Female Health History Questionnaire

(To be completed by patient)

We would like to take the time to thank you for choosing our office to assist you with your journey to optimal health. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Name:_____ Date:_____
Address _____ City _____ State ___ Zip Code_____
Home Phone (___) _____-_____ Work (___) _____-_____ Cell (___) ____-_____
Email _____
Age _____ Date of Birth ____/____/_____ Gender: Female__Male___
Referred by:
Name, address, & phone number of primary care physician:
Marital Status:
Single____ Married____ Divorced____ Widowed____ Long Term Partnership____
Occupation _____ Hours per week _____ Retired
Nature of Business
Height:_____ Weight:_____

What diagnosis or explanation(s), if any, have been given to you for these concerns?

When was the last time that you felt well?

What seems to trigger your symptoms?

What seems to worsen your symptoms?

What seems to make you feel better?

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?

How much time have you lost from work or school in the past year due to these conditions?

ILLNESS	WHEN/ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		

Heart Attack, Angina
Heart Failure
Hepatitis
Herpes Lesions/Shingles
High blood fats (cholesterol, triglycerides)
High blood pressure (hypertension)
Irritable bowel (or chronic diarrhea)
Kidney stones
Measles
Mononucleosis
Mumps
Pneumonia
Rheumatic Fever
Sinusitis
Sleep Apnea
Stroke
Thyroid disease
Whooping Cough
Other (describe)
Other (describe)

Back injury
Broken bones or fractures (describe)
Head injury
Neck injury
Other (describe)

Blood Tests
Bone Density Test
Bone Scan
Carotid Artery Ultrasound
CAT Scan (Please indicate type)
Colonoscopy
EKG
Liver Scan
Mammogram
Neck X-Ray
MRI
X-Ray (Please indicate type)
Other (describe)
Other (describe)
Appendectomy
Dental Surgery
Gall Bladder
Hernia
Hysterectomy
Tonsillectomy
Tubes in Ears
Other (describe)

HOSPITALIZATIONS	**WHEN**	**Reason**

How often have you taken antibiotics? (BE SPECIFIC)

How often have you taken oral steroids? (BE SPECIFIC)
(Prednisone, Cortisone, etc)

List all medications you are currently on. Include all over the counter non-prescription drugs.

List all vitamins, minerals, and any nutritional supplements that you are taking now.

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?
Yes___ No ___
If yes, please list:

Was your childhood diet high in any of these (Y or N)

Sugar? (Sweets, Candy, Cookies, etc)
Soda?
Fast food, pre-packaged foods, artificial sweeteners?
Milk, cheeses, other dairy products?
Meat, vegetables, & potato diet?
Vegetarian diet?
Diet high in white breads?

FEMALE MEDICAL HISTORY

(For women only)
Female Anatomy / Reproductive Health *(to be completed by all women)*
Age at onset of first period: _____ Approximate date of onset: _____
What are you using for contraception at the moment? _____
Have you ever used ***oral, injected, patch, or ring*** hormone contraceptives, or used *Emergency Contraception ("the day after" pill)?* Yes___ No___
From _____to_____
Did you suffer from any side effects? Yes___ No___ Explain:_____
Are you currently or have you ever used an IUD? Yes___ No___
When? _____ For how long? _____
While under the use of any and all birth control methods, did you experience the following? Y*east, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.* ***(Please circle and use extra space provided if explanation is needed)***
_____
_____
_____
Are you currently, or have you ever used fertility treatment? Yes___ No___
If yes, please explain. _____
_____
Are you currently, or have you ever used bio-identical hormones, such as DHEA, Pregnenolone, Progesterone, Estrogen, Testosterone, etc.? Yes___ No___
If yes, what hormone(s), dosage and for how long? **Please be specific with dates of use.**
_____
_____
Do you have any history of abnormal Pap Tests? Yes___ No___
If yes, please explain: _____
Please describe any treatment and/or medication for this: _____
Do you have any history of vaginal infections? Yes___ No___
If yes, please describe: _____

Please describe any treatment and/or medication for this: _____
Do you have any history of the following conditions? (*Please circle appropriate answer)*
Ovarian Cysts, Fibrocystic Breasts, Polycystic Ovarian Syndrome (PCOS), Uterine Fibroids, Endometriosis, Lichen Sclerosis, Vulvodynia

DIAGNOSTIC TESTING

Last PAP test:_____/_____/_____ Normal: Abnormal
Last Mammogram:_____/_____/_____ Breast biopsy? Date:_____/_____/_____
Date of last bone densitiy:_____/_____/_____ Results: High____ Low____ Within normal range____

Pregnancy History *(to be completed by all women, if applicable)*

Have you been pregnant before? Yes___ No___
Please list the age(s) of your children: _____
Please explain important details/complications below:
Number of pregnancies: _____ _____
Number of live births: _____ _____
Number of miscarriages: _____ _____
How many weeks gestation at the time of miscarry? _____ Weeks
Number of premature births: _____ _____
Number of cesarean births: _____ _____
Number of stillbirths: _____ _____
Number of ectopic pregnancies: _____ _____

Cycling History *(to be completed by all women who have not reached menopause)*

What was the first date of your last menstrual period (LMP)? _____
Have you ever had tubal ligation surgery? Yes___ No___
If so, please list the date and specific details: _____
_____
Counting from the first day of your cycle to the first day of your next cycle, how many days is your current cycle? *(Please circle appropriate answer)*
<20 days 20-30 days 30-40 days 40-50 days >50 days
What is the length of days your menstruation typically lasts? _____
Do you consider your cycle to be regular? Yes___ No___ Not Always___
Details: _____
What is your typical menstrual flow like? Light Medium Heavy
Details: _____
How many pads and/or tampons *(circle)* do you use on heavy days? _____
During menstruation, do you pass blood clots? Yes___ No___
How often? _____

How would you describe your cramping? None Mild Moderate Severe
At what point in your cycle? _____
Have you noticed any recent changes to your cycle? If yes, explain: _____
Do you experience any unusual or excessive vaginal discharge throughout the month?
Yes___ No___ When? _____
Do you ever experience itching or odor in the vaginal area? Yes___ No___
When? _____
Do you experience any breast tenderness? None Mild Moderate Severe
If yes, at what point in your cycle? _____
Do you have nipple discharge at any point in your cycle? Yes___ No___
If yes, at what point in your cycle? _____ Color? _____

Menopausal Women

What age were you at the onset of menopause? _____ Year of onset? _____
Date of your last menstrual period? _____
Please describe any recent changes and/or symptoms associated with your cycle prior to menopause:_____
_____

_____
_____
Please list any and all GYN surgeries: What was the reason for each surgery?
1. _____
2. _____
3. _____
4. _____
5. _____

Please give an in depth explanation of how you perceive your experience transitioning into menopause: *(for example, please list symptoms, emotional changes, thoughts, stressors, etc.)*
_____
_____
_

Are you currently, or have you ever used conventional hormone replacement (HRT)? _____
If yes, please list the name of the prescription: _____
What is/was the dosage? _____ For how long? _____
Menopausal Women Continued…
Are you currently, or have you ever used bio-identical hormone creams/gels/sublingual, troche, oral? Yes___ No___
If yes, please list the name(s) of each product: _____
What is/was the dosage? _____ For how long? _____
Are you currently, or have you ever used any alternative, complementary, or natural remedies to treat your menopause? Yes___ No___
If yes, please list the name(s) of each product: _____
What is/was the dosage? _____ For how long? _____
Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? Yes___ No___
If yes, what? _____
Treatment: _____
Below please describe your cycle history.
Would you have described your menstruation as: Easy Uncomfortable Difficult Debilitating
What was your typical menstrual flow? Light Medium Heavy
When you were cycling would you describe your cycle as regular? Yes___ No___
If no, please give explanation: _____
_____
In the past, if you have ever received any type of "treatment" for any cycle issues would you please explain: _____
_____
_

REVIEW OF SYMPTOMS

Check (√) those items that applied to you in the ***past***. **Circle** those that ***presently*** apply.

GENERAL

- ❑ Fever
- ❑ Chills/Cold all over
- ❑ Aches/Pains
- ❑ General Weakness
- ❑ Difficulty sweating
- ❑ Excessive Sweating
- ❑ Swollen Glands
- ❑ Cold hands & Feet
- ❑ Fatigue
- ❑ Difficulty falling asleep
- ❑ Sleepwalker
- ❑ Nightmares
- ❑ No dream recall
- ❑ Early waking
- ❑ Daytime sleepiness
- ❑ Distorted vision

SKIN:

- ❑ Cuts heal slowly
- ❑ Bruise easily
- ❑ Rashes
- ❑ Pigmentation
- ❑ Changing Moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness/cracking skin
- ❑ Oiliness
- ❑ Itching
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on Nails
- ❑ Peeling Skin
- ❑ Shingles
- ❑ Nails Split
- ❑ White Spots/Lines on Nails
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot
- ❑ Cellulite
- ❑ Bugs love to bite you
- ❑ Bumps on back of arms & front of thighs
- ❑ Skin cancer
- ❑ Strong body odor

Is your skin sensitive to:

- ❑ Sun
- ❑ Fabrics
- ❑ Detergents
- ❑ Lotions/Creams

HEAD:

- ❑ Poor Concentration

- ❑ Confusion
- ❑ Headaches:
- ❑ After Meals
- ❑ Severe
- ❑ Migraine
- ❑ Frontal
- ❑ Afternoon
- ❑ Occipital
- ❑ Afternoon
- ❑ Daytime
- ❑ Relieved by:
- ❑ Eating Sweets
- ❑ Concussion/Whiplash
- ❑ Mental sluggishness
- ❑ Forgetfulness
- ❑ Indecisive
- ❑ Face twitch
- ❑ Poor memory
- ❑ Hair loss

EYES:

- ❑ Feeling of sand in eyes
- ❑ Double vision
- ❑ Blurred vision
- ❑ Poor night vision
- ❑ See bright flashes
- ❑ Halo around lights
- ❑ Eye pains
- ❑ Dark circles under eyes
- ❑ Strong light irritates
- ❑ Cataracts
- ❑ Floaters in eyes
- ❑ Visual hallucinations

EARS:

- ❑ Aches
- ❑ Discharge/Conjunctivitis
- ❑ Pains
- ❑ Ringing
- ❑ Deafness/Hearing loss
- ❑ Itching
- ❑ Pressure
- ❑ Hearing aid
- ❑ Frequent infections
- ❑ Tubes in ears
- ❑ Sensitive to loud noises
- ❑ Hearing hallucinations

NOSE/SINUSES

- ❑ Stuffy
- ❑ Bleeding
- ❑ Running/Discharge
- ❑ Watery nose

- ❑ Congested
- ❑ Infection
- ❑ Polyps
- ❑ Acute smell
- ❑ Drainage
- ❑ Sneezing spells
- ❑ Post nasal drip
- ❑ No sense of smell
- ❑ Do the change of seasons tend to make

your symptoms worse? Yes/No

If yes, is it worse in the:

- ❑ Spring
- ❑ Summer
- ❑ Fall
- ❑ Winter

MOUTH:

- ❑ Coated tongue
- ❑ Sore tongue
- ❑ Teeth problems
- ❑ Bleeding gums
- ❑ Canker sores
- ❑ TMJ
- ❑ Cracked lips/ corners
- ❑ Chapped lips
- ❑ Fever blisters
- ❑ Wear dentures
- ❑ Grind teeth when sleeping
- ❑ Bad breath
- ❑ Dry mouth

THROAT:

- ❑ Mucus
- ❑ Difficulty swallowing
- ❑ Frequent hoarseness
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Constant clearing of throat
- ❑ Throat closes up

NECK:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell

CIRCULATION/RESPIRATION:

- ❑ Swollen ankles
- ❑ Sensitive to hot
- ❑ Sensitive to cold
- ❑ Extremities cold or clammy
- ❑ Hands/Feet go to sleep/numbness/tingling
- ❑ High blood pressure
- ❑ Chest pain

- ❑ Pain between shoulders
- ❑ Dizziness upon standing
- ❑ Fainting spells
- ❑ High cholesterol
- ❑ High triglycerides
- ❑ Wheezing
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Low exercise tolerance
- ❑ Frequent coughs
- ❑ Breathing heavily
- ❑ Frequently sighing
- ❑ Shortness of breath
- ❑ Night sweats
- ❑ Varicose veins/spider veins
- ❑ Mitral valve prolapse
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/Pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Prior heart attack ? When___/___/_____

GASTROINTESTINAL

- ❑ Peptic/Duodenal Ulcer
- ❑ Poor appetite
- ❑ Excessive appetite
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Nervous stomach
- ❑ Full feeling after small meal
- ❑ Indigestion
- ❑ Heartburn
- ❑ Acid Reflux
- ❑ Hiatal Hernia
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Abdominal Pains/Cramps
- ❑ Gas
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in bowels
- ❑ Rectal bleeding
- ❑ Tarry stools
- ❑ Rectal itching
- ❑ Use laxatives
- ❑ Bloating
- ❑ Belch frequently
- ❑ Anal itching

- ❑ Anal fissures
- ❑ Bloody stools
- ❑ Undigested food in stools

KIDNEY/URINARY TRACT:
- ❑ Burning
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Night time urination
- ❑ Problem passing urine
- ❑ Kidney pain
- ❑ Kidney stones
- ❑ Painful urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Syphilis
- ❑ Bedwetting
- ❑ Have trichomonas

WOMEN'S HISTORY (for women only)
- ❑ Fibrocystic breasts
- ❑ Lumps in breast
- ❑ Fibroid Tumors/Breast
- ❑ Spotting
- ❑ Heavy periods
- ❑ Fibroid Tumors/Uterus

WOMEN'S HISTORY (for women only)
- ❑ Painful periods
- ❑ Change in period
- ❑ Breast soreness before period
- ❑ Endometriosis
- ❑ Non-period bleeding
- ❑ Breast soreness during period
- ❑ Vaginal dryness
- ❑ Vaginal discharge
- ❑ Partial/total hysterectomy
- ❑ Hot flashes
- ❑ Mood swings
- ❑ Concentration/Memory Problems
- ❑ Breast cancer
- ❑ Ovarian cysts
- ❑ Pregnant
- ❑ Infertility
- ❑ Decreased libido
- ❑ Heavy bleeding
- ❑ Joint pains
- ❑ Headaches
- ❑ Weight gain
- ❑ Loss of bladder control
- ❑ Palpitations

JOINT/MUSCLES/TENDONS
- ❑ Pain wakes you
- ❑ Weakness in legs and arms
- ❑ Balance problems
- ❑ Muscle cramping

- ❑ Head injury
- ❑ Muscle stiffness in morning
- ❑ Damp weather bothers you

EMOTIONAL:

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Blackouts/Amnesia
- ❑ Had prior shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Startled by sudden noises
- ❑ Anxiety/Feeling of panic
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless/groggy
- ❑ Withdrawn feeling/Feeling 'lost'
- ❑ Had nervous breakdown
- ❑ Unable to concentrate/short attention span
- ❑ Vision changes
- ❑ Unable to reason
- ❑ Considered a nervous person by others
- ❑ Tends to worry needlessly
- ❑ Unusual tension

EMOTIONAL (CONTINUED)

- ❑ Frustration
- ❑ Emotional numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Previously admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Misunderstood by others
- ❑ Irritable
- ❑ Feeling of hostility/volatile or aggressive
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness
- ❑ Am a workaholic
- ❑ Have had hallucinations
- ❑ Have considered suicide
- ❑ Have overused alcohol
- ❑ Family history of overused alcohol
- ❑ Cry often
- ❑ Feel insecure
- ❑ Have overused drugs
- ❑ Been addicted to drugs

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____
How much of the following do you consume each week? **(BE SPECIFIC)**
Candy
Cheese
Chocolate
Cups of coffee containing caffeine
Cups of decaffeinated coffee or tea
Cups of hot chocolate
Cups of tea containing caffeine
Diet soda
Ice cream
Salty foods
Slices of white bread (rolls/bagels, etc)
Soda with caffeine
Soda without caffeine

Do you feel **worse** when you eat a lot of: **(BE SPECIFIC)**

High fat foods high protein foods high carb foods (breads/pasta)

Refined sugar (junk food) fried food alcohol drinks

Do you feel **better** when you eat a lot of: **(BE SPECIFIC)**

High fat foods high protein foods high carb foods (breads/pasta)

Refined sugar (junk food) fried food alcohol drinks

Does skipping meals greatly affect your symptoms? Yes _____ No _____
Has there ever been a food that you have craved or 'binged' on over a period of time?
Yes _____ No _____ If yes, what food(s) _____
_____
Do you have an aversion to certain foods? Yes _____ No _____
If yes, what food(s) _____
_____

Circle which applies to your bowel movements **(BE SPECIFIC)**

More than 3x/day
1-3x/ day
4-6x/week
2-3x/week
1 or fewer x/week
Dark brown consistently
Medium brown consistently
Very dark or black
Greenish color
Blood is visible
Varies a lot
Yellow, light brown

Consistency √

Soft and well formed
Greasy, shiny appearance

Often floats
Difficult to pass
Diarrhea
Thin, long or narrow
Small and hard
Loose but not watery
Alternating between hard and loose

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____
If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____
Have you ever had a problem with alcohol? Yes____ No____
If yes, indicate time period (month/year) From_____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____
If yes, what type(s) and method? (IV, inhaled, smoked, etc)_____
_____
To your knowledge, have you ever been exposed to toxic metals in your job or at home?
Yes___No___
If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you have trouble falling asleep

Do you use sleep aids

Feel rested upon waking

Have insomnia, now or ever

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____
Do you feel you can easily handle the stress in your life? Yes ____ No
If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____
If yes, do you believe that you know the source of your stress? Yes____ No____
If yes, what do you believe it to be?
Have you ever contemplated suicide? Yes____ No____
If yes, how often? When was the last time?
Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc)
Did it help?

Have you ever been involved in abusive relationships in your life? Yes ___ No___
Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes__ No___
Did you feel safe growing up? Yes ___ No___

Is there anything that you would like to discuss with the doctor today that you feel was not covered on this form? Yes_____ No_____
Comments _____
_____
_____

READINESS ASSESSMENT

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

In order to improve your health, how willing are you to:
Significantly modify your diet 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Take 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 relaxation techniques 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Engage in regular exercise 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Have periodic lab tests to assess progress 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.
We look forward to helping you achieve lifelong health and wellbeing.
Yours in Health

Drs. Jason & Kimberly Stephenson

I understand that Nutritional counseling/Applied kinesiology is an assessment system and it is used to assist the practitioner and help the

patient improve his/her physical state through nutritional and life style recommendations. I also, understand that it is to assist the practitioner in establishing and monitoring patient nutritional progress. I understand that Nutritional counseling/Applied kinesiology procedures do not diagnose or treat any disease or physical illness. I understand that Nutritional counseling/Applied kinesiology does not replace standard laboratory or other clinical diagnostic tools or procedures, and in themselves do not treat anything. I specifically authorize Stephenson Chiropractic & Wellness Center, P.C. to develop a natural, complementary health improvement program based on the information I have given the doctor for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease. I understand that this is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional or dietary programs recommended, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health. I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success. I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered to me will be immediately due and payable, and to agree to arbitration for any disputes. I Understand that the office may choose the arbitrator and both parties agree to abide by the arbitrator's decision. To wave the right of notice or exemption within the state of Alabama or any other state in regard to personal property, allows one and one half (1.5 %) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

Patient name (Please print)_____ Patient signature_____ Date M/D/Y_____

Witness name (Please print)_____ Witness signature_____ Date M/D/Y_____