Wholesome Health Integrative Family Medicine

2410 E 25th Circle | Idaho Falls, Idaho | (208) 557-0200

PATIENT INFORMATION

Today's Date: ____ /____ /____ Name: _____
Last Name First Name Middle Initial

DOB: ____ /____ /____ Age: _____ Gender: ☐ M ☐ F Height: _____ Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed SSN: _____

Addresss: _____ _____ _____ _____
Street City State Zip Code

Home: (____) _____ Cell: (____) _____

Work: (____) _____

Emergency Contact: _____ Emergency Phone: (____) _____

How did you hear about us? ☐ Facebook ☐ Website ☐ Friend or Famliy Member ☐ Phonebook

Who can we thank for sending you to our office? _____

☐ Yes, you would like to receive clinic updates and informational material. Your email and personal information will never be sold, lent, or given to any third party company, person, or entity. It will solely be used within Whole Health Clinic for clinic purposes only.

Email: _____

GUARDIAN INFORMATION (IF APPLICABLE)

Name: _____ DOB: ____ /____ /____
Last Name First Name Middle Initial

SSN: _____ Relationship to Patient: _____

Gender: ☐ M ☐ F Phone: (____) _____

I, the above mentioned guardian, make an oath and say that I am the lawful guardian of the above mentioned patient, and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person, and I can make decisions for the above mentioned patient, and take full responsibility for those decisions .

INSURANCE INFORMATION AND DISCLAIMER

Primary Insurance Carrier

Insurance Carrier: _____

Carrier Phone: (_____) _____

Co-Pay Amount: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's DOB: ____ /____ /_____

Policy Holder's SSN: _____

Relationship to Guarantor: _____

Secondary Insurance Carrier

Insurance Carrier: _____

Carrier Phone: (_____) _____

Co-Pay Amount: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's DOB: ____ /____ /_____

Policy Holder's SSN: _____

Relationship to Guarantor: _____

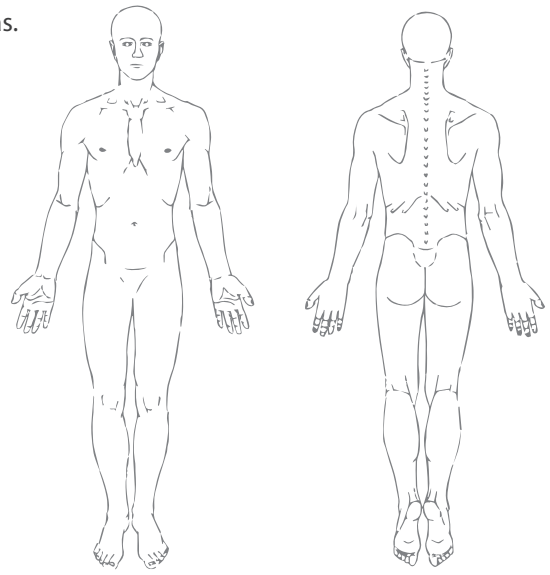
The cutting-edge, outside-the-box approaches we take in addressing your health issues related to your condition may not be covered by your insurance. We will make every effort we can to help you utilize your insurance for office visits, treatments, and procedures, but please keep in mind that insurance companies are getting more restrictive in what they will and won't pay for. Often they determine payments based on the "standard of care" and we have found that some of our most beneficial diagnostic and therapeutic strategies (i.e. endobiogeny panel, custom tinctures, IV nutritional therapies, prolozone) are not standard of care require and require that patients pay out of pocket.

REASONS FOR VISIT

List the main problems you are having, or reason for this appointment. _____

_____

Please mark the affected areas.



OFFICE NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

GENERAL INFORMATION / HISTORY

When do you remember the problem starting? _____

Does anything make it feel better? ☐ Yes ☐ No If yes, what makes it feel better? _____

Does anything make it feel worse? ☐ Yes ☐ No If yes, what makes it feel worse? _____

When does it hurt more? ☐ Morning ☐ Evening ☐ All Day

Is there something more you feel than pain (dizziness, nausea, etc.)? _____

Do you believe your condition is due to a particular accident, illness, or other event? ☐ Yes ☐ No If Yes, please explain.

Have you already seen other medical professionals for this condition? ☐ Yes ☐ No

May we have permission to request relevant records from those medical professional facilities? ☐ Yes ☐ No

Please list the facilities. _____

Have you had a previous physical examination? ☐ Yes ☐ No If so, when was your last? ____ /____ /____

Have you been treated for health conditions in the last year? ☐ Yes ☐ No

Are you now, or is there a chance, you may be pregnant? ☐ Yes ☐ No

Have you been treated for health conditions other than what you mentioned? ☐ Yes ☐ No If Yes, please explain.

Please list any major illnesses you may have suffered from (measels, chicken pox, shingles, etc.). _____

Please indicate the location of any significant scars. _____

GENERAL INFORMATION / HISTORY (CONT.)

Please list any prescriptions or medications that you're taking, if any.

Name	Reason for Taking	Form	Dosage	Frequency

Please list any vitamins, minerals, herbal formulas, or other supplements you are taking.

Name	Manufacturer	Form	Dosage	Frequency

Please list any allergies or sensitivities. _____

Have you been exposed to occupational chemicals or toxins? ☐ Yes ☐ No If yes, please explain. _____

SURGICAL HISTORY

Were you ever hospitalized or had any surgeries? ☐ Yes ☐ No If Yes, please indicate the month and year, if possible.

Do you have any foreign objects or implants inside you (e.g. breast implants, pins/screws/rods, shrapnel, IUD)? ☐ Yes ☐ No

Do you have a history of poor tolerance/reaction to anesthesia? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

A brief medical history of your immediate family is important to help identify any higher-than-usual chances at disorders, disease, or rare conditions. However, this doesn't necessarily mean that you have any disorder, disease, or condition that a relative may have had. Please indicate if they are deceased, cause and age of death; and if alive, list age and any illness or conditions they may be suffering from.

If there is a history of cancer please specify what type (e.g. lung, kidney, prostate, breast) and what side of the body is started on.

Your Mother: _____

Your Father: _____

Siblings: _____

_____

Grandparents (Mother's side): _____

Grandparents (Father's side): _____

HISTORY: CHILDHOOD AND ADOLESCENCE

You were born: ☐ Full Term ☐ Premature ☐ Overdue If not Full Term, how premature or overdue? _____

Vaginal or cesarean birth? ☐ Vaginal ☐ Cesarean

Breast-fed or Bottle-fed? ☐ Breast-fed ☐ Bottle-fed

Was your mother under a lot of stress when she was pregnant with you? ☐ Yes ☐ No

How many children did you mother give birth to? _____ Which number were you? _____

Are you aware of any particular environmental toxins your mother was exposed to while she was pregnant? ☐ Yes ☐ No

Temperament as a baby? _____

What was your growth rate? ☐ Slow ☐ Fast ☐ Normal

Did you have a lot of throat or ear infections as a baby or young child? ☐ Yes ☐ No

Did you receive vaccinations? ☐ Yes ☐ No If so, did you tolerate them? ☐ Yes ☐ No

Did your bowels move well as a baby or young child? ☐ Yes ☐ No

How stressful do you remember childhood being? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Low → High

Did you feel loved and supported by your parents and family? ☐ Yes ☐ No

Did you struggle with bedwetting? ☐ Yes ☐ No If yes, until what age? _____

HISTORY: CHILDHOOD AND ADOLESCENCE (CONT.)

Did you make friends easily? ☐ Yes ☐ No

Did you tend to be more outgoing/gregarious or withdrawn/shy? ☐ Yes ☐ No

Did you struggle with acne? ☐ Yes ☐ No

HISTORY: DENTAL

Have you had cavities? ☐ Yes ☐ No Estimate how many. _____

When were these diagnosed? _____

What type of filling was used in these? _____

Have you had a root canal? ☐ Yes ☐ No If so, which teeth and when? _____

Did you have braces? ☐ Yes ☐ No What age and how long? _____

Do you have a problem with gum recession? ☐ Yes ☐ No

Do you have current tooth pain or sensitivity? ☐ Yes ☐ No If so, where?

Do you struggle with TMJ or jaw pain? ☐ Yes ☐ No

HISTORY: NUTRITIONAL

Do you feel you eat a well-balanced diet? ☐ Yes ☐ No

Please describe a typical breakfast, lunch, and dinner.

BREAKFAST _____

LUNCH _____

DINNER _____

Do you crave sugar? ☐ Yes ☐ No What triggers these cravings? _____

Do you crave salt? ☐ Yes ☐ No What triggers these cravings? _____

Do you crave late night snacks? ☐ Yes ☐ No

Do you consider yourself a stress eater or emotional eater? ☐ Yes ☐ No

How many days a week do you eat fast food? _____

What percentage of your diet comes from fresh (non-cooked) foods? ☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

HISTORY: NUTRITIONAL (CONT.)

Are you regularly snacking throughout the day? ☐ Yes ☐ No

Do you drink soda? ☐ Yes ☐ No

Do you drink sports drinks? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No How sensitive are you to alcohol's effects? ☐ Very Little ☐ A Little ☐ A Lot

How much caffeine do you drink or ingest per week? _____

What are the sources of caffeine (e.g. coffee, tea, guarana, soda, etc.)? _____

How sensitive are you to caffine? ☐ Very Little ☐ A Little ☐ A Lot

Do you have significant fluctuations in energy after high-carb meals? ☐ Yes ☐ No

Have you noticed that your moods are affected by what you eat? ☐ Yes ☐ No If yes, explain. _____

_____

HISTORY: TOXINS

Have you been exposed to chemicals such as pesticides, petroleum-based products, heavy metals, or industrical chemicals? ☐ Yes ☐ No

If so, when was this exposure? _____ What was the duration of this exposure? _____

Have you spent a lot of time surrounded by agriculture? ☐ Yes ☐ No

What is your water source (i.e. municipal, well-water, etc.)? _____ Is your water fluorinated? ☐ Yes ☐ No

HISTORY: EXERCISE

How many days a week do you exercise? _____

What type of exercise do you engage in? _____

Do you sweat much with exercise? ☐ Yes ☐ No

Describe your exercise tolerance (intensity, minutes, etc.). _____

How long does it take you to recover from an intense workout? _____

How do you generally feel during a workout (energetic, tired, nauseous)? _____

How do you generally feel immediately after a workout? _____

Is exercise limited by pain or previous injury? ☐ Yes ☐ No

What are your biggest barriers to a regular exercise regimen (i.e. cost, time, energy, etc)? _____

Are you interested in working with a wellness coach for further training/education? ☐ Yes ☐ No

HISTORY: MENTAL HEALTH / TRAUMA / HAPPINESS

How easily do you laugh? _____

How easily do you cry? _____

Do you still find joy in the things you used to love to do? ☐ Yes ☐ No

Do you startle easily? ☐ Yes ☐ No

Do you feel stuck / trapped in your current situation? ☐ Yes ☐ No

How much do you enjoy your daily work? ☐ Yes ☐ No What is your occupation? _____

What is your source of social connection / support? _____

Do you make time to nurture relationships that uplift you? ☐ Yes ☐ No

Do you feel like you set appropriate boundaries with toxic people / situations? ☐ Yes ☐ No

How often do you feel guilt? _____

How often do you feel fear? _____

What is your level of stress? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Low → High

What are your biggest sources of stress? _____

How in control do you feel over your life / situation? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Low → High

How often do you feel overwhelmed? _____

How often do you feel depressed? _____

Do you find that you respond differently to stressors than you use to? ☐ Yes ☐ No

What brings you joy? _____

How do you generally talk to yourself (i.e. angrily, lovingly, beratingly, patiently, etc.)? _____

What would it take for your internal dialogue to leave you uplifted and encouraged? _____

_____

Do you generally give yourself permission to take the time, money, and energy necessary for physical, emotional, and spiritual health? ☐ Yes ☐ No

Do you tend to quickly blame others when things go wrong? ☐ Yes ☐ No

How often do you experience moments of happiness / joy? _____

Do you find that your emotional state affects your physical symptoms? ☐ Yes ☐ No

Do you consider yourself addicted to any substance or behavior (e.g. alcohol, cigarettes, pornography, etc.)? ☐ Yes ☐ No

HISTORY: WEIGHT

Are you happy with your current weight? ☐ Yes ☐ No

If not, what efforts have you made to get your ideal weight? _____

_____

HISTORY: SEXUAL HISTORY

Are you currently sexually active? ☐ Yes ☐ No

Do you consider yourself... ☐ Heterosexual ☐ Homosexual ☐ Bisexual

How many sexual partners have you had in the past 10 years? _____

Do you have any history of sexually transmitted infections (e.g. HIV, hepatitis B or C, chlamydia)? ☐ Yes ☐ No

Is intercourse painful? ☐ Yes ☐ No If yes, what area hurts, and how long does it take to recover? _____

_____

How would you rate your libido? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Poor → Great

Do you find it difficult to climax? ☐ Yes ☐ No

Do you struggle with vaginal dryness (women)? ☐ Yes ☐ No

Is premature ejaculation a problem (for men)? ☐ Yes ☐ No

Do you struggle with problems with erections (for men)? ☐ Yes ☐ No

How connected to you feel to your partner? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not at all → Very Connected

How safe do you feel in your current relationship? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not at all → Very Safe

How supported do you feel in your relationship? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not at all → Very Supported

If sex is an issue, how much is it impacting your marriage/relationship? ☐ Not an issue ☐ Somewhat ☐ Greatly

How often do you have bowel movements? _____

Do you strain or cramp with bowel movements? ☐ Yes ☐ No

Are your stools watery or loose? ☐ Yes ☐ No

Are you stools ever sticky / pasty and difficult to wipe / clean? ☐ Yes ☐ No

HISTORY: DIGESTION

Do you ever see food particles or grease spots in the toilet? ☐ Yes ☐ No

Do you ever feel nauseous, sweaty, or drained after a bowel movement? ☐ Yes ☐ No

Do you have black or bloody stools? ☐ Yes ☐ No

Do you have abdominal pain after eating? ☐ Yes ☐ No If yes, where is the pain located? _____

What type of pain is it? _____ Does it radiate in any direction? ☐ Yes ☐ No

Are there any particular foods that you cannot tolerate? _____

_____

Do your bowel habits seem to be affected by stress? ☐ Yes ☐ No

Have you used digestive aids? ☐ Yes ☐ No If yes, which ones? _____

Were they effective? ☐ Yes ☐ No

HISTORY: OTHER

Do you sweat easily? ☐ Yes ☐ No

Do you struggle with hair loss? ☐ Yes ☐ No

Do you struggle with generalized pain in joints or muscles? ☐ Yes ☐ No

How much time do you spend in the sun? _____

Have you had vitamin D levels checked recently? ☐ Yes ☐ No

How much do your finances contribute to your stress, food choices, and overall health? ☐ Not at all ☐ A little ☐ A lot

Please rate your energy level throughout the day.

Morning: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Low → High

Afternoon: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Low → High

Evening: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Low → High

Do you smoke? ☐ Yes ☐ No How many per day? _____ For how long? _____

HISTORY: SLEEP

Do you feel refreshed when you wake up in the mornings? ☐ Yes ☐ No

What time do you generally get to bed? _____ What time do you generally get to sleep? _____

What time do you generally wake up? _____ What time do you generally WANT to wake up? _____

Do you toss and turn a lot in your sleep? ☐ Yes ☐ No

Do you talk in your sleep? ☐ Yes ☐ No Do you have nightmares? ☐ Yes ☐ No

Do you have vivid dreams? ☐ Yes ☐ No Do you see bright colors or have vivid conversations? ☐ Yes ☐ No

Is your sleep interrupted by a need to urinate? ☐ Yes ☐ No How many times a night? _____

Do you get leg cramps at night? ☐ Yes ☐ No

Do you itch at night? ☐ Yes ☐ No If so, where is the itching? _____

HISTORY: FOR WOMEN ONLY

When was your last period? _____ At what age did you start your period? _____

Do you struggle with hot flashes? ☐ Yes ☐ No

Do you struggle with irregular periods? ☐ Yes ☐ No How frequently do you menstrate? _____

Are your periods painful? ☐ Yes ☐ No

Do you have abdominal carmps, bloating, or diarrhea with periods? ☐ Yes ☐ No

Do you get headaches with periods? ☐ Yes ☐ No Do you get breast tenderness with periods? ☐ Yes ☐ No

How much do your emotions change with periods? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not at all → A lot

How many days do you bleed with periods? ☐ Yes ☐ No How heavy is your flow? ☐ Yes ☐ No

Have you had a hysterectomy? ☐ Yes ☐ No What was the reason? _____

Were ovaries removed? ☐ Yes ☐ No How well did you recover? ☐ Yes ☐ No

Have you been on hormone replacement therapy? ☐ Yes ☐ No What types? _____

How long were on them? _____ Are you still on them?

If you have stopped them, what is your reason? _____

_____

Did they relieve your symptoms? ☐ Yes ☐ No Did you experience side effects from them? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Check any that apply:

GENERAL

- [ ] Weight change
- [ ] Change in strength or exercise tolerance
- [ ] Change in overall feelings of wellness

NEUROLOGICAL

- [ ] Headaches
- [ ] Dizziness
- [ ] Numbness
- [ ] Tingling

EYES

- [ ] Change in vision
- [ ] Double vision
- [ ] Seeing spots or floaters
- [ ] Difficulty with focus

EARS

- [ ] Change in hearing
- [ ] Ringing in ears

NOSE

- [ ] Chronic congestion
- [ ] Sinus problems
- [ ] Frequent nosebleeds
- [ ] Deviated septum
- [ ] Polyps

MOUTH

- [ ] Dental difficulties
- [ ] Bleeding of gums
- [ ] Pain with chewing
- [ ] Jaw pain

NECK

- [ ] Stiffness,
- [ ] Difficulty with movement
- [ ] Enlarged or tender lymph nodes

BREAST

- [ ] Lumps
- [ ] Change in size
- [ ] Nipple discharge
- [ ] Tenderness or masses in armpits
- [ ] Skin changes

LUNGS

- [ ] Wheezing, coughing, difficulty breathing
- [ ] Pain with respirations

HEART

- [ ] Chest pains
- [ ] Palpitations
- [ ] Skipping beats

ABDOMEN

- [ ] Pain
- [ ] Constipation, diarrhea, black or bloody stools
- [ ] Nausea

BLADDER

- [ ] Pain with urination
- [ ] Blood in urine
- [ ] Nighttime urination
- [ ] Frequent urination
- [ ] Difficulty starting or stopping urinary stream
- [ ] Change in strength of urinary stream

UTERUS/OVARIES (WOMEN)

- [ ] Changes in periods
- [ ] Pelvic pain
- [ ] Difficulty with sexual function
- [ ] Vaginal discharge
- [ ] Vaginal dryness

PROSTATE (MEN)

- [ ] Bloody semen
- [ ] Painful ejaculations
- [ ] Difficulty with sexual function

PROSTATE (MEN)

- [ ] Bloody semen
- [ ] Painful ejaculations
- [ ] Difficulty with sexual function

MUSCULOSKELETAL

- [ ] Pain in muscles or joints
- [ ] Limitations in movement or range of motion

NERVES

- [ ] Weakness
- [ ] Tremors
- [ ] Headaches
- [ ] Seizures
- [ ] Changes in balance

MUSCULOSKELETAL

- [ ] Anxiety
- [ ] Depression
- [ ] Manic episodes

FINANCIAL POLICY

1. Insurance

If you have health insurance coverage:

- You are responsible to supply us with correct current insurance information. Insurances require a picture ID if we are billing the insurance for your visit. Please be prepared to provide a valid photo ID.
- Please notify us of any change in your address or telephone number.
- All copays are due at the time of service.
- Referrals are your responsibility and must be current prior to your visit.
- Your estimated portion, including any deductibles, will be expected at the time of service (our office will notify you in advance if this is required).
- You may not receive a self-pay discount and then ask us to file your insurance at a later date. Insurance companies will not allow this. It is considered insurance fraud.
- You are ultimately responsible for payment of all charges whether or not such charges are covered & paid (either fully or partially) by your insurance.
- It is your responsibility to know what is and is not covered under your policy. For the services not covered, you will be responsible for payment.

2. IF YOU DO NOT HAVE HEALTH INSURANCE OR IF YOU REQUEST A COSMETIC PROCEDURE:

- Payment in full is due at the time of service.
- We accept, cash, check, credit
- We charge 18% APR on all balances over 60 days

Our office is available from 8 AM to 4 PM Monday through Friday to answer any questions or address any concerns you may have. If you receive a statement from our office, then we expect payment from you within 30 days. If you disagree with the balance for any reason, please contact our business office immediately. **We will no longer carry account balances over 60 days past insurance payment.**

Billing Office: (208) 821-6698

3. A parent who brings a minor child to our office for medical care is responsible for payment of all of the child's charges. Unaccompanied minors will be denied non-emergency treatment unless pre-authorized by parent/guardian.

4. A $25 fee is charged for appointments not cancelled 24 hrs in advance or for any missed appointment. Also a $25 fee is charged for returned checks.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or any dependent) by Wholesome Health Integrative Family Medicine. I understand and agree that if the office places my account with an agency or attorney for collection, the office shall be paid by me for all collection costs to the extent allowed by applicable law.

I HAVE READ AND AGREE TO THIS FINANCIAL POLICY:

Signature of Patient or Responsible Party

Date

CONDITIONS OF TREATMENT AND INFORMED CONSENT TO TREAT

This document is a binding agreement (the "Agreement") between Wholesome Health, Dr. Laramie Wheeler ("We" or "Us"), and the individual patient whose name and signature appears below ("You" or "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines next to each section and by signing in the space provided):

_____ 1. **Consent for Treatment.** You hereby authorized Us to provide You with health care treatment, including without limitation medical, diagnostic, nutritional treatment, (together the "Treatment") administered by Us, physicians, or assistants. You understand that the practice of health care/ medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You acknowledge that we have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment.

_____ 2. **Experimental Nature of Treatment.** You acknowledge and agree that the evaluation, diagnosis, and treatments may consist in whole or part of experimental procedures and methods, including without limit Intravenous Micronutrient Therapy, Stem Cell, Prolotherapy, and Mesotherapy, on which no governmental (including the U.S. Food and Drug Administration ("FDA")), scientific or medical authority has issued any guidelines or statements as tot he safety or efficacy thereof. You acknowledge that the safety record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe. We have informed you that the Treatments MAY alter, address, or decrease your pain, symptoms, or complaints, but also may have no effect.

_____ 3. **Risks, Side Effects, Complications.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation infections; swelling; increased pain; bleeding; scarring; scar or wound enlargement; keloid formation; asymmetry; temporary or permanent alteration in sensation; allergic reaction; discoloration; the need for additional surgery; soreness, itching, infection, injury to nerves, internally and externally leaking fluid and scarring at injection sites (all of which except the leaking of fluid may be permanent); a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments; spinal cord injuries, Pneumothorax (air on the outside of the lung), paralysis, dizziness, numbness, no benefit from Treatments; or other serious or debilitating injuries or death.

_____ 4. **Description of Treatments.** You acknowledge that the Treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, homeopathic medicines, and FDA approved prescriptive medicines, local anesthetic (Procaine or Lidocaine), concentrated sugar water or dextrose, and, on occasion ozone therapy and local subcutaneous anesthetic infiltration. The exact solution and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to You when We actually administer the Treatments.

_____ 5. **Health Care Staff.** You are aware that among those who attend You on Your behalf are medical, nursing, and other health care personnel in training, who unless requested otherwise, may participate in patient care as part of their education. You further consent to the presence of service representatives and/ or technicians from manufacturers of equipment or devices to assist in performing and/or operation of such equipment and/or devices during operation, procedures, and Treatments. These workforce members have signed confidentiality agreements with us.

_____ 6. **Information You Provide Us.** You have provided Us with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided us with a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements or medical treatments of any kind. You covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 6, is true, accurate, complete, and up-to-date to the best of Your knowledge.

_____ 7. **Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement or the Treatments that you have, you are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever be fully explain every possible risk, side effect, or complication that may or could arise from the Treatments, but that by signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatment s is willing, voluntary, and informed.

_____ 8. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action.

_____ 9. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and Us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by You. This Agreement shall be binding on You and Your successors, heirs, legal representatives and assigns. In case any one of the previsions of this Agreement is held invalid or illegal, such provisions shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the state of Idaho without regard to any choice of the law principal. Any dispute between You and Us shall be adjudicated in state or federal court in Pocatello, Idaho, and You submit to the jurisdiction of any such court.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (if applicable) Date