Traditional Health Clinic & Salt Spa
6210 Highland Place Way, Knoxville, TN 37919
Tel: (865) 588-1125 www.TraditionalHealthClinic.com

Advanced Initial Intake Checklist

Thank you for selecting our Advanced Initial Intake. We are looking forward to helping you get well and stay well.

We have included the checklist below to assist you in preparing for your initial consultation. Please note that your completed intake forms and medical records must be received at our office at least 7 days prior to your appointment. This will allow us to make the most of our scheduled time together and will enhance the quality of your care. If your packet is late or incomplete, you may be required to schedule another consult appointment to complete the intake phase of your care.

We realize that most people have never prepared for a medical consultation like this – it can be quite a project that may require considerable time and unusual efforts on your part. Our patients tell us that it's worth the investment and that they appreciate our efforts to gather and organize as many pieces of your health puzzle as possible. This is a key difference in our approach as compared to the conventional medical approach of "disease care."

Your intense self-reflection required in the process of compiling your complete health history marks the beginning of your health and wellness partnership with our practitioner. Take time and enjoy the process of getting your complete health story ready for someone who really wants to hear it.

Please complete the following steps:

Let us know if you are unable to download the documents. Please print out as single sided pages and complete using ink (not pencil).

- ☐ Complete the Advanced Initial Intake Questionnaire
- ☐ Complete the Personal and Medical History Timeline
- ☐ Complete the 3-Day Diet Diary
- ☐ Complete the Medication and Supplement Log
- ☐ Bring in all supplements, vitamins, herbs, and medications so that our practitioner can review the actual bottles
- ☐ Complete Consent & HIPAA Forms, Agreement to Cancellations and Late Appointment Policies
- ☐ Mail or drop off all completed forms at least 7 days prior to your scheduled initial appointment
- ☐ Please arrive at least 10 minutes before your scheduled appointment time to be sure we have all your materials organized and we are both ready to get started on time
- ☐ Please read our practice policies and FAQs

Medical Records:

- ☐ Obtain medical records from all healthcare providers as far back as possible. Include labs (blood, saliva, urine, minerals, hair, stool, ultrasounds, radiology reports, etc.). These should be sent to you - not to our office (see next step)
- ☐ Make copies of medical records. We require a copy for our files and are not able to copy these for you. Please arrange in chronological order with most recent documents on top of stack
- ☐ Mail or drop off **all forms** to Traditional Health Clinic at 6210 Highland Place Way, Knoxville, TN 37919. Records must be received at least 7 days prior to your appointment
- ☐ Please do not FAX records to us

NOTE: We require 48 hours notification if you are not able to come for your initial intake appointment. You will be charged the full price of your appointment ($400) if you do not show up for your appointment and you do not inform our office (via phone or email) at least 48 hours prior to your scheduled appointment time.

INITIAL INTAKE QUESTIONNAIRE

William C. Foster, L.Ac., D.O.M.
Traditional Health Clinic and Salt Spa
6210 Highland Place Way, Knoxville, TN 37919

Tel: (865) 588-1125 www.TraditionalHealthClinic.com Email: clinic@traditionalhealthclinic.com

Please take the time to carefully answer each part of each question by checking/circling/writing your answers. Please print clearly. Your information will be kept completely CONFIDENTIAL. Thank you!

Last name First name Middle initial Today's date / / 20___

Preferred name: Date of birth / Place of birth / Time of birth

Age _____ □ single □ married □ long-term partnership □ separated □ divorced □ widow / er

Genetic Background: □ African □ European □ Native American □ Mediterranean □ Bi-Racial
□ Asian □ Hispanic □ Middle Eastern □ Other _____

Highest Education Level: □ High School □ Under-Graduate □ Post-Graduate

□ Employed □ Retired Since when? _____

Employer:
Nature of Business / Occupation:

For how many years: Hours worked each day / week:

Previous employers / job(s): Hours worked each day / week:

Primary Address Number, Street _____ Apt. No. _____

City _____ State _____ Zip Code _____

Home phone _____ Mobile Phone _____
Work phone _____ Email 1 _____
FAX _____ Email 2 _____

Emergency Contact: Name _____ Their Phone _____
Address _____ Apt. No. _____
City _____State _____ Zip Code _____
Their relationship to you:

Who are your primary healthcare provider(s)? Name(s):

Office Location(s):

Date and reason(s) last seen:

How did you hear about our clinic? ☐ Website / Internet ☐ Media _____ ☐ Friend or Family Member ☐ Healthcare Provider ☐ Other:

Do you have children (Number and their ages): Number of children living at home:

Pets (Type and number):

ALLERGIES / SENSITIVITIES

Medication / Supplement / Food	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

COMPLAINTS / CONCERNS

What do you hope to achieve in your visit with us? _____

_____

If you could 'magically' do away with two health-related problems, what would they be?

1) _____ 2) _____

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel worse? What makes you feel better?

Please list current and ongoing problems in order of priority:

Describe Problem	**Mild**	**Moderate**	**Severe**	**Prior Treatment / Approach**	**Success**		
					Excellent	**Good**	**Fair**
1)							
2)							
3)							
4)							

What are the **major stressors** in your life?

1) _____ 3) _____

2) _____ 4) _____

Unfortunately abuse of all kinds (verbal, emotional, physical and sexual) are leading contributors to chronic stress and immune system dysfunction. If you are experiencing abuse it is very important that you feel comfortable letting us know so that we can support you and optimize your treatment outcome.

Do you currently feel safe in your home? ☐ Yes ☐ No
Do you feel safe, respected and valued in your current relationship? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY

☐ = *Past Condition (less than 6 months)* ☐ = *Ongoing Condition (greater than 6 months)*

DISEASES / DIAGNOSIS / CONDITIONS Check appropriate box and provide date of onset

GASTROINTESTINAL

☐ ☐ Irritable Bowel Syndrome (IBS)
☐ ☐ Inflammatory Bowel Disease (IBD)
☐ ☐ Crohn's Disease
☐ ☐ Ulcerative Colitis
☐ ☐ Gastritis / Peptic Ulcer Disease
☐ ☐ GERD (reflux)
☐ ☐ Celiac Disease
☐ ☐ H. pylori infection
☐ ☐ Diverticulosis / Diverticulitis
☐ ☐ Constipation / Diarrhea
☐ ☐ Other _____

CARDIOVASCULAR

☐ ☐ Coronary Disease
☐ ☐ Thromboses
☐ ☐ Heart Attack
☐ ☐ Angina (Stable/Unstable)
☐ ☐ Stroke
☐ ☐ Aneurysm
☐ ☐ Pericardium issues
☐ ☐ Myocardium issues
☐ ☐ Endocardium / Valve issues
☐ ☐ Conduction / Arrhythmic issues
☐ ☐ Cardiomegaly
☐ ☐ Hypertension (high blood pressure)
☐ ☐ Hypotension (low blood pressure)
☐ ☐ Rheumatic Fever
☐ ☐ Other _____

METABOLIC / ENDOCRINE

☐ ☐ Type 1 Diabetes
☐ ☐ Type 2 Diabetes
☐ ☐ Hypoglycemia
☐ ☐ Metabolic Syndrome (Insulin Resistance)
☐ ☐ Elevated Cholesterol
☐ ☐ Hypothyroidism (low thyroid)
☐ ☐ Hyperthyroidism (overactive thyroid)
☐ ☐ Adrenal Fatigue
☐ ☐ Polycystic Ovarian Syndrome (PCOS)
☐ ☐ Infertility

METABOLIC / ENDOCRINE (Continued)

☐ ☐ Weight Gain
☐ ☐ Weight Loss
☐ ☐ Frequent Weight Fluctuations
☐ ☐ Bulimia
☐ ☐ Anorexia
☐ ☐ Binge Eating Disorder
☐ ☐ Night Eating Disorder
☐ ☐ Eating Disorder (non-specific)
☐ ☐ Other _____

CANCER

☐ ☐ **Head and Neck** (mouth, nose, throat, larynx, sinus, salivary glands)

☐ ☐ **Digestive System** (Esophageal, gastric, small intestine, colorectal, anal)

☐ ☐ **Respiratory System** (Small-Cell Lung Carcinoma SCLC; Non-Small-Cell Lung Carcinoma NSCLC)

☐ ☐ **Bone Cancer**

☐ ☐ **Skin Cancer** (Basal Cell, Squamous Cell, Melanoma)

☐ ☐ **Blood Cancer** (Leukemia: ALL, AML, CLL, CML); Lymphoma (Hodgkin / Non-Hodgkin, Multiple myeloma)

☐ ☐ **Urogenital Cancer** (Cervical, Uterine, Endometrial, Ovarian; Prostate, Testicular; Kidney, Bladder)

☐ ☐ **Breast Cancer** (Ductal Carcinoma in situ DCIS, Invasive Ductal Carcinoma IDC, Lobular Carcinoma in situ LCIS, Invasive Lobular Carcinoma ILC, Medullary Carcinoma, Inflammatory Breast Cancer, Estrogen Receptor Positive, Progesterone Receptor Positive, HER2 Receptor Positive, Triple Negative TNBC)

☐ ☐ **Nervous System Cancer** (Nerve Sheath, Optic Nerve, Brain or Spine Tumor, Meningeal)

☐ ☐ **Endocrine System** (Thyroid, Adrenal, Pituitary, Pancreas, Parathyroid, Pineal)

☐ ☐ **Cancer Treatments** (Surgery, Radiation, Chemotherapy)

GENITAL AND URINARY SYSTEMS

- ☐ ☐ Kidney Stones
- ☐ ☐ Gout
- ☐ ☐ Interstitial Cystitis
- ☐ ☐ Frequent Urinary Tract Infections
- ☐ ☐ Frequent Yeast Infections
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ Sexual Dysfunction
- ☐ ☐ STDs: _____
- ☐ ☐ Other_____

MUSCULOSKELETAL / PAIN

- ☐ ☐ Osteopenia / Osteoporosis
- ☐ ☐ Osteoarthritis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Chronic Pain
- ☐ ☐ Other: _____

INFLAMMATORY / AUTOIMMUNE

- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Autoimmune Disease
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Psoriatic Arthritis
- ☐ ☐ Lupus SLE
- ☐ ☐ Multiple Sclerosis MS
- ☐ ☐ Immune Deficiency Disease
- ☐ ☐ Herpes - Genital
- ☐ ☐ Severe Infectious Disease
- ☐ ☐ Poor Immune Function (frequent infections)
- ☐ ☐ Food Allergies
- ☐ ☐ Environmental Allergies
- ☐ ☐ Multiple Chemical Sensitivities
- ☐ ☐ Latex Allergy
- ☐ ☐ Raynaud's Disease
- ☐ ☐ Other _____

RESPIRATORY DISEASES

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitis
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema / COPD
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep Apnea (Use of CPAP / BiPAP?)
- ☐ ☐ Other _____

SKIN DISEASES

- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Acne
- ☐ ☐ Other _____

NEUROLOGIC / MOOD DISORDERS

- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Seasonal Affective Disorder (SAD)
- ☐ ☐ Schizophrenia
- ☐ ☐ Headaches / Migraines
- ☐ ☐ ADD / ADHD
- ☐ ☐ Autism
- ☐ ☐ Mild Cognitive Impairment
- ☐ ☐ Memory Problems
- ☐ ☐ Parkinson's Disease
- ☐ ☐ ALS
- ☐ ☐ Seizures
- ☐ ☐ Tremors
- ☐ ☐ Areas of Numbness / Tingling
- ☐ ☐ Lack of Coordination
- ☐ ☐ Loss of Balance
- ☐ ☐ Disorientation
- ☐ ☐ Vertigo
- ☐ ☐ Irritability / Easily Angered
- ☐ ☐ Other _____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy
- ☐ Gall Bladder
- ☐ Prolapse Repair
- ☐ Hernia Repair
- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Sinus Surgery
- ☐ Deviated Septum
- ☐ Cosmetic Surgery
- ☐ Dental Surgery
- ☐ Breast Surgery
- ☐ Back / Spine Surgery
- ☐ Joint Replacement – Shoulder, Hip, Knee
- ☐ Heart Surgery - Bypass
- ☐ Angioplasty or Stent
- ☐ Pacemaker
- ☐ Hysterectomy +/- Ovaries
- ☐ Fibroids / Cysts
- ☐ Endometriosis
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Other _____
- ☐ NONE

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam ☐ Bone Density Scan
- ☐ ECG (Electro Cardio Gram)
- ☐ Cardiac Stress Test
- ☐ EBT Heart Scan
- ☐ Liver Scan
- ☐ NMR / MRI
- ☐ Upper Endoscopy ☐ Upper GI Series
- ☐ Colonoscopy
- ☐ Sigmoidoscopy
- ☐ Hemoccult Test – test for blood in stool
- ☐ Ultrasound
- ☐ X-Ray
- ☐ Other _____

INJURIES:

Check box if yes and give dates

- ☐ Back Injury
- ☐ Neck Injury
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Other _____

BLOOD TYPE:

- ☐ A
- ☐ B
- ☐ AB
- ☐ O
- ☐ Rh+
- ☐ Unknown
- ☐ Significant Blood Loss
- ☐ Blood Transfusions

HOSPITALIZATIONS ☐ NONE

Date ***Reason***

_____

_____

_____

FAMILY HEALTH HISTORY

Please list your family members' current age and any medical conditions they have or have had.

Family Member **Age** **Medical Condition(s)**

Mother: _____
Father: _____
Brother(s): _____
Sister(s): _____
Children: _____
Maternal Grandmother: _____
Maternal Grandfather: _____
Paternal Grandmother: _____
Paternal Grandfather: _____
Aunts: _____
Uncles: _____
Other: _____

CONDITIONS TO LIST (please add any others not listed):

Cancers (Colon, Breast, Ovarian), Heart Disease, Hypertension, Obesity, Diabetes, Stroke, Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis), IBD, IBS, MS, ALS, Lupus, Celiac Disease, Asthma, Eczema, Psoriasis, Food Allergies / Sensitivities, Environmental Sensitivities, Dementia, Parkinson's, Genetic Disorders, Substance Abuse, Psychiatric Disorders, Depression, Schizophrenia, ADHD, Autism, Bipolar Disease.

Are there any conditions that run in your extended family?

PHYSICAL HEALTH INFORMATION

Circumstances of your birth:

☐ premature ☐ prolonged labor ☐ forceps delivery ☐ drug induced delivery ☐ C-section

Did your mother smoke / drink / take drugs / experience trauma when pregnant with you?

Did either of your parents or household members smoke when you were growing up?

Immunizations / vaccinations: ☐ Standard schedule ☐ Variation on standard schedule ☐ Military deployment

Please provide details:

Do you routinely get a flu shot?

How often do you contract a common cold / flu? How recently have you had a cold / flu?

Current Exercise Program: (list type of activity, number of sessions/week, and duration)

Activity	**Type**	**Frequency Per Week**	**Duration in Minutes**
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, Pilates, gyro, etc.)			
Sports or Leisure Activities (golf, tennis, skating, cycling, etc.)			

List problems that limit activity:

Do you feel unusually fatigued after exercise?

Do you usually sweat when exercising?

Please rate your overall **energy level** on a scale of one to ten (one is lowest) 1 2 3 4 5 6 7 8 9 10

Are there times of the day when you feel especially ☐ tired What time?

☐ energetic What time:

Have you ever had **sleep problems**? ☐ past ☐ present Please describe:

Have you ever used any sleeping aides (drugs, supplements, self-help techniques, etc.)? Which ones?

Has your *job schedule or home environment* ever interfered with normal sleep patterns?

How so and for how long?

Home sleeping environment conditions:

Noise levels: ☐ Very quiet ☐ Quiet ☐ Outside sounds ☐ House sounds ☐ People sounds ☐ Other:

TV and/or computer screens: ☐ In bedroom ☐ Nearby ☐ Other:

Light: ☐ Completely dark bedroom ☐ Nightlight ☐ Outside light ☐ Ambient light ☐ Digital light(s)

Other: ☐ (pets, kids, spouse, etc.)

Activities within 3 hours of laying down to sleep:

What time do you usually go to sleep at night? What time do you usually wake up in the morning?

Have you had any trouble falling asleep? What keeps you awake?

Have you often awoken during the night? What has woken you up? What time do you wake?

Have you had trouble falling back to sleep after you have awoken? What do you do to fall asleep?

Do you wake feeling rested? Do you have trouble waking / getting out of bed in the morning?
Do your dreams disturb your sleep? What type of dreams bother you?

Do you snore? Do you have sleep apnea (stop breathing while sleeping)?
Do you sleep-walk or sleep-talk?

Do you nap during the day? How frequently and for how long?

What is your overall feeling of your **body temperature**?
Do you typically feel: ☐ hot ☐ cold ☐ temperature fluctuates ☐ normal / stable

Do you feel you are **heat or cold sensitive**?

When do parts of your body feel: ☐ colder ☐ warmer

Do you feel better or worse in certain conditions / times of the year? (heat, cold, humidity, dryness, wind; winter, spring summer, fall)

Do you **perspire:**
☐ normally ☐ little or not at all ☐ only under exertion ☐ spontaneously ☐ more than average
☐ excessively ☐ at night ☐ cold sweats ☐ unusual odor ☐ Other:

Do you use antiperspirants / deodorants? Do they contain aluminum?

Do you have any **acute or chronic pain** problems? Please describe location(s):

Please **describe sensations of pain** as best as you can:
☐ intense ☐ sharp ☐ burning ☐ boring ☐ tearing ☐ piercing ☐ stabbing ☐ dull ☐ aching ☐ heavy
☐ cramping ☐ fixed ☐ moving ☐ comes and goes ☐ constant ☐ throbbing ☐ spontaneous
☐ painful with pressure ☐ accompanied by swelling ☐ radiates to:
☐ Other (please describe):

Skin: ☐ dryness ☐ itching ☐ rashes ☐ acne ☐ hives ☐ moles ☐ warts ☐ ulcerations
☐ sensitivity ☐ birthmarks ☐ varicose veins ☐ dandruff ☐ itchy scalp ☐ psoriasis
☐ eczema ☐ dermatitis ☐ color changes ☐ bruise easily ☐ Other:

Do you use lotion / moisturizer? What kind? (brand): How often: Where on your body:

Do you use sun screen? What kind? (brand and SPF): How often?
Do you use artificial tanning products or tanning beds?

Body Modification (Tattoo / Piercing) / Cosmetic Surgery:

Scars: Cause and Location: Do any of your scars bother you?

Hair: Is your hair naturally: ☐ straight ☐ curly ☐ kinky ☐ dry ☐ brittle ☐ oily
☐ growth rate (fast / slow / normal) ☐ hair loss ☐ early graying / whiting
☐ use of chemicals for hair

Nails: ☐ dry / brittle ☐ soft / hard ☐ growth rate (fast / slow/ normal) ☐ ridges ☐ white specks
☐ discoloration ☐ fungal problems (where?) ☐ misshapen ☐ use of nail polish / remover
☐ Other:

Any **eye / vision** complaints? Do you wear glasses or contact lenses? ☐ progressive lenses
☐ redness ☐ itchiness ☐ watery ☐ blurry ☐ heat in the eyes ☐ light sensitivity
☐ dryness ☐ poor night vision ☐ glaucoma ☐ cataracts ☐ macular degeneration
☐ color blindness ☐ floaters (objects floating across field of vision) ☐ grit in the eyes
☐ near or farsightedness ☐ Other:

Any **ear / hearing** problems? ☐ ringing in the ears ☐ hearing difficulties ☐ excessive wax ☐ sensitivity to sounds
☐ discharge ☐ recurring / chronic earaches or infections ☐ ear tubes / implants ☐ Other:

Teeth: ☐ history of extensive dental work (born with extra teeth, extractions, braces, etc.)
☐ mercury amalgam replacement ☐ sensitivity to temperature (hot or cold / sugar)
Current number of fillings: Mercury (silver) Amalgam _____ Composite _____ ☐ Other _____
History of: ☐ root canals ☐ bridges ☐ crowns ☐ implants ☐ abscesses / infections
☐ looseness of teeth ☐ discoloration of teeth ☐ clenching / grinding teeth ☐ TMJ
☐ wear mouth guard ☐ Other:

Gums: ☐ bleeding ☐ receding ☐ gingivitis ☐ sores / ulcers ☐ periodontal disease ☐ Other:

Mouth / Tongue: ☐ sores / ulcers ☐ bad breath ☐ thick coating on the tongue (please describe color, etc.):
☐ tongue sensitivity ☐ Other:

Lips: ☐ unusual coloration ☐ moisture problems ☐ lipstick / lip balm / etc. use ☐ Other:

Throat / Glands: ☐ swelling ☐ soreness ☐ dryness ☐ itchiness ☐ feeling of something stuck in throat
☐ difficulty swallowing ☐ Other:

Voice: ☐ speech pathologies / difficulties ☐ sighing ☐ weak / strong voice ☐ stuttering / stammering
☐ Do you sing? ☐ hoarseness of voice ☐ Other:

Muscular Tension: places where you hold tension: ☐ neck ☐ shoulders ☐ upper / middle / lower back
☐ abdomen ☐ pelvis ☐ hips ☐ thighs ☐ calves ☐ ankles / feet ☐ TMJ
☐ Other:
Does your body usually feel: ☐ flexible **or** ☐ tight/stiff

Muscular Weakness: ☐ Atrophy ☐ Shaking upon exertion ☐ Twitching ☐ Cramping ☐ Other:

Which muscles? When / How often?

Bones / Joints: ☐ joint pain ☐ joint swelling / redness ☐ sensation of heat / coldness ☐ fluid in joints
☐ dry / abrasive / noisy joints ☐ osteopenia / osteoporosis ☐ bone fracture or injury
☐ tendonitis / bursitis ☐ Other:

Memory / Concentration / Will Power: ☐ poor short-term memory ☐ poor long-term memory ☐ easily distracted ☐ poor retention ☐ irresolute ☐ Other:

How is your **sense of smell**?
How is your **sense of taste**?

Have you had any type of **paralysis**? **Seizures**? Have you had any head injuries? **Concussions**?

Do you or have you ever felt **dizzy** or had a spinning sensation? **Vertigo** (world turning around you)?

When does / did this occur? ☐ upon standing / lying down ☐ under stress ☐ bending over ☐ tipping head backwards ☐ Other:
How long does / did it last? How long has this been happening?

Have you experienced **headaches?** Do you have any history of **migraine headaches**?
☐ never ☐ rarely ☐ occasionally ☐ frequently (how frequent?) ☐ constantly ☐ migraine aura?

Please describe your **headache symptoms**:
Location: ☐ forehead ☐ temples ☐ back of head ☐ top of head ☐ behind eyes ☐ sinuses ☐ one sided ☐ entire head ☐ shifting / moving ☐ fixed position ☐ Other:
Sensations: ☐ dull / heavy / achy pain ☐ sharp / intense pain ☐"band around head"
☐ nausea / vomiting ☐ throbbing / pulsating ☐ visual disturbances
☐ poor mental functions ☐ Light / Sound Sensitivity ☐ Other:

Please describe the **level of pain** during headaches: (1=slight pain) 1 2 3 4 5 6 7 8 9 10 (10=debilitating pain)

What makes headaches better? ☐ rest / sleep ☐ quietness ☐ stillness ☐ movement ☐ bright light ☐ darkness ☐ lying down ☐ remaining upright ☐ food ☐ caffeine ☐ drugs (which ones?) ☐ heat ☐ cold ☐ pressure ☐ humidity ☐ Other:

Do your headaches occur at certain times of day / night? Seasonally / with weather conditions / times of month?

Do you feel there is an emotional and/ or a stress component to your headaches?

Do you have any **history of respiratory illness**?
☐ hayfever or airborne allergies ☐ allergy to animals ☐ asthma ☐ pneumonia ☐ bronchitis ☐ emphysema / COPD ☐ pleurisy ☐ sleep apnea ☐ Other:

Do you have any **respiratory or breathing difficulties**?
☐ shortness of breath ☐ labored / difficult breathing ☐ wheezing ☐ cough ☐ chest congestion ☐ painful breathing ☐ shallow breathing ☐ holding breath ☐ irregular breathing ☐ positional breathing difficulties ☐ sinus congestion ☐ recurring sinus infections ☐ runny nose ☐ sneezing ☐ post nasal drip ☐ nose bleeds ☐ sore throat ☐ dry throat ☐ swollen glands ☐ mouth breathing ☐ Other:

Is one of your nostrils usually clearer than the other? Which one? When?

Have you ever been a **smoker / tobacco chewer**? How many / how much per day & for how long?

How many times did you attempt to quit?

Have you had any significant exposure to **second hand smoke**?

Do you have a history of **substance abuse** of any kind?

Recreational drug use: Drug(s) of choice in the Past: Use: ☐ Casual ☐ Moderate ☐ Excess

Present: Use: ☐ Casual ☐ Moderate ☐ Excess

How many times during the day do you **urinate**? How many times at night?

Color / quality of your urine:

☐ 'normal' ☐ clear ☐ dark yellow ☐ reddish (blood) ☐ cloudy ☐ foamy ☐ odorous ☐ burning / painful
☐ difficult ☐ hesitant ☐ dribbling ☐ retention ☐ urgent ☐ frequent ☐ weak stream ☐ bed wetting
☐ incontinence (lack of control with jumping / laughing / coughing / sneezing, etc.) ☐ Other:

Any history of kidney and/or urinary tract infections? Frequency: Date of last infection:

Any history of kidney stones? Frequency: When did you last have kidney stones?

Do you have regular **bowel movements**? How many each day? Week?

What time(s) of day do you normally have a bowel movement?

Do you experience **constipation** or **diarrhea**? ☐ past ☐ present When and for how long?

What is the consistency of your stools: ☐ well-formed ☐ hard / pellets ☐ loose / unformed ☐ alternating

Color of stool: ☐ brown ☐ yellow / tan ☐ black ☐ red (blood) ☐ white/grey ☐ green ☐ alternates

Any mucous regularly in the stool? Color of mucous: ☐ clear ☐ white ☐ yellow ☐ green / brown

Any difficulty passing stools? Any pain associated with passing stool? ☐ before ☐ during ☐ after

Do you have a feeling of incomplete evacuation after passing stools?

Have you ever used laxatives? ☐ past ☐ present ☐ intermittent ☐ long term Which types / brands?

Have you used a stool softener or fiber product? ☐ past ☐ present What brand and how often?

Have you used enemas or colonics? ☐ past ☐ present How frequently?

Have you suffered from **hemorrhoids** or **fissures**? ☐ past ☐ present ☐ protruding ☐ bleeding

Cardiovascular issues: □ palpitations □ fast/slow heart rate □ arrhythmias □ fibrillations □ heart disease
□ blood clots □ phlebitis □ rheumatic fever □ fainting □ ankle swelling □ heart murmur
□ angina/chest pain □ heart related surgery □ bleeding / clotting disorders □ Other:

How frequently (daily, weekly, monthly)? Do they occur in relation to any particular activity?

How long do symptoms/conditions last when they do occur (seconds, minutes, hours)?

Have you ever had: □ low blood pressure □ high blood pressure

Have you ever had high cholesterol?

Do you ever have swelling in your arms or legs?

WOMEN ONLY IMPORTANT: REGARDLESS OF AGE AND STAGE OF LIFE
PLEASE RESPOND TO THE FOLLOWING QUESTIONS ABOUT YOUR HEALTH – PAST AND PRESENT

Age of first menses (menarche): Dates of last period: Where are you in your cycle today?

Are you currently pregnant or trying to get pregnant?

Date of last gynecological exam: Date of last PAP smear:

Number of pregnancies: Number of miscarriages (dates): Number of abortions (dates):

Have you had any difficulties with conception? If yes, please describe:

Have you had any Laparoscopies? When? Why?

Do you want to have (more) children?

Any birthing difficulties? □ C-section □ premature □ prolonged □ hemorrhaging
□ ectopic pregnancy □ severe pain □ induced labor □ Other (please describe):

Have you had postpartum depression / weakness? Other postpartum complications?

Have you ever used birth control drugs or practiced birth control methods? (IUD, BC Pill, Depo Provera injection, Rhythm Method, Tubal Ligation, etc.)

When and for how long?

Have you had a hysterectomy? □ Partial □ Complete Date: Reason for hysterectomy:

Have you had menopausal symptoms? Since when? Please describe:

Have you ever used hormone replacement therapy? For what and for how long?

Have you ever missed periods (other than when pregnant / lactating)? If so, please describe:

Has your cycle always been regular? If not, please explain:

How many days between the start of each cycle? How many days do/did you typically flow?

Please describe the quantity and quality of the flow:

☐ light ☐ normal ☐ heavy ☐ clotting
☐ pale ☐ bright red ☐ dark red ☐ brown ☐ Other:

Have you ever had unusual bleeding / spotting or vaginal discharge between periods or otherwise?

Have you experienced pain / cramps associated with your period? For how many years?
☐ before period ☐ during period ☐ after period ☐ mild ☐ strong ☐ intense / debilitating
The pain was / is reduced with: ☐ warmth / heat ☐ rest / inactivity ☐ activity / movement ☐ start of period
☐ drugs (name): ☐ Other:

Have you experienced any of the following before or during your period?
☐ water retention ☐ breast tenderness / swelling ☐ fatigue ☐ emotional ups / downs
☐ depression ☐ irritability ☐ headaches ☐ nausea/vomiting ☐ low back pain
☐ change in bowel habits ☐ food cravings ☐ Other:

Any vaginal dryness or itching? Bleeding and / or pain during or after intercourse? Libido issues?

Any history of: ☐ Yeast infections ☐ Pelvic inflammatory disease ☐ Endometriosis

How frequently do you have breast exams / mammograms? Have you ever had lactation difficulties?

Have you had any breast lumps / cysts / fibroids? Any bleeding or discharge from nipples?

MEN ONLY

Have you ever had any prostate problems? If so, please describe:

Ever had a vasectomy? When? Reversal of vasectomy?

Any physical problems with the penis / scrotum / testicles (masses / cysts / tumors)?

Any sensations of ☐ coldness ☐ numbness ☐ pain Any swelling?

Any defect / deficiencies in sperm function or production?

Any experience of impotency (inability to have and / or maintain an erection)? Libido issues?

Have you ever experienced:
☐ premature ejaculation ☐ wet dreams ☐ pain during / after sex / ejaculation
☐ loss of sperm with urination and / or bowel movement ☐ tiredness / exhaustion after orgasm

SOCIAL / EMOTIONAL HEALTH AND LIFESTYLE INFORMATION (men & women)

Are you an adopted child? At what age? Do you have contact with your biological parent(s)?

Are any of your siblings adopted? Do you have step-siblings?

Are your parents separated or divorced? If so, how old were you at the time of the separation or divorce?

Number of brothers and sisters: Your place in sequence (first born, youngest, etc.)

Significant childhood / adolescent / adult trauma: Major losses in your life:

Use of **technology**: ☐ TV ☐ Computer ☐ Microwave ☐ Hair dryer ☐ Electric blankets ☐ drive a lot ☐ Cell phone ☐ Headset / Ear buds

Exposure to: ☐ electromagnetic fields ☐ radiation ☐ fumes ☐ excessive noise ☐ fluorescent lights ☐ chemicals: ☐ damp / moldy environments ☐ Other:

Do you enjoy your life? Are you happy?
Do you feel your life has meaning and purpose?
Do you believe stress is presently reducing the quality of your life?
Do you feel you have an excessive amount of stress in your life?
Do you feel you can easily handle the stress in your life?
Is your job satisfying to you?
Do you spend the majority of your time and money to fulfill responsibilities and obligations?

What do you do for **recreation**? Any hobbies?

Are you satisfied with your significant relationships?

Do your home and work environments provide support for your health and well being?

How would you describe your personality?

What are your predominate emotions?

What are your greatest fears?

What are your greatest desires?

What do you consider to be your greatest strength(s)? Weakness(es)?

What emotions come up when you feel stressed?

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At School				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

Do you have any **nervous habits**? Is there anything that you feel is a habit or addiction in your life?

Have you ever considered or attempted **suicide**?

Do you practice **relaxation / meditation / prayer**? Do you have moments of quietude in daily life?

Have you ever sought counseling? Are you currently in therapy?

Do you travel a lot? □ past □ present □ business □ pleasure

Recent **foreign travel** (within last 2 years): Any sickness during and/or after travel?

Foreign countries in which you have lived: Dates of residence:

DAILY ROUTINE

Please describe your daily routine from the time you wake in the morning until going to bed at night:
Please describe how your routine differs on your days off / weekends:

The spaces in which you live, work, eat, sleep, socialize, travel, etc. all can (and do) influence your body and mind. Please bear this in mind and be prepared to describe these environments and to explore their potential influence on your health and health concerns. [Sounds/noise levels, temperature/humidity, light sources, chemical exposure, TV/computer screens, furniture used, air flow, human/animal interactions, level of physical activity, etc., etc.]
Please list anything that you feel could be of significance:

Briefly describe your daily work environment:

Home environment conditions:

DIET AND NUTRITION

Were you breastfed? If so, for how long?

Please describe your **diet in your youth**:

Please describe your **present diet**: □ vegetarian □ vegan □ carnivore □ omnivore □ low salt
□ low fat □ low sugar □ low carbohydrate □ no dairy □ no wheat □ Gluten restricted □ low protein
□ high protein □ high fat □ Other:

Have you ever had a nutrition consultation?

Have you followed any **diets**? Please describe the diet, diet objectives, length of time you adhered to it and the result:

Do you have any experience with cleanses / detoxification programs or fasting?

Do you eat regular meals? Do you skip meals? If so, which one(s), how often and why?

Do you snack between meals? Typical snack foods:

Do you eat near bedtime or at night? What do you eat then?

How often do you eat out each week? Where / what type of food when dining out:

Do you grocery shop? Do you read food labels?

Check all the factors that apply to your current lifestyle and eating habits:

□ Erratic eating pattern
□ Eat too much
□ Dislike healthy food
□ Time constraints
□ Travel frequently
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Rely on convenience foods
□ Poor snack choices
□ Significant other or family members have special food preferences
□ Significant other or family members don't like healthy foods
□ Love to eat
□ Eat because I have to
□ Have a negative relationship with food
□ Emotional eater (eat when sad, lonely, depressed, bored)
□ Eat too much under stress
□ Eat too little under stress
□ Don't care to cook
□ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:

What percentage of your food intake is raw? Do you actually cook much?

Do you cook with: □ Aluminum pots □ Stainless Steel pots □ Non-stick pots □ Cast Iron pots
□ Clay pots □ Stoneware □ Glass / Pyrex □ Other:

Are you relaxed when you eat? Do you usually eat in a relaxed environment?
Do you often eat while: □ reading □ watching TV □ driving □ standing up □ talking □ Other:

Any history of eating disorders, emotional or binge eating? Please describe:

Do you **crave** any of the following foods? □ sweets □ breads □ fatty foods □ meats □ fish □ milk □ Other:

What do you usually drink with food / meals? □ cold fluids □ warm fluids □ hot fluids Please List:

Which tastes do you **prefer**: □ sweet □ salty □ sour □ pungent / spicy-hot □ bitter □ astringent

Do you strongly **dislike** any particular tastes or foods?

Have you used any **artificial sweeteners**? Which ones, how much and for how long?

How would you describe your **appetite**: □ normal □ weak □ strong □ variable □ constant

What factors cause **appetite** to vary and how so?
□ exercise □ caffeine □ medication □ stress □ time of day / month (when ?) □ weather /season
□ Other:

How do you generally feel after eating? Does your energy level go: □ up □ down □ stay the same?

Does it depend on the type and / or amount of food eaten? Which foods cause which reaction?

What are your favorite foods? What foods do you eat regularly?

Please describe your **typical daily meals / snacks** and the **times** you eat them.
**Please indicate your largest meal of the day.*

Time	**Meal**	**Foods / Beverages**
___:___ am / pm	**Breakfast:**	
	Snacks (after breakfast):	
___:___ am / pm	**Lunch:**	
	Snacks (after lunch):	
___:___ am / pm	**Supper:**	
	Snacks (after supper):	
___:___ am / pm	Before sleep / During night / sleep	

Please indicate (circle and / or check) **liquid intake** amounts (ounces):

____Ounces per day / week / month □ **Water** (□ tap □ bottled □ filtered/purified)
____Ounces per day / week / month □ **Coffee** (□ caffeinated □ decaffeinated)
____Ounces per day / week / month □ **Teas** (□ caffeinated □ decaffeinated □ herbal (types: _____)
____Ounces per day / week / month □ **Soft drinks** (type):
____Ounces per day / week / month □ **Alcohol** (type of alcohol: □ beer □ wine □ hard liquor)
____Ounces per day / week / month □ **Juice** (please give types):
____Ounces per day / week / month □ **Other** [energy drinks, etc.]:

Which **fats / oils** do you use?

□ margarine □ butter / ghee □ olive □ safflower □ sunflower □ corn □ Crisco □ canola □ grape seed
□ coconut □ peanut □ soybean □ sesame □ mayonnaise □ flax □ lard □ fish/cod liver
□ Other:

Do you feel like you digest your food well?

Do you have any **digestive complaints**?

□ bad breath □ intestinal gas □ foul gas □ belching □ hiccups □ bloating □ nausea/vomiting
□ abdominal cramping □ pain (where?) □ pain relieved by passing gas?
□ noisy stomach / intestines (gurgling, etc.) □ heart burn □ acid reflux / regurgitation (GERD)
□ hiatal hernia □ burning pain after eating □ jaundice □ gall bladder disease
□ liver disease (fatty liver, cirrhosis, hepatitis) □ IBS □ ulcers □ Other:

Have you had any problems with **blood sugar fluctuations** (hypoglycemia, insulin resistance, diabetes, etc.)?

Do you chew **gum**? If so, what kind, how often, and since when?

Do you **chew your food** well or "inhale" it?

Would you like to **decrease / increase** your **body weight**? If so, by how much?
When did you last have a significant (more than 10 pounds) **change in weight**?

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):
In order to improve your health, how wiling are you to:

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

Comments_____
_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):
How confident are you of your ability to organize and follow through on the above health related activities?
☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?_____
_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):
At the present time, how supportive do you think the people in your household will be to your implementation of the above changes? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments_____
_____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):
How much on-going support and contact (e.g. telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments_____
_____

If you would like to add or bring anything in particular to our attention please use the space below.

Thank you very much for taking the time and effort to fill out these extensive intake forms. Your input provides an extremely important contribution towards our effort to understand the underlying causes of your health concerns. Your detailed information will be utilized in the creation of a unique and effective personalized treatment plan.

Your Signature _____ Date _____

Traditional Health Clinic & Salt Spa
6210 Highland Place Way, Knoxville, TN 37919

Patient Name: _____ **Date:_____**

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS: ***Last 10 years***

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Traditional Health Clinic & Salt Spa
6210 Highland Place Way, Knoxville, TN 37919

Patient Name: **Date:**

CURRENT NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement Name and Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Cancellation and Late Appointment Policy

Late Appointments

We are committed to prompt service, and will work very hard, barring emergencies, to stay on time. We may ask you to reschedule if you arrive more than 10 minutes after your scheduled appointment time. Please arrive 10 minutes early for an appointment to complete any paperwork associated with your visit.

If the practitioner is more than 15 minutes late for your scheduled appointment, you will receive a 5% discount for your service fees for that appointment.

Cancellations

Patients are required to contact our office within 24 hours if they cannot make their appointment.

Patients will be charged the full price for a missed appointment that is not cancelled 24 hours in advance.

Agreed and signed,

Name_____

Date _____

Traditional Health Clinic HIPAA Contact Consent Information

Patient's Name _____ Date of Birth _____/_____/_____

May we contact you by home phone?	Yes	No	N/A
May we leave a detailed message?	Yes	No	
May we leave a message with a call back number?	Yes	No	
May we contact you by cell phone?	Yes	No	N/A
May we leave a detailed message?	Yes	No	
May we leave a message with a call back number?	Yes	No	
May we contact you at work?	Yes	No	N/A
May we leave a detailed message?	Yes	No	
May we leave a message with a call back number?	Yes	No	
May we speak with someone else regarding your medical care?	Yes	No	

Name of Person_____ Relationship_____

Name of Person_____ Relationship_____

Name of Person_____ Relationship_____

From time to time we like to check in with our patients to learn how we can best meet their needs and provide the highest level of care possible.

Please initial below if you are NOT willing to be contacted as part of our efforts to learn about your experience.

____ I do not want to be contacted

Traditional Health Clinic – Notice of HIPAA Privacy Practice

The attached Notice describes how health information about you may be used, and your rights, regarding that information. Please review this summary and the full Notice carefully.

Traditional Health Clinic Pledge: Staff and employees of Traditional Health Clinic (THC) understand that information about you and your health is personal. We are committed to protecting your health information.

Who will follow rules in this notice: All THC staff and volunteers must follow these rules.

You have the right to:
-Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
-Ask to correct information that you believe is wrong in your health record.
-Ask that your health information not be shared with certain individuals.
-Ask that your health information not be used for certain purposes: for example, research.
-Ask that THC to send copies of your health record to whomever you wish (charges may apply).
-Be informed about who has read your record (for reasons other than treatment, payment & program improvement purposes).
-Specify where and how THC employees may contact you.
-Receive a paper copy of the full Notice of Privacy Practices.

Who is authorized to see confidential Patient Health Information (PHI) at THC?
The Acupuncturist may access the entire medical record, based on his "need to know". All other members of our workforce have access only to the information to do their jobs. The "Notice of Privacy Practices" describes the ways in which we may use PHI without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted.
1. Treatment of the patient, including appointment reminders.
2. Payment of health care bills.
3. Health care operations and business operations, teaching and medical staff quality activities, research (when approved and with a written patient permission); health care communications between a patient and their health care practitioner.

Minimum Necessary Standard
THC will apply the "minimum necessary" standard regarding PHI. For example, although clinical Administration, Acupuncturists and other health care providers may need to view the entire record, a billing clerk or data entry staff member might only need to see a specific report to determine the billing codes. An admissions staff member may not need to see the medical record at all, only an order form with the admitting diagnosis and identification of the admitting physician.

Written Authorizations
To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. If you do not understand what you can do with PHI, please read the "Notice of Privacy Practices".

Exceptions to the Rules
Under HIPAA, there are certain exceptions to these rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement and based on a judicial request or subpoena.

If you have concerns about how your health information might be (or has been) shared, please speak with the THC privacy coordinator, or call 865-588-1125. If you believe your rights have not been maintained you may file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filling a complaint.

Printed Name:_____ Today's Date:____/_____/_____

Signature:_____ Date of Birth:___/____/_____

Relation (if other than patient):_____ Patient declined to sign receipt:_____

Patient unable to sign (witness signature):_____

Reason Unable:_____ Interpreter:_____

Traditional Health Clinic & Salt Spa
6210 Highland Place Way, Knoxville, TN 37919
Tel: (865) 588-1125

INFORMED CONSENT TO HEALTHCARE BY A LICENSED ACUPUNCTURIST

I hereby request and consent to the performance of the following on me (or the patient named below for whom I am legally responsible) by William Foster, L.Ac. and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for William Foster, including those working at his office or any other associated office whether signatories to this form or not:

Acupuncture and other oriental medical procedures including, but are not limited to:

- diagnostic techniques such as questioning, pulse evaluation, manual palpation on a variety of areas on my body, observation, range of motion evaluation, muscle, orthopedic and neurologic testing
- modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation
- the application of herbal oils, ointments, salves and/or liniments to the body
- the prescription of herbal and dietary supplements
- dietary recommendations
- advice regarding exercise regimens and lifestyle counseling

I have had an opportunity to discuss with the practitioner (William Foster) the nature and purpose of Oriental medicine, Ayurveda and other oriental medical procedures. I understand that results are not guaranteed.

I understand that in the initial undertaking of treatment, the most effective results are obtained by receiving regular treatments each week at a frequency recommended by the practitioner for my specific condition. I realize that if treatments are less frequent or erratic, improvement in my condition will be less likely and slower. I also understand that if I am unable or unwilling to follow the doctor's recommendations regarding taking of herbs, supplements, exercise, or lifestyle change that the effectiveness of the acupuncture will be reduced and my progress impeded.

I understand and am informed that there are some risks to treatment, including but not limited to bleeding, bruising, inflammation, infections, burns, general aches, sprains, strains, dislocations, fractures, disc injuries, strokes, puncture of organs, pain or other strong sensations at the location where a needle is inserted or radiating from that location, nerve pain, aggravation of current symptoms and appearance of new symptoms.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the doctor's judgment based on the facts known at the time.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT'S PRINTED NAME: _____

PATIENT'S SIGNATURE: _____

If patient is dependent: PATIENT REPRESENTATIVE / GUARDIAN:

Name: _____ Signature: _____

Relationship to patient: _____

DATE: _____

I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment.

PRACTITIONER'S SIGNATURE: _____

DATE: _____