐ Chocolate	☐ Coffee/Tea	☐ None	☐ Other

CHEMICALS THAT CAUSE SYMPTOMS

☐ Insecticides & pesticides	☐ Paints &household cleaners	☐ Perfumes & cosmetics
☐ Gasoline & auto exhaust	☐ Stove or furnace emissions	☐ The smell of new fabrics or fabric store
☐ Chemicals in the work place	☐ Laundry detergent	☐ Newsprint

☐ None ☐ Other_____

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMOCAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

PREVIOUS DIAGNOSIS OF ALLERGY? ☐ Yes ☐ None

☐ Yes-Allergy shots helped ☐ Did not help ☐ Yes-Medication helped ☐ Did not help

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandparents
☐ Son/Daughter ☐ Spouse ☐ None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

☐ Constant/Chronic with little change
☐ Present part of the time
☐ Prevents some normal activities
☐ Slight interference with normal life
☐ Present most of the time
☐ Present rarely
☐ Considerable interference with normal life
☐ No interference with normal life

SYMPTOMS ARE WORSE

☐ Outdoors and better indorse
☐ In the bedroom or when in bed
☐ During wet or damp weather
☐ During known pollen seasons
☐ When exposed to tobacco smoke
☐ When sweeping or dusting the house
☐ In air conditioning
☐ Tobacco smoke bothers me more than anything else
☐ At nighttime
☐ During windy weather
☐ When the weather changes
☐ In certain rooms or buildings
☐ With yard work, cut grass, leaves, hay or barns
☐ In areas with mold or mildew
☐ In fields or in the country

SYMPTOMS ARE BETTER

☐ After shower or bath ☐ In air conditioning ☐ Indoors
☐ During or after physical activity ☐ After taking antihistamines ☐ With allergy shots
What makes you feel better? _____

ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

☐ Dogs ☐ Cats ☐ Horses or Cattle
☐ Rabbits ☐ Birds or Feathers ☐ Rodents (mice, guinea pigs, etc.)
☐ Bees ☐ None ☐ Other _____

Have You Been Vaccinated Against Communicable Diseases - ☐ Yes ☐ No

Have You experienced and adverse reactions or symptoms after vaccination administered ☐ Yes ☐ No

At What Age were symptoms / reactions experienced _____

Name of Vaccine _____ (age in months,years) _____

Name of Vaccine _____ (age in months,years) _____

Name of Vaccine _____ (age in months,years) _____

3. PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU

Digestive Track
- ☐ nausea & vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ bloated feeling
- ☐ stomach pains or cramps
- ☐ heart burn
- ☐ blood and/or mucous in stools

TOTAL ____

Ears
- ☐ itchy ears
- ☐ ear aches/ear infections
- ☐ drainage from ear
- ☐ ringing in ears
- ☐ hearing loss
- ☐ reddening of ears

TOTAL ____

Emotions
- ☐ mood swings
- ☐ anxiety/fear/nervousness
- ☐ anger/irritability/aggressiveness
- ☐ argumentative
- ☐ frustrated/cries easily
- ☐ depression

TOTAL ____

Eyes
- ☐ watery or itchy eyes
- ☐ red/swollen/itchy eyelids
- ☐ bags or dark circles under eyes
- ☐ blurred or tunnel vision

TOTAL ____

Head
- ☐ headaches
- ☐ faintness
- ☐ dizziness
- ☐ insomnia/sleep disorder
- ☐ facial flushing

TOTAL ____

Heart
- ☐ irregular/skipped heartbeat
- ☐ rapid/pounding heartbeat
- ☐ chest pain

TOTAL ____

Joints & muscles
- ☐ pains/aches in joints
- ☐ arthritis/osteoarthritis
- ☐ stiffness/limited movement
- ☐ pain/aches in muscles
- ☐ feeling weak/tired
- ☐ swollen/tender joints
- ☐ growing pains in legs
- ☐ psoriatic/gouty arthritis

TOTAL ____

Lungs
- ☐ chest congestion
- ☐ asthma/bronchitis
- ☐ shortness of breath
- ☐ difficult breathing
- ☐ persistent cough
- ☐ wheezing

TOTAL ____

Mind
- ☐ poor memory
- ☐ difficulty completing projects
- ☐ difficulty with mathematics
- ☐ underachiever
- ☐ poor/short attention
- ☐ confusion
- ☐ easily distracted
- ☐ difficulty making decisions
- ☐ learning disabilities

TOTAL ____

Mouth & Throat Thrush
- ☐ chronic coughing
- ☐ gagging/clearing throat often
- ☐ sore throat/hoarse voice/voice loss
- ☐ swollen/discolored tongue/lips
- ☐ cancer sores
- ☐ itching on roof of mouth

TOTAL ____

Nose
- ☐ stuffy nose
- ☐ chronically red/inflamed nose
- ☐ sinus problems
- ☐ hay fever
- ☐ sneezing attacks
- ☐ excessive mucous formation

TOTAL ____

Skin
- ☐ acne
- ☐ itching
- ☐ hives/rash/dry skin
- ☐ hair loss
- ☐ flushing/hot flashes

TOTAL ____

Weight
- ☐ binge eating/drinking
- ☐ craving certain foods
- ☐ excessive weight
- ☐ compulsive eating
- ☐ water retention

TOTAL ____

Genitourinary
- ☐ kidney
- ☐ frequent/urgent urination
- ☐ bladder
- ☐ yeast infections
- ☐ genital itch/discharge/anal itching
- ☐ yeast infections

TOTAL ____

Other conditions
- ☐ Autism
- ☐ A.D.H.D.
- ☐ A.D.D.
- ☐ Psoriasis
- ☐ Eczema
- ☐ Auto Immune Disorder
- ☐ Chronic Fatigue
- ☐ Multiple Chemical Sensitivities
- ☐ Asthma
- ☐ Congestive Heart Failure
- ☐ Sever Diabetes
- ☐ Severe Depression
- ☐ Obsessive Compulsive Disorder

Symptoms of Hypothyroidism (Overcoming THYROID Disorders, David Brownstein, MD)

- ☐ Fatigue, sluggishness or weakness
- ☐ Dry skin
- ☐ Brittle nails
- ☐ Hair loss and/or coarse or dry hair
- ☐ Increased sensitivity to cold
- ☐ Constipation
- ☐ Memory problems or having trouble thinking clearly
- ☐ Heavy or irregular menstrual periods
- ☐ Weight gain
- ☐ Swelling of the arms, hands, legs, and fee
- ☐ Facial puffiness, especially around the eyes
- ☐ Hoarseness
- ☐ Muscle aches and cramps
- ☐ Low blood pressure
- ☐ Elevated blood cholesterol
- ☐ Infertility
- ☐ Sleep irregularities
- ☐ Depression

Thytrophin PMG for Hypothyroidism

Symptoms of Iodine Deficiency (Iodine why you need it, David Brownstein, MD)

- ☐ ADD/ADHD
- ☐ Atherosclerosis
- ☐ Breast Disease
- ☐ Dupuytren's Contracture
- ☐ Excessive Mucous Production
- ☐ Fatigue
- ☐ Fibrocystic Breasts
- ☐ Goiter
- ☐ Hemorrhoids
- ☐ Headaches and Migraine Headaches
- ☐ Hypertension
- ☐ Infections
- ☐ Keloids
- ☐ Liver Disease
- ☐ Nephrotic Syndrome
- ☐ Ovarian Disease
- ☐ Parotid Duct syndrome
- ☐ Peyronie's
- ☐ Prostate Disorders
- ☐ Sebaceous Cysts
- ☐ Thyroid Disorders
- ☐ Vaginal Infections

IODINE PATCH TEST INSTRUCTIONS

1. Begin the test in the morning (after showering)
2. Use Tincture of Iodine to paint a size of quarter (25 cents) on the inner arm Tincture of Iodine is available from any drug store or pharmacy. Be sure it's the Original orange colored solution not the clear solution. Make the following notes.
   - Hour patch begun to lightened :_____ : _____ am/pm
   - Hour patch disappeared completely:_____ : _____ am/pm
3. Write down your starting time:_____ : _____ am/pm
4. Observe the coloration of the patch over the next 24 hours.
5. Describe the site after 24 hours:
   _____
6. Any other observations or comments:_____

- Patch begins to slightly lighten after 24—NORMAL
- Patch almost disappears in under 24 hours consider **Iodomere** (standard process) 2-3 or more per day
- Patch disappears, or almost in under 10 hours consider **Prolamine Iodine** (standard process) 1-2 or more per day

Repeat patch test ever 2 weeks, when patch no longer disappear after 24 hours lower iodine dose appropriately

BIOScan

INFORMED CONSENT FOR THE BioScanSRT WELLNESS SYSTEM

Name:_____ DOB:_____ EMAIL: _____

Background: I desire to be tested to determine possible undesirable reactions to various stressors that are natural constituents of my diet, environment or body chemistry. I understand that the device being used is FDA cleared for Galvanic Skin Response Testing and not intended to directly treat or cure any specific condition, symptom or illness. The physician has explained, and I understand, the benefits of receiving stress reduction and relaxation therapy and the direct relationship between stress, illness and disease.

Procedures: I understand that this is a non-invasive procedure (the skin is not pierced). A metal clip or electrodes are attached to the skin to measure electrical conductivity on the hands. Homeopathic remedies, nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of the immune system and related symptoms are of an unpredictable nature and therefore the facility cannot guarantee any results. _____ cannot guarantee that new stressors will not contribute toward my health conditions in the future and that in some cases a person may not wholly respond to the treatment.

I choose to be tested with the BioscanSRT Standard-of-Care Wellness System. I understand that this testing has not been scientifically proven to be reliable and that my physician must still rely upon my observations as to the efficacy of the test and any treatment based on the results of this test.

Risks: The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight risk or electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as those substances are taken as recommended, but please report any discomfort you may experience from taking these substances to your examiner or physician. Please report any significant health problems (i.e. Diabetes, High Blood Pressure, , Pacemaker, Defibrillator, Cancer or Neoplasm, Pregnancy,etc.) to your physician. I understand that there is a risk factor where as a result of exposure to these bio-energetic stressors, that I may experience temporary symptoms not unusual to the regular symptoms currently experienced when exposed to these stressors. I assume all responsibility for the unpredictable immune reactions that may lead to increased symptoms. I agree to seek immediate medical attention should this occur and understand that this facility does not treat cases of patients suffering from anaphylactic allergic reactions and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis.

Additionally, I am not in the first trimester of pregnancy, and desire to have this procedure performed by the physician/office named above. I understand the nature and risks of ANY procedure, and am willing to accept the unlikely negative effects to either myself or my unborn child, should any occur, and agree to hold harmless PRACTITIONER NAME and any and all staff associated with his practices. I also believe and understand the doctor will follow all precautionary steps he knows, that will maximize any benefit received and minimize risks to me.

Questions: I have been provided with the opportunity to ask any pertinent questions I have regarding the BioScanSRT procedure, protocol or treatment program.

Free to Decline: I understand that I may decline to the BioScanSRT testing and Processing.

Important: There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.

Payment of Services: You are responsible for the payment of the normal and necessary fees associated with the NanoSRT Assessment and services performed as a result of that testing, if purchased in this clinic.

I have read and understand the above information about the BiioScanSRT Wellness System and my rights and responsibilities and hereby consent to the use of the BioScanSRT Wellness System. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research and scientific purposes provided that my identity is kept confidential.

Date_____ Name_____ Signature_____

Signature of Parent or Guardian if Patient is a minor_____