FRYE Functional Health Center

3809 S. State Route 159 Glen Carbon, IL 62034
Ph: 618-692-1800 Fax: 618-205-8664 www.fryehealth.com

INTAKE FORM

Patient Information

Acct. #

First Name:_____ MI:_____ Last Name:_____ Suffix: _____ Called Name:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Ph:_(_____)_____ Work Ph:_(_____)_____ Cell Ph:_(_____)_____

Email:_____ Sex: M F Marital Status: Single / Leg. Separated / Married / Widowed / Divorced

Date of Birth: _____ Who Referred You To Our Office?_____

If the patient is a minor, please list the name(s) of the parent(s)/guardian(s):_____

Person to Contact In Case of An Emergency: _____ Relationship: _____ Ph:_(_____)_____

CONSENT TO TREAT

I, being the patient or legal guardian of the above patient, authorize Dr. Clinton Frye and/or Dr. Brooke Frye and whomever he/she may designate as assistants to administer treatment as necessary to myself/son/daughter/grandchild/other.

☐ **Patient Signature:** ☐ **Parent Signature:** ☐ **Legal Guardian Signature:**

HIPAA – NOTICE OF PRIVACY POLICIES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. By signing this form, you understand and agree to the following:

- Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurances, public health research, and law enforcement activities.
- Disclosure of your protected health information is allowed for the purpose of treatment, payment, or practice operations.
- This provision does not apply to the transfer of medical records for treatment. We maintain a history of protected health information disclosures that is accessible to you. You may inspect and receive copies of your records within 30 days of a request to do so. You may also request that we disclose specific portions of your protected health information with other providers. There may be a reasonable cost-based fee for photocopying, postage, and preparation.
- In the future, we may contact you by mail, email, or telephone for appointment reminders or office announcements. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

According to HIPAA, we are not allowed to release any health information to spouses, significant others, parents (unless patient is a minor), children, friends, employers, and/or other family members unless we have your written consent. Please list the name of the person/ persons with whom FRYE Functional Health Center can share your health information with or check the box below:

Person #1: **Person #2:** **Person #3:**

OR [ ] At this time there is no one in which my health information should be shared with. **Signature:**

FINANCIAL AGREEMENT

By signing this form, I understand and agree to the following:

- I understand that all services are my full and complete responsibility and must be rendered on a cash, check, or credit card basis.
- I understand that if I present with insurance, as a courtesy, FRYE Functional Health Center will contact my insurance company to verify my benefits, but the benefits quoted are not a guarantee of payment. Payment from my insurance company will be determined at the time of processing based on the policy coverage I carry with my insurance company. I understand that any services denied or deemed non-covered, investigational, or not medically necessary by my insurance company are my full responsibility.
- I understand that after FRYE Functional Health Center verifies my benefits, they will attempt to contact me either via phone or at my next visit (so long as it is within the next 4 weeks). If I do not answer my phone, I consent to allow them to leave a message outlining the benefits as they were quoted to them. If I do not respond to their phone call within 7 days, they will automatically bill my insurance for any services quoted to be covered by my insurance policy. They will not bill my insurance for any services quoted to be non-covered, investigational, or not medically necessary.
- I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office, by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
- In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe you.
- I further agree that this Financial Agreement is irrevocable until all monies owed FRYE Functional Health Center are paid in full. In the event that an unpaid balance is sent to a collection agency, I agree to pay all other costs incidental to collection including but not limited to attorney fees, court costs, processor fees, interest and late fees.
- I understand that I will be responsible for an Insufficient Funds Fee of $20 should any payment I make not go through due to insufficient funds.

Signature:

CANCELLATION, MISSED APPOINTMENT, & TARDINESS POLICY

By signing this form, I understand and agree to the following: Out of respect and consideration to your Physician(s) and other patients, we kindly ask that you honor your scheduled appointment time. Please note that our office schedules back to back appointments while managing a wait list. We understand that unanticipated events occasionally do happen in everyone's life. In our desire to be effective and fair to all of our patients' time, we kindly ask that you give at least 24 hour advance notice when cancelling and/or rescheduling an appointment. This allows the opportunity for someone else to schedule an appointment. It is advisable to arrive approximately 15 minutes prior to your first visit and 10 minutes prior to your subsequent visits. In the event that you arrive late to your appointment, we will do our best to accommodate and honor your full scheduled time, but your appointment may be shortened in order to accommodate others whose appointments follow yours. Regardless of the length of the treatment actually given, you will be responsible for the "full" appointment booked. Please plan accordingly. Anyone who either forgets or consciously chooses to forgo their scheduled appointment time will be considered a "no show/missed appointment" and FRYE Functional Health Center reserves the right to charge 100% of the fee for the "missed appointment". Insurance will not be billed for these charges. Missed appointment fees are the responsibility of the patient and must be paid in full before the next visit.

Signature:

FOR OFFICE USE ONLY (DATE OF NP APPT): _____

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PATIENT HEALTH QUESTIONNAIRE

MAIN HEALTH ISSUES/COMPLAINTS
Please list the top 5 reasons for seeking care in our office:
1.
2.
3.
4.
5.

Who makes up your current healthcare team? (Primary Care, OB/GYN, Specialists, Alternative Providers):

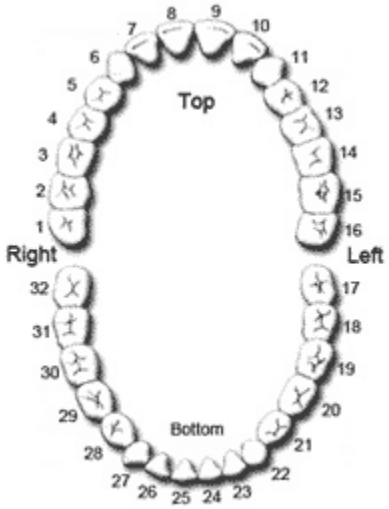
Name:_____ **Type of Provider:**_____ **Contact Ph:**_(_____)_____
Name:_____ **Type of Provider:**_____ **Contact Ph:**_(_____)_____
Name:_____ **Type of Provider:**_____ **Contact Ph:**_(_____)_____
Name:_____ **Type of Provider:**_____ **Contact Ph:**_(_____)_____

When was the last time you felt well? _____
Did something specific happen to trigger the change in your health? _____
Please mark which of the following testing you have had within the last year:

- ☐ Bloodwork
- ☐ Saliva Testing
- ☐ Allergy Testing
- ☐ Stool Analysis
- ☐ Urine Analysis
- ☐ Hair Analysis
- ☐ Bone Density
- ☐ Thermography
- ☐ X-Ray
- ☐ Ultrasound
- ☐ CT Scan
- ☐ MRI

Medications:	**Why Prescribed?**	**Hospitalizations:**	**Surgeries/Traumas:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your job associated with any potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) YES NO
If yes, what is your occupation?_____ **What is your blood type? ☐ A ☐ B ☐ AB ☐ O ☐ I do not know**
Have you ever been vaccinated? YES NO If yes, was it: ☐ as a child ☐ as an adult
If you were vaccinated, what, if any, adverse reactions did you experience?_____
Please note below which teeth you have had dental work on and what type of dental work was done:



(C) Cavity (F) Filling (I) Implant (R) Root Canal (A) Abscess

Right Top	Left Top	Left Bottom	Right Bottom
1_____	9_____	17_____	25_____
2_____	10_____	18_____	26_____
3_____	11_____	19_____	27_____
4_____	12_____	20_____	28_____
5_____	13_____	21_____	29_____
6_____	14_____	22_____	30_____
7_____	15_____	23_____	31_____
8_____	16_____	24_____	32_____

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Medical History (Global Issues)

- ☐ Anemia (type: _____)
- ☐ Arthritis (type: _____)
- ☐ Cancer (type: _____)
- ☐ Diabetes
- ☐ Environmental sensitivities
- ☐ Food intolerance
- ☐ Genetic disorder
- ☐ Hemochromatosis
- ☐ Infection, chronic
- ☐ Obesity
- ☐ Parasite Infestation
- ☐ Polycythemia vera
- ☐ Thalassemia
- ☐ Other: _____

Family Health History (Parents and Siblings)

- ☐ Arthritis (type: _____)
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer (type: _____)
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Hemochromatosis
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Neurological disorders (MS, Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Polycemia vera
- ☐ Stroke
- ☐ Suicide
- ☐ Thalassemia

Other: _____

Endocrine

- ☐ Energy Level: low / high
- ☐ Slow start in the morning
- ☐ Energy crash: at ____ am / pm
- ☐ Dizzy when standing quickly
- ☐ Light bothers your eyes
- ☐ Perspire easily or excessively
- ☐ Sex Drive: flat / low / high
- ☐ Splitting headaches
- ☐ Tired/ Sluggish throughout the day
- ☐ Chills/Cold hands, feed, body
- ☐ Require excessive sleep
- ☐ Unexplained weight gain
- ☐ Depression or lack of motivation
- ☐ Hair loss or thinning of hair
- ☐ Thinning of outer 1/3 of eyebrows
- ☐ Inward trembling

Medical (Men)

- ☐ Benign prostatic hyperplasia (BPH) Prostate cancer
- ☐ Infertility
- ☐ Sexually transmitted disease
- ☐ Other: _____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Breast pain with period
- ☐ Sexually transmitted disease
- ☐ Menopause ☐ natural ☐ surgical
- ☐ Other recent changes in menstrual flow (e.g., heavier, large clots, scanty): _____

Age of first period: _____
Start date of last menstrual cycle: _____
Length of last menstrual cycle: _____days
Length of time between cycles: _____days
Date of last gyno exam: _____
Last mammogram ☐ + ☐ -
Last PAP ☐ + ☐ -
# of Children: _____
# of Pregnancies: _____
# of Births:___C-Section/___Natural

Digestion & Glycemic Management

- ☐ Nausea / vomiting
- ☐ Gas: belching
- ☐ Heartburn
- ☐ Indigestion
- ☐ Anorexia / bulimia
- ☐ Gout
- ☐ Change in appetite
- ☐ Peptic ulcers
- ☐ High cholesterol / tryiglycerides
- ☐ Hiatal hernia
- ☐ Headache at the base of the skull
- ☐ Greasy, fatty foods cause distress
- ☐ Dry, itchy skin
- ☐ Yellow cast to eyes
- ☐ Clay colored stool
- ☐ History of Gallbladder attacks
- ☐ Foul smelling sweat
- ☐ Difficulty swallowing
- ☐ SIBO (small intestine bacterial overgrowth)
- ☐ Gluten sensitivity
- ☐ Irritable when skips a meal
- ☐ Light-headed when skips a meal
- ☐ Eating relieves fatigue

Digestive & Glycemic Management (Continued)

- ☐ Bouts of blurred vision
- ☐ Fatigue after meals
- ☐ Frequent urination
- ☐ Increased thirst
- ☐ Difficulty losing weight
- ☐ Lower bowel gas / flatulence
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Appendicitis
- ☐ Crohn's Disease
- ☐ Pain or cramps
- ☐ Rectal pain
- ☐ Bloody / black / tarry stool
- ☐ Sensitive abdomen
- ☐ Bloating after eating
- ☐ Ulcers / Ulcerative colitis
- ☐ Swollen/ distended / bloody anus
- ☐ Burning or itchy anus
- ☐ Diverticular disease
- ☐ Takes laxative to regulate bowel
- ☐ Uses suppositories
- ☐ Enemas and/or colonics
- ☐ Irritable bowel syndrome (IBS)
- ☐ # of bowel movements/day: ____
- ☐ Consistency of bowel: ☐ normal ☐ soft ☐ hard ☐ pebbles ☐ dry ☐ ribbon-like ☐ bulky ☐ mucousy
- ☐ Other: _____

Bioterrain/ Mineral Pillar

- ☐ Twitching around eyes
- ☐ Difficulty falling asleep
- ☐ Restlessness
- ☐ Don't remember dreams
- ☐ Nail spots or weakness
- ☐ Air hunger / frequent sighs
- ☐ Cramps: ☐legs ☐feet ☐arms ☐hands
- ☐ Aches: ☐legs ☐feet ☐arms ☐hands
- ☐ Fevers

Bioterrain/ Mineral Pillar (Continued)

- ☐ Restless: ☐legs ☐feet ☐arms ☐hands
- ☐ Frequent thirst
- ☐ Shallow rapid breathing
- ☐ Poor muscle endurance
- ☐ Swelling in ankles and wrists
- ☐ Uterine cramps (women)
- ☐ Urination leakage
- ☐ Other: _____

Cardiovascular & Respiratory

- ☐ Chest tension
- ☐ Chest tightness
- ☐ Chest pressure
- ☐ Chest heaviness
- ☐ Chest heart pain
- ☐ Heart palpitations / fluttering
- ☐ Skipped heartbeat
- ☐ Heart racing
- ☐ Slowed heartrate
- ☐ Constant shortness of breath
- ☐ Sleep apnea
- ☐ Mitral valve prolapse
- ☐ Murmur
- ☐ Bleed & Bruise easily
- ☐ Other: _____

Neuropsychology

- ☐ Seizures / epilepsy
- ☐ Poor memory
- ☐ Bad temper
- ☐ Muscle tremor / twitching
- ☐ Poor coordination
- ☐ Depression
- ☐ Multiple Sclerosis (MS)
- ☐ Concussion
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Anxiety
- ☐ Easily stressed
- ☐ Parkinson's
- ☐ Suicidal attempt(s)
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Learning disability
- ☐ Seasonal affective disorder
- ☐ Under current treatment for emotional imbalance
- ☐ Other: _____

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Sleeping Patterns/Habits

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Wakes at a specific time each night:
  - ☐ 9-11pm ☐ 11-1am
  - ☐ 1-3am ☐ 3-5am
  - ☐ 5-7am
- ☐ Feels tired throughout the day:
  - ☐ 7-9am ☐ 9-11am
  - ☐ 11-1pm ☐ 1-3pm
  - ☐ 3-5pm ☐ 5-7pm
  - ☐ 7-9pm
- ☐ Must take some form of medication/supplement to help go to/stay asleep
- ☐ Use CPAP or BiPAP

HEENT

- ☐ Dizziness / Vertigo
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches
- ☐ Eye strain
- ☐ Color/ night blindness
- ☐ Blurry vision
- ☐ Glasses / contacts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Spots in eyes / floaters
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Gum problems
- ☐ Sores on lips / tongue
- ☐ Nose bleeds
- ☐ Tonsilitis
- ☐ Facial pain
- ☐ Tongue coating/cracks/swelling
- ☐ Bad breath
- ☐ Clicking jaw
- ☐ Dry mouth / dry throat
- ☐ Concussions
- ☐ Headaches:(type: _____)
- ☐ Migraines:(type:_____)
- ☐ Other: _____

Emotions

- ☐ Frustration, anxiety, or anger
- ☐ Lack of or excessive joy
- ☐ Excessive need for sympathy, excessive introspection, or obsessional thinking
- ☐ Grief, sadness, or melancholia
- ☐ Fear

Genito-Urinary

- ☐ Pain while urinating
- ☐ Burning while urinating
- ☐ Unable to hold urine
- ☐ Wakes up to urinate
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Bladder infection
- ☐ Impotency
- ☐ Blood in urine
- ☐ STDs
- ☐ Kidney disease
- ☐ Prostate problems
- ☐ Other: _____

Health Habits

- ☐ Tobacco:

Cigarettes: #/day_____
Chew: #/day_____
Cigars: #/day_____
Vaping: #/day_____

- ☐ Alcohol:

Wine: #glasses/day or wk_____
Liquor: #glasses/day or wk_____
Beer: #glasses/day or wk_____

- ☐ Caffeine:

Coffee: #6 oz cups/day_____
Tea: #6 oz cups/day_____
Diet soda w/caffeine: #cans/day_____
Reg. soda w/caffeine: #cans/day_____

- ☐ Water: #glasses/day_____

Nutrition & Diet

- ☐ Vegan
- ☐ Vegetarian
- ☐ Paleo
- ☐ Primal
- ☐ Pescatarian
- ☐ Ketogenic
- ☐ GAPS
- ☐ FODMAP
- ☐ Intermittent Fasting
- ☐ Salt (sodium) restriction
- ☐ Fat restriction
- ☐ Starch/carb restriction
- ☐ Total calorie restriction
- ☐ Do you eat foods that contain any of the following:
  - ☐ wheat ☐ corn
  - ☐ soy ☐ MSG
  - ☐ food coloring / dyes
  - ☐ artificial sweeteners such as sucralose and aspartame
- ☐ Specific food restrictions:
  - ☐ dairy ☐ wheat ☐ eggs
  - ☐ soy ☐ corn ☐ all gluten
  - ☐ other_____

Eating Habits

- ☐ Skip breakfast
- ☐ Graze

Avg. # Meals/Day: ☐ 1 ☐ 2 ☐ 3 ☐ 4

- ☐ Fast eater
- ☐ Erratic eating pattern
- ☐ Eat too much
- ☐ Late night eater
- ☐ Dislike "healthy" food
- ☐ Eat out often
- ☐ Travel frequently
- ☐ Does not meal plan
- ☐ Rely on convenience foods
- ☐ Poor snack choices
- ☐ Other family members have special dietary needs
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have a negative food relationship
- ☐ Binge eat
- ☐ Chronic dieter
- ☐ Emotional eater
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't like to cook
- ☐ Cravings:
  - ☐ Sweet ☐ Salty
  - ☐ Protein ☐ Fruit
  - ☐ Carbohydrates
  - ☐ Vegetables
- ☐ Confused about what to eat

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes duration per workout
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lift
- ☐ Crossfit
- ☐ Swim
- ☐ Box
- ☐ Yoga/Pilates
- ☐ HIIT
- ☐ Circuit training
- ☐ Other: _____

Seasonal Preferences

Is there a specific season in which you tend to feel the best/worst?

Best: ☐ Summer ☐ Fall ☐ Winter ☐ Spring

Worst: ☐ Summer ☐ Fall ☐ Winter ☐ Spring

Skin & Hair

- ☐ Hair loss /alopecia
- ☐ Dandruff
- ☐ Psoriasis
- ☐ Eczema / rashes
- ☐ Hives / itching
- ☐ Vitiligo
- ☐ Acne (location:_____)
- ☐ Other:_____

Current Supplements

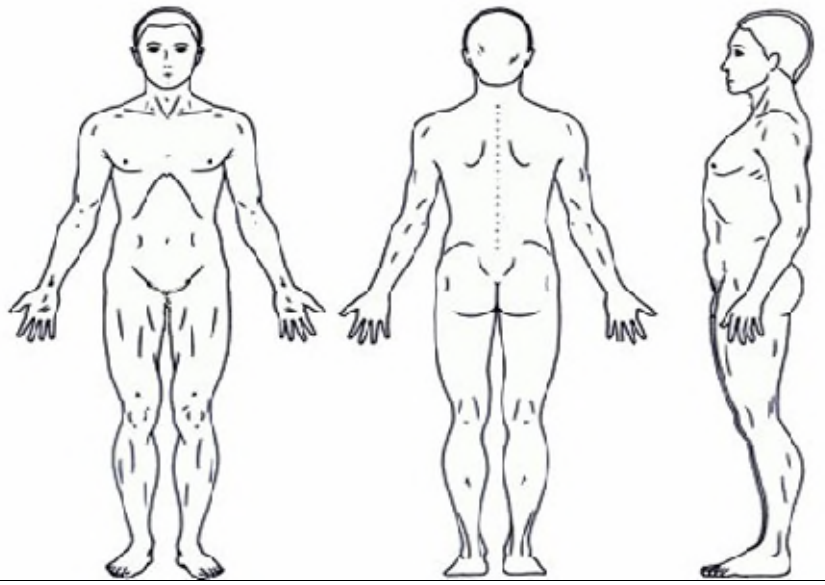
- ☐ Multivitamin/mineral
- ☐ Fish oil/DHA/EPA
- ☐ Vitamin C
- ☐ Vitamin D
- ☐ Vitamin E
- ☐ Calcium
- ☐ Magnesium
- ☐ Zinc
- ☐ Pro/Prebiotic
- ☐ Amino Acids
- ☐ Protein powders
- ☐ CoQ10
- ☐ Digestive enzymes
- ☐ Herbs (teas, pills)
- ☐ Homeopathy
- ☐ Other: _____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve complexion
- ☐ Have stronger hair/nails
- ☐ Be less moody
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ De better on tests
- ☐ Not use over-the-counter medications
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Have better breath
- ☐ Have less boy odor
- ☐ Get less colds/flus
- ☐ Get rid of allergies

FRYE
Functional Health Center

Musculoskeletal Complaint(s)	
Complaint(s):	
When did it begin?	Is the condition getting progressively worse?
How did it begin?	
How often do you experience the issue (pain/discomfort/etc.)?	
Is it constant or does it come and go?	
On a scale of 1 (least amount of pain) to 10 (most severe pain), what would you rate the pain? Circle one: 1 2 3 4 5 6 7 8 9 10	
Does anything make it feel better? If so, what?	
Does anything make it feel worse? If so, what?	
Does it interfere with any of the following? Circle those that apply: Work Sleep Daily Routine Recreation	
Please circle those activities that are difficult/painful/uncomfortable to perform due to this condition: Sitting Standing Walking Bending Lying Down Turning your Head Coughing Sneezing Bearing Down	

Musculoskeletal Symptoms	Please mark on the picture below where your problem areas are:
☐ Neck pain ☐ Back pain ☐ Muscle pain/ spasms ☐ Joint pain ☐ Arthritis (type: _____) ☐ Numbness ☐ Tingling ☐ Headaches (type: _____) ☐ Prosthesis ☐ Osteoporosis / Osteopenia ☐ Shooting / Radiating pain ☐ Fractures ☐ Hernia (type: _____) ☐ Other: _____	

Readiness

Rate the following on a scale of:
1 (not willing) to 5 (very willing)

In order to improve your health,
how willing are you to do the following:

Significantly modify your diet:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Take nutritional supplements each day:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Keep a record of everything you eat each day:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Modify your lifestyle (e.g. work schedule, sleep habits):
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Practice relaxation techniques:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Engage in regular exercise:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Have periodic lab tests to assess progress:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Comments:_____

As you will quickly learn, our practice is heavily focused on different aspects of alternative medicine and holistic healing. These include nutritional care and whole-food supplementation, acupuncture, chiropractic, and massage therapy. In the process of your initial history, consultation, exam, and/or future appointments the doctor may recommend any one (or a combination) of the following treatments and/or testing methods to properly evaluate and successfully treat your condition(s).

Please designate below which of the following treatment/testing options you are open to and willing to explore should the doctor(s) recommend them for you:

☐ Chiropractic Care ☐ Acupuncture ☐ Massage Therapy
☐ Hair Analysis ☐ Homeopathy ☐ Nutritional Supplementation
☐ Saliva Testing ☐ Far Infrared Sauna ☐ Food Sensitivity Testing
☐ SHAPE Reclaimed Nanomolecular Health Transformation program for reducing inflammation, cleansing and detoxification, strengthening immunity, and releasing toxic weight.

Please understand that even though you may not choose a certain option,
if the doctor finds a specific treatment/ testing option necessary based on your body's needs,
he/she will discuss this with you in more detail.

I understand this and agree that all information I have provided is true to the best of my knowledge.

Patient Name: _____
Signature: _____
Date: _____