SALT LAKE HOMEOPATHY
A Private Healthcare Membership Association (PHMA)
Informed Consent

Advanced Nutritional Programs

Homeopathy is an alternative remedy based on the law of similars – that is, the use of tiny doses of the very things that cause symptoms in healthy people. These minute doses of plant, animal, or mineral origins are used to stimulate the body's ability to heal itself.

In strengthening deficient areas of the body, Homeopathy focuses on a holistic treatment approach and differs from traditional Western medicine. While Homeopathy predates Naturopathy, Homeopathy is considered a naturopathic discipline; Salt Lake Homeopathy focuses on approaches rooted solely in pure Homeopathic principles. As such, WE ARE NOT LICENSED NATUROPATHIC OR TRADITIONAL MEDICAL PHYSICIANS.

Homeopathic Practice (our approach) vs. Naturopathic Doctors or Physicians:

In the state of Utah, Homeopaths are not subject to licensing requirements. On the other hand, Naturopathic Physicians, or "Naturopaths" often utilize medical modalities in their practices and consequently are required to submit to certain licensing requirements in the state of Utah. Among other things, a licensed Naturopath may be licensed to give injections, perform minor surgeries and administer various medical examinations. Additionally, like traditional medical doctors, Naturopaths may be licensed to prescribe controlled substances to patients.

The Homeopaths at Salt Lake Homeopathy PHMA are not licensed as Naturopathic Physicians or traditional medical doctors, and do not conduct the procedures outlined above, nor do they conduct invasive testing or prescribe medications. Under our approach, we utilize muscle testing techniques to attempt to identify specific weaknesses in the systems of the body, and to determine the appropriate homeopathic or herbal remedy to strengthen or support the area of concern. However, the Homeopaths at Salt Lake Homeopathy do not treat or diagnose medical conditions, illnesses, or diseases, and, in cases of an immediate medical emergency, we refer all clients to immediately contact a medical doctor.

Name and location of our Homeopaths:

Mr. Gene Harkins and
Ms. Lorraine Lonnie
Salt Lake Homeopathy PHMA
1121 East 3900 South, C-140, Millcreek, UT 84124

Payment and fees:

The Homeopaths at Salt Lake Homeopathy are not contracted with insurance providers in any form. Payment to Salt Lake Homeopathy is expected at the time of service via cash, check, or credit card. Initial and Follow-up visits are minimum of $250 and $125 respectively. (see Service Menu.) We accept most credit cards. Outstanding balances are carried at the annual rate of 18%

Appointments can be changed or cancelled up to 24 hours before the scheduled time. Missed appointments are subject to a $125.00 missed appointment fee. You will be notified if there are any changes of services or charges.

Product Sales:

Homeopathic and herbal remedies and other nutritional supplements are available for purchase on site at Salt Lake Homeopathy for your convenience. The Homeopaths' recommendation for supplements is not a prescription for medication, however, and the supplements offered by Salt Lake Homeopathy are not prescription drugs intended to cure medical illness. You are not required to purchase any items or supplements recommended by the Homeopaths at Salt Lake Homeopathy. You are free to decline any recommended remedy or to purchase these or similar quality products at the retailer of your choice.

Rights:

The Homeopaths at Salt Lake Homeopathy will inform you of the procedure involved in your care, the options and alternatives for treatment and the risks involved. You have the right to have your questions about the process answered completely.

You have the right to know your Homeopath's assessment and proposed remedies.

You have the right to courteous service, free from abuse.

Your records and transactions with Salt Lake Homeopathy will be kept confidential and will not be released to any third party unless authorized by you or as required by law.

You have the right to access other community services, to change Homeopaths at anytime, and to refuse services.

_____ _____
Signature Date

_____ _____
Printed Name Witness

_____
Date

Please note: This form must be signed, witnessed and dated.

HEALING FOR THE PATTERN OF LIFE

Services and rates for services offered by Salt Lake Homeopathy A Private Healthcare Membership Association (PHMA)

Salt Lake Homeopathy PHMA, uses an advanced computer repertory for Classical and Constitutional Homeopathic recommendations per hour at the rate of $500.00 per hour.

Essentials Program

Step 1

Initial Para-cleansing Program and Follow-up Appointments $250

*Initial and Follow-ups evaluations may be accomplished through Muscle Testing of signature, photograph or untouched digital images with the same conclusions as though in person.

Step 2

EAV /Electro dermal Screening

Session One - Restoring cellar pathways and communications (49 testing) $250
Session Two Building a Solid Adrenal Foundation $250
Session Three Hormone Balancing $250
Session Four Immune System $250
Session Five Dental Scan $250

- Fees do not include any homeopathic, single or combination remedies, nutritional supplements or herbal combinations

Quantum Reflex Analysis - QRA

The office visit fee is $280.00 per hour (based on 55 minutes per hour), prorated for the actual time spent with the client. The complete initial visit is typically 60 to 90 minutes which includes a thorough review of present nutritional concerns and an advanced, comprehensive nutritional program including recommended state-of-the-art nutritional supplements. Nutritional testing will be performed to pinpoint-target special body needs. in addition, QRA Kinesiological testing may be used to help identify specific needs and interference fields. Follow-up appointments are usually recommended at *4* to 8 week intervals and average 60 minutes or less per session, depending on the extent of each client's needs and concerns.

Complete Initial Evaluation Appointment (allow 60 - 90 minutes) .....$500-$750

QRA "Set Up" Testing $250
Includes: Command Centers: Test for Encoding, Test for Medi-Body Packs, Testing for Targeted Nutrition, Testing Kidney/Brain Function, Power Chain Testing, Nutrition Testing
Step I — Restoring an Alkaline pH (allow 30 –45 minutes)..... .....$250- $500
Step II — Normalize Hormone Balance (allow 30 – 45 minutes) $250- $500
Step IV — Eliminate Chronic Infections (allow 60 minutes)..... $500
Step V — Rejuvenate the Body's Systems (allow 90 minutes) $500

*Evaluations can take longer than the estimated time when problems are more complicated or there is a large number of questions asked during the appointment Client handouts are available to provide information on many common questions. What will keep the evaluation time to a minimum is completing the "FIRST TIME EVALUATION" form prior to the initial appointment. You will need to complete the "ON-GOING EVALUATION" form for each additional visit. If time has to be used during the appointment to complete the "FIRST TIME EVALUATION" or the "ON-GOING EVALUATION" forms the cost may be more for the appointment. Nutritional and Detoxification Products are in addition to the fees.

Vastu Planning and Remediation

Home Energy Remediation (Vastu-shasta work) .....$500 per hour
Materials are ordered after planning session and require a 50% deposit.

*Telephone consulting – no charge for clarification calls. Normal charges apply for all other calls.

SALT LAKE HOMEOPATHY, A PRIVATE HEALTHCARE MEMBERSHIP ASSOCIATION - STANDARD OF CARE STATEMENT

Salt Lake Homeopathy is a Private Healthcare Membership Association which requires a Membership agreement to be signed and a $10 membership fee to be paid in advance of making an appointment, discussing particular health concerns or purchasing available homeopathies or nutritional products.

Standard of Care and Scope of Practice: The standard of care at Salt Lake Homeopathy, A Private Healthcare Membership Association (PHMA) may differ in some areas from those standards deemed acceptable by the Utah Medical Association, the Utah State Board of Medical Practice, the American Medical Association, the American College of Physicians, and many other organizations who are thought to represent the standard of conventional medical care. Many of Salt Lake Homeopathy's standards are also consistent with those of the American Holistic Medical Association, the newer American Board of Integrative Medicine, the American College for the Advancement of Medicine, and the Institute of Functional Medicine and the American Institute of Homeopathy. By signing our disclosure statement, members acknowledge that these more progressive medical standards and approaches may be a significant part of their consulting and recommendation regimen at Salt Lake Homeopathy, PHMA. We encourage you to have a primary MD within the usual and customary insurance system. Since we are not participating providers in the usual sense, there may be expensive procedures that may be appropriate for you that will be covered only if ordered through such a physician. We are not medical doctors, naturopathic physicians or licensed as such. We emphasize that we are not an emergency room or urgent care facility. Serious problems such as acute chest pain, shortness, of breath, severe abdominal pain, etc., should be handled in an acute care setting or by calling 911.

This practice is consistent with the standard of medical care in Utah. All practices are otherwise consistent with the standard of medical care in Utah and/or the standards for non-licensed practitioners in Utah.

We use a non-prescriptive consulting method whereby we do not diagnosis or treat disease but we do use kinesiology muscle testing, computer assisted testing and repertorization to determine what weaknesses that may exist in body systems and what nutritional, herbal remedies or homeopathic remedies may be suggested. We disclose all the remedies that are discovered that may be helpful including in office subtle energy regimes. It is your responsibility to purchase suggested remedies and to use them as suggested. It is your responsibility to keep your follow up appointments. Your health is your responsibility. We make no guarantees.

Disclosure: Salt Lake Homeopathy is a private practice. All members may choose to purchase recommended prescriptions or nutraceuticald (dietary supplements) elsewhere. There is no obligation to purchase them here. We only vend the highest quality supplements, although many supplements recommended may be found in lower quality versions elsewhere. We urge members to choose the highest quality supplements available. PLEASE REFER TO THE RETURN OF PRODUCT RESTRICTIONS POLICY. As a courtesy a $100 visit charge is available for members that purchase the suggested remedies and nutritional products from Salt Lake Homeopathy PHMA otherwise the $400 per hour rate applies.

Office visits a follow up: Our responsibility for consultation is no different from any other health care office. Phone calls and email, unless otherwise specified, are not a substitute for appropriate office follow up. Failure to follow up in a timely fashion based on our suggested schedule precludes our capacity to consult with you. Changes in treatment plans requiring documentation will be done only by appointment or specified telephone and/or email consultation. Members who are more than 3 months in arrears for recommended follow up visits will be required to be seen before any additional orders are recommended. SALT LAKE HOMEOPATHY, A PRIVATE HEALTHCARE MEMBERSHIP ASSOCIATION OFFICE VISIT POLICY IS THAT CONSULTING FEES ARE NOT REFUNDABLE.

Cancellations: New members who fail to cancel appropriately within 2 full business days are charged the full new member fee that is nonrefundable. Failure to cancel follow up appointments within 2 business days will be duly noted. Members who repeatedly fail to appropriately cancel follow up visits will be required to pay in advance for subsequent visits.

Fees: Consultations are $400 per hour. Follow up consultations are billed at the same rates. Fees for Office Policies seminars and forums will vary based on the specific venue and topic. Currently there is a $100 standard fee that is charged for most visits that fall into the Muscle Testing evaluation of heath conditions and weakness which may include that may include nutrition, herbal remedies, homeopathy or life style recommendation. This $100 charge is available for members that purchase the suggested remedies and nutritional products from Salt Lake Homeopathy PHMA.

Payment: Our payment policies are different from those of most clinics in that payment is expected at the time of service. We do not participate in any way whatsoever with Medicare or health insurance. Claims for our services cannot be submitted to Medicare. We do not have any control over these policies. There is no guarantee that submitted claims will result in coverage by health insurance providers or heath savings accounts of various forms.

Privacy: Salt Lake Homeopathy, A Private Healthcare Membership Association, Membership Agreement describes privacy and other certain implied and acknowledged rights of privacy. A copy is available on the internet at WWW.saltlakehomeopathy.com or a copy can be provided if you do not have access to the internet.

Email: Simple inquiries by existing members will be answered at no charge. If the question is deemed a follow up or is a photo or signature check appointment, there will be a minimum $100 charge or the customary hourly charge for more complex consultations. Please be prepared to offer credit card # unless we already have it on file. We only answer email inquiries for registered members. Telephone consultations: Available on request and will require appropriate scheduling. These will be charged out at the customary hourly rates for that practitioner. Payment will be requested by credit card or check in advance.

I acknowledge that I have read and understand the above policies:
I have reviewed and agree to the above policies:

_____ _____

Print Name Signature and date

FIRST TIME EVALUATION

Please complete the following questions carefully. This information will help us to build a specialized Nutritional Program, personally designed for you.

Today's Date: _____ Referred by: _____

Name: _____ M ☐ F ☐ Birthdate: ___/___/___ Age: ___

Mailing Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Height: _____ Weight: _____ Marital Status: S ☐ M ☐ D ☐ W ☐ No. of children: _____

Daytime phone: (_____)_____ Evening phone: (_____) _____

Please do not take any supplements for 2 meals before your first evaluation.

1. **Complaints** Please rank your current complaints and rate their severity (on a scale of 1 to 10, 10 being the most severe):

_____

_____

2. **Other Information** Please tell us any additional information or concerns about your health:

_____

_____

3. **Medications** Please list any medications you are currently taking and how long you have taken them (including birth control pills, aspirin, pain medications, etc.):

_____

_____

4. **Smoking** Do you currently smoke? _____ If yes, how much? _____ How long have you smoked?_____
Do you frequently breathe second-hand smoke from others who are smoking (either at work or at home)?_____

5. **Surgeries** What surgeries, operations, traumas, car accidents, etc. have you had?

_____

_____

a.) Have you ever had full-body anesthesia (i.e., to remove tonsils, wisdom teeth, etc.)?_____
b.) Do you have breast implants?_____ Other surgical implants or prostheses?_____
c.) Have you had elective surgery (tummy tuck, face-lift, burned off moles, liposuction, etc.)?_____
d.) Do you have any metal or plastic inside your body (such as pins, clamps, plates, etc.)?_____
e.) Do you have pierced ears or other body piercings?_____ Tatoos?_____

6. **Scars** Please describe any scars on your body (major and minor ones):_____

_____

7. **Drugs** *This is strictly confidential information.* Do you currently use recreational drugs? _____ *[Circle all that apply: marijuana, cocaine, heroin, uppers, downers]* Others:_____ How often?_____
Have you used recreational drugs in the past?_____ If yes, for how long?_____

8. **Stress** Please rate your current stress level *(on a scale of 1 to 10, 10 being the highest stress):* _____
What is the main reason(s) for your stress? _____
If over level 5, what step(s) are you taking to reduce your stress level? _____

9. **Dental Work** Please indicate how many of the following you have:

Silver fillings _____	Gold crowns or inlays _____	Root canals _____	Braces _____
Composites *(tooth-colored)* _____	Stainless steel crowns or inlays _____	Root canals with EndoCal ____	Bleeding Gums ____
Extractions _____	Porcelain crowns or inlays _____	Posts _____	Sensitive teeth _____
Bridgework _____	DeGussa Porcelain crowns or inlays _____	Implants _____	Bad Bite _____
Partial or full dentures _____	Veneers _____	Temporaries _____	New cavities _____

Have you had any teeth extracted (wisdom teeth, four bicuspid extraction etc.)? _____
Have you had dental surgery (gum surgery, jaw surgery, etc.)? _____
Do you need further dental work? _____ If so, what? _____

Health Overview *For the following questions, please circle the phrases that apply to you.*

1. **Sleep** How is your sleep? *[**Circle:** restful, restless, hard to get to sleep, wake up often, get up during the night, bad dreams]*
Other symptoms? _____
What time do you usually go to sleep? _____ Number of hours of sleep per night? _____

2. **Digestion** How is your digestion? *[**Circle:** adequate, poor, acid reflux, burp often, bloating, burning/pain in stomach]*
Other symptoms? _____

3. **Urination** How are your daily urinations? *[**Circle:** every 2 to 3 hours, too frequent, sense of urgency, too small amount, too large amount, burning, dribbling, up at night several times]*
Other symptoms? _____

4. **Bowels** How are your bowel eliminations? Circle the phrases that apply: *[How often? 3 times daily, once per day, skip days Amount: normal, too little, too large Consistency: normal, too hard, very soft, diarrhea Color: brown, black, whitish Other: lots of mucus, lots of gas, foul smell]*
Other symptoms? _____

5. ***Women Only:*** Are you pregnant? _____ Are you breast-feeding? _____ Do you have monthly periods? _____
Date of last menstrual period? _____ Are you going through menopause? _____ Have your periods stopped? _____
Had a hysterectomy? _____ (If so, when? _____)

Menstrual Cycle. Are your monthly periods regular (28 day cycles)? _____
Number of days of your menstrual flow? _____
Circle any symptom you experience associated with your period: cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood
Other menstrual symptoms? _____

6. **Exercise** What kind of exercise do you do? _____
How often? _____ For how long at a time ? _____

7. **Sunlight** Amount of natural sunlight you receive daily outside? _____ Amount of sunlight you receive daily through windows? _____ Hours spent daily under fluorescent lights? _____ Do you use Chromalux light bulbs at home? _____ At work? _____

8. **Eyewear** Do you wear contact lenses? _____ Glasses? _____ If so, how many hours per day? _____
Do your lenses have tints? _____ An anti-glare coating? _____ A scratch-resistant coating? _____

9. **Electromagnetic Exposure** *How many hours do you spend daily:*
Watching TV? _____ Working on a computer? _____ Talking on a phone? _____ Talking on a cellular phone? _____
Wearing a pager? _____ Wearing a headset? _____ Wearing a wrist-watch *(with battery)*? ____ Wearing a hearing aid? _____
Riding in a car/truck/vehicle? _____ Near electrical equipment for long periods of time *(such as copy machines, high power lines, computers, etc.)*? _____ When you sleep, is your head within 10 feet of a plug-in clock (such as on a nite stand)? _____

10. Personal Care Products Please check which of the following you use:

- ☐ Shampoo
- ☐ Shave Cream
- ☐ Deodorant
- ☐ Dish Washing Liquid/Powder
- ☐ Toothpaste
- ☐ Laundry Soap
- ☐ Soap
- ☐ Hair Permanent
- ☐ Tub/Tile Cleaner
- ☐ Hand/Body Lotion
- ☐ Glass Cleaner
- ☐ Facial Cleanser/Moisturizer
- ☐ All-Purpose Cleaner
- ☐ Hair Spray/Gel
- ☐ Finger Nail/Toenail Polish
- ☐ Face Make-up/Eye Make-up
- ☐ Perfume/Cologne
- ☐ Personal (Sexual) Lubricant
- ☐ Roach/Ant Spray
- ☐ Contraceptive Jelly/Spermacide
- ☐ Toilet Freshener
- ☐ Hair Dye
- ☐ Other Chemical Exposure (from yard, workplace, art chemicals, etc.)

_____

11. Appliances *Please circle which of the following you use:*
Gas stove Electric stove Electric heater Electric blanket Water bed Turbo Blend Microwave oven
Air purifier (*Brand:*_____) Water purifier (*Brand:*_____)

12. Cookware What type of cookware do you use? *[**Circle**: stainless steel, aluminum, iron, teflon-coated, **glass**, Premier Waterless Cookware]* Other types:_____

13. Shower Filter What brand of shower filter do you use *(for chlorine protection)*?_____
When was your filter last changed?_____

14. Pets Do you have a pet(s)?_____ If so, what kind/how many?_____
Is it allowed in the house?_____ On your bed?_____ What do you feed your pet(s)?_____

Food Choices

Please circle each type of food that you eat often (once a week or more):

1. Pre-made foods: a) canned food b) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food

2. Red meat *(beef, pork, lamb):* a) commercially grown b) naturally raised *(Brand:*_____)

3. Chicken: a) commercially grown b) naturally raised *(Brand:*_____)

4. Turkey: a) commercially grown b) naturally raised *(Brand:*_____)

5. Fish: a) canned tuna b) fresh fish c) frozen fish d) at restaurants

6. Fresh vegetables: a) commercially grown *(store-bought)* b) organically grown *(store-bought)* c) organically grown *(direct from farmer)*

7. Fresh fruit: a) commercially grown *(store-bought)* b) organically grown *(store-bought)* c) organically grown *(direct from farmer)*

8. Whole grains: a) commercially grown *(store-bought)* b) organic *(store-bought)* c) organic (*direct from farmer*)

9. Whole beans: a) commercially grown *(store-bought)* b) organic *(store-bought)* c) organic (*direct from farmer*)

10. Eggs/ Butter: a) commercial eggs *(store-bought)* b) naturally grown eggs c) commercial butter d) natural butter

11. Milk: a) commercial milk b) organic pasteurized milk c) organic goat's milk d) good quality, raw whole milk

12. Cheese: a) commercial cheese b) organic cheese *(store-bought)* c) recommended aged cheeses *(see list)*

13. Condiments: a) commercial salt and/or pepper b) pink sea salt *(PRL)* c) artificial sweeteners *(Equal, Sweet 'N Low, Coffeemate, etc.)* d) commercial ketchup or mustard e) commercial vinegar f) commercial olive oil g) PRL Olive Oil h) other PRL oils

Food Stressors

Please indicate how many times per week you consume the following foods:

Stimulants		Toxic Oils		Commercial Dairy		Highly Heated Foods	
Coffee *(including decaf.)*		Fried foods		Cow's Milk		Bread *(store-bought)*	
Black tea, caffeine drinks		Fast food		Yogurt		Crackers *(store-bought)*	
Soft drinks *(colas, etc.)*		Potato or corn chips		Ice cream		Bagels *(store-bought)*	
Drinks with NutraSweet		Roasted nuts		Cottage cheese		Buns *(store-bought)*	
Alcohol *(wine, beer, etc.)*		Mayonnaise		Sour cream		Pasta *(store-bought)*	
Chocolate		Margarine		Cheese *(commercial)*		Muffins *(store-bought)*	
Candy, pastries, sweets		Peanut butter *(commercial)*				Cookies *(store-bought)*	

Food Habits

1. **Eating Out** Do you eat out at restaurants?_____ If yes, how often?_____ Where?_____
   What type of food do you eat at restaurants?_____

2. **Home Meals** Do you prepare meals at home?_____ If so, how often?_____
   If yes, what type of food do you prepare?_____
   _____

3. **Meal Habits** *Do You: [circle]* a) skip meals often b) have irregular eating times c) eat food past 7 PM

4. **MSG** Do you avoid food/drinks that list "natural flavors" *(which means hidden MSG)* on the label?_____

5. **Water** Do you drink tap water?_____What brand of drinking water do you use?_____
   If you have a home water purifier, when was the cartridge last changed?_____

Typical Diet

Please fill out your typical diet for the last few weeks. Please be as detailed as possible. (For example, instead of writing "chicken," identify what brand and how it was made such as "baked organic chicken." Instead of writing "salad," identify what it's made of, such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Olive Oil.") PLEASE BE HONEST!

BREAKFAST (Typical time eaten:_____) _____

_____

_____

_____

LUNCH (Typical time eaten:_____) _____

_____

_____

_____

DINNER (Typical time eaten:_____) _____

_____

_____

_____

SNACKS (Typical time eaten:_____) _____

_____

_____

_____

Bedroom/Sleep Considerations

1. Bedding Materials. What type of sheets and blankets do you use?_____
(i.e., 100% cotton, silk, polyester, poly-blends, wool, etc.)

What type of pillow do you use?_____

2. Mattress. What type of mattress do you sleep on?

_____
(such as box springs, synthetic, futon, latex, etc.)

3. Head Direction. What direction does the top of your head point when you sleep? _____
(i.e., south, north, northwest, etc.)

4. Darkness. Do you sleep with the curtains drawn tightly (so the room is very dark) or is there considerable light in the room when you sleep? _____

_____

5. Electrical Appliances. Is there a computer, TV or electrical appliance near your bed? _____
If so, how far away?_____

Are any electrical appliances left on in the room when you sleep (such as a TV or computer)?_____

6. Clock-Radio. Do you sleep with a clock-radio near your head (within one to two feet)? _____

7. Windows. Do you sleep near a window?_____
If yes, what direction does the window face? _____

8. Alarm. Do you sleep with a whole-house alarm turned on (which uses infrared beams/sensors within the house)?

_____

9. EMF Exposure. Do you sleep with your head at least one foot away from the wall? _____

Electrical Devices Worn on Body

1. Hearing Aid. Do you wear a hearing aid? _____
If yes, which ear(s)? _____

2. Watch. Do you wear a battery-operated watch?

_____

3. Pacemaker. Do you wear a pacemaker? _____

4. Other. Do you wear any other electrically-powered devices on your body? _____
If yes, what and where? _____

EMF Exposure

1. Cell Phone. Do you use a cell phone? _____
If yes, how often? _____

2. Cell Phone Tower. Do you live or work within 1/2 mile of a cell phone tower? _____

3. Transformers. Do you live or work within 100 ft. or less of a power transformer (on a telephone pole)?

_____

4. Pager. Do you wear a pager? _____
If yes, how often? _____

Toxic Body Exposure

1. Nail Polish. Do you wear fingernail or toenail polish?

_____
Have you ever worn fingernail or toenail polish?

_____
If yes, for how long? _____

2. Toxic Chemicals. Have you ever had toxic chemicals spill on your body? _____
If yes, what? _____

Personal Health Goals

1. Do you want to lose weight?_____ If so, how much?_____

2. How important is your health to you, on a scale from 1 – 10 (1 = lowest; 10 = the highest importance)?

_____

3. How much confidence do you have in medical drugs, on a scale from 1- 10 (1 = low; 10 = high confidence)?

_____

4. How much confidence do you have in your body's ability to heal itself (if given the right nutrients/natural therapies), on a scale from 1 to 10 (1 = low; 10 = high confidence)? _____

5. List any nutritional supplements that you regularly take: _____

_____

6. What best describes your diet overall? Check all that apply: *(Please be honest.)*

__ mostly eat out (fast food)
__ mostly eat out (but try to eat healthier items)
__ eat whatever is available
__ occasional binges
__ would never give up meat
__ eat a lot of fresh food (very little from cans, boxes)
__ mostly homemade meals
__ vegetarian
__ eat mostly organic
__ eat a lot of raw food
__ in transition to eating better

7. What are your specific health goals? (What do you *really* want?) _____

_____

8. How far are you willing to commit to achieve your health goals? *(Please be honest.)*

__ don't really want to change much
__ willing to change some
__ willing to change a reasonable amount
__ willing to do whatever it takes

9. How much money do you spend per month on your health, out of pocket? _____

10. How long do you want to live? (Check all that apply.)

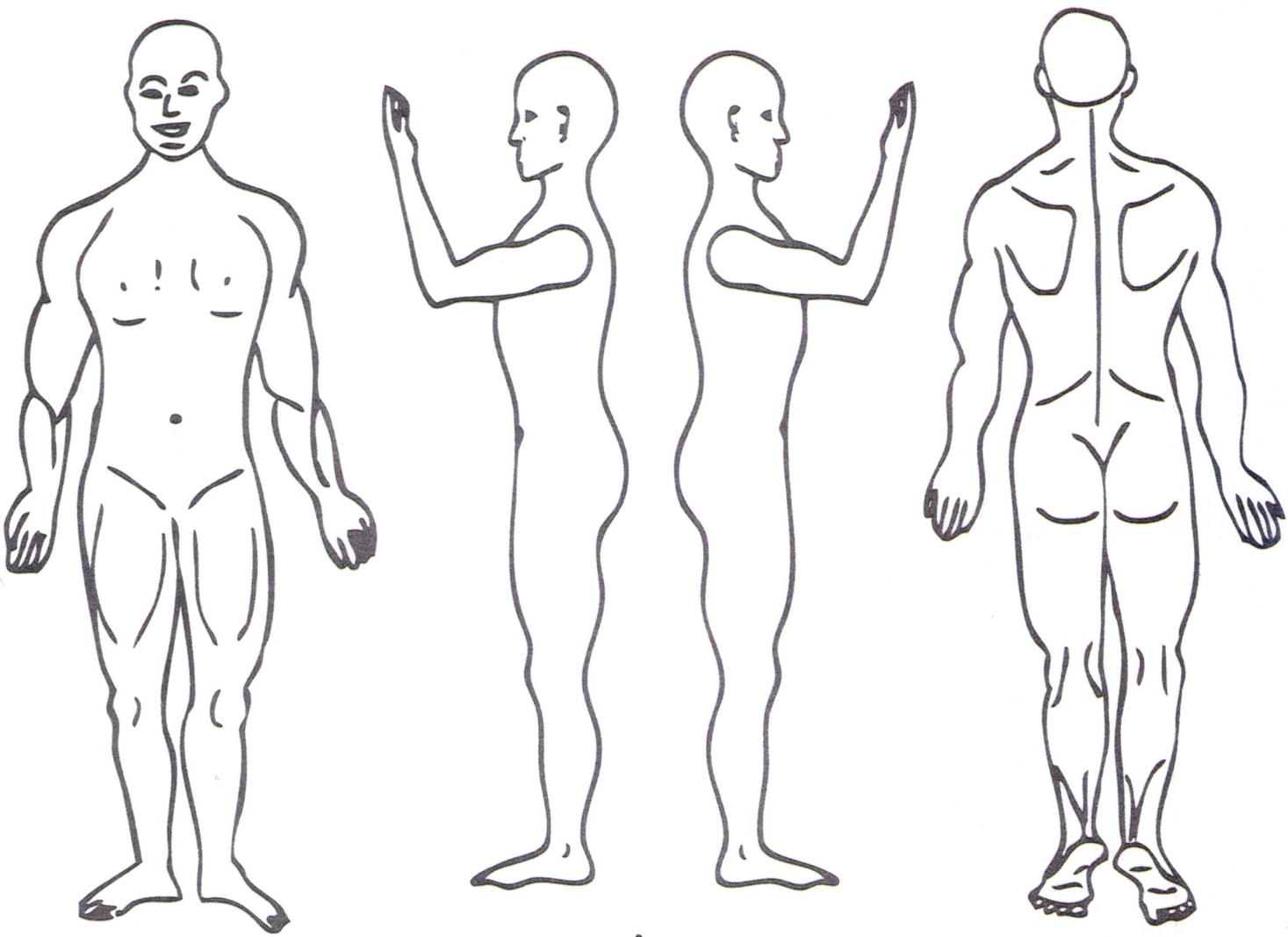
__ age 60-70
__ age 70-80
__ age 80-90
__ age 90-100
__ age 100+

__ as long as I'm healthy
__ as long as I have been granted
__ until I complete my mission (purpose) on earth
__ only if my significant other is still alive also
__ forever
__ it's already enough

Scar/Trauma Chart

Name: _____

Date: _____



Directions

All Scars. Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, all injection sites (no matter how long ago), old burn areas, etc.

All Trauma Areas. Please put a red X where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

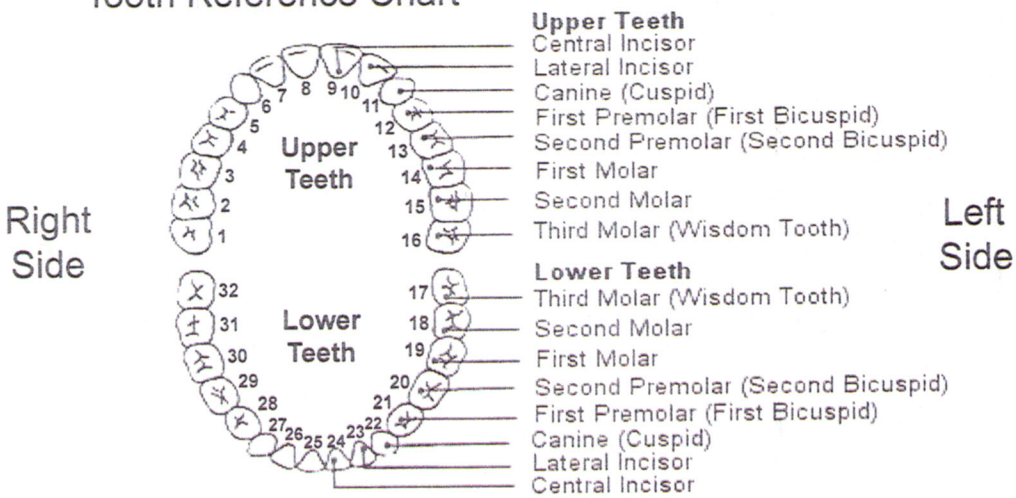
Date of injury and type of injury. Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988.")

Rev. 07-18-07

Dental History Chart

Name: _____ Date: _____

Tooth Reference Chart

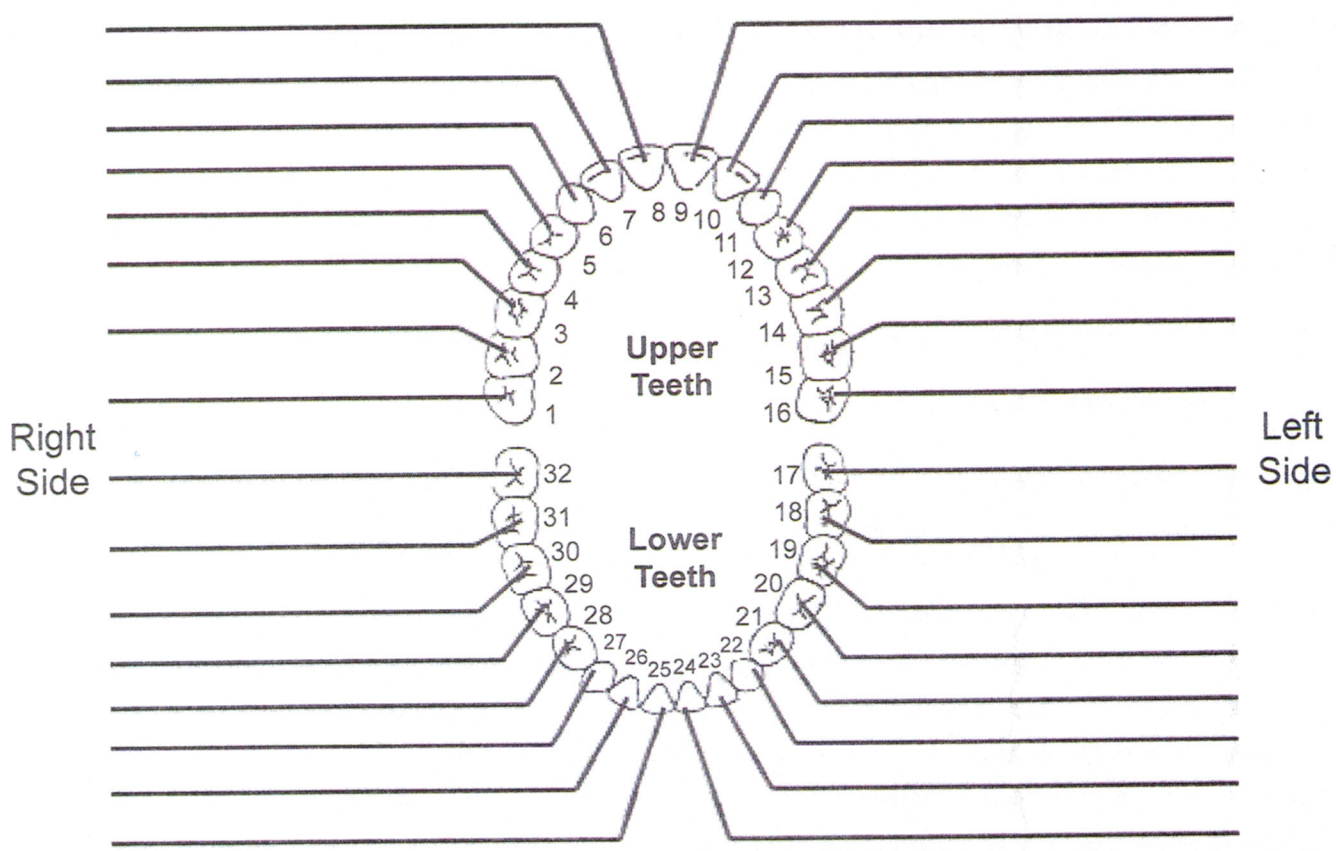


Directions: Please fill in the Dental History Chart below by writing down what was done to each tooth and the approximate age it was done. For an extracted tooth, put an X over the tooth. For example, on the line for left lower second molar, you might write: "Silver filling, age 22." **Please see Example Chart on back.**

Please use the following descriptors when filling in the chart:

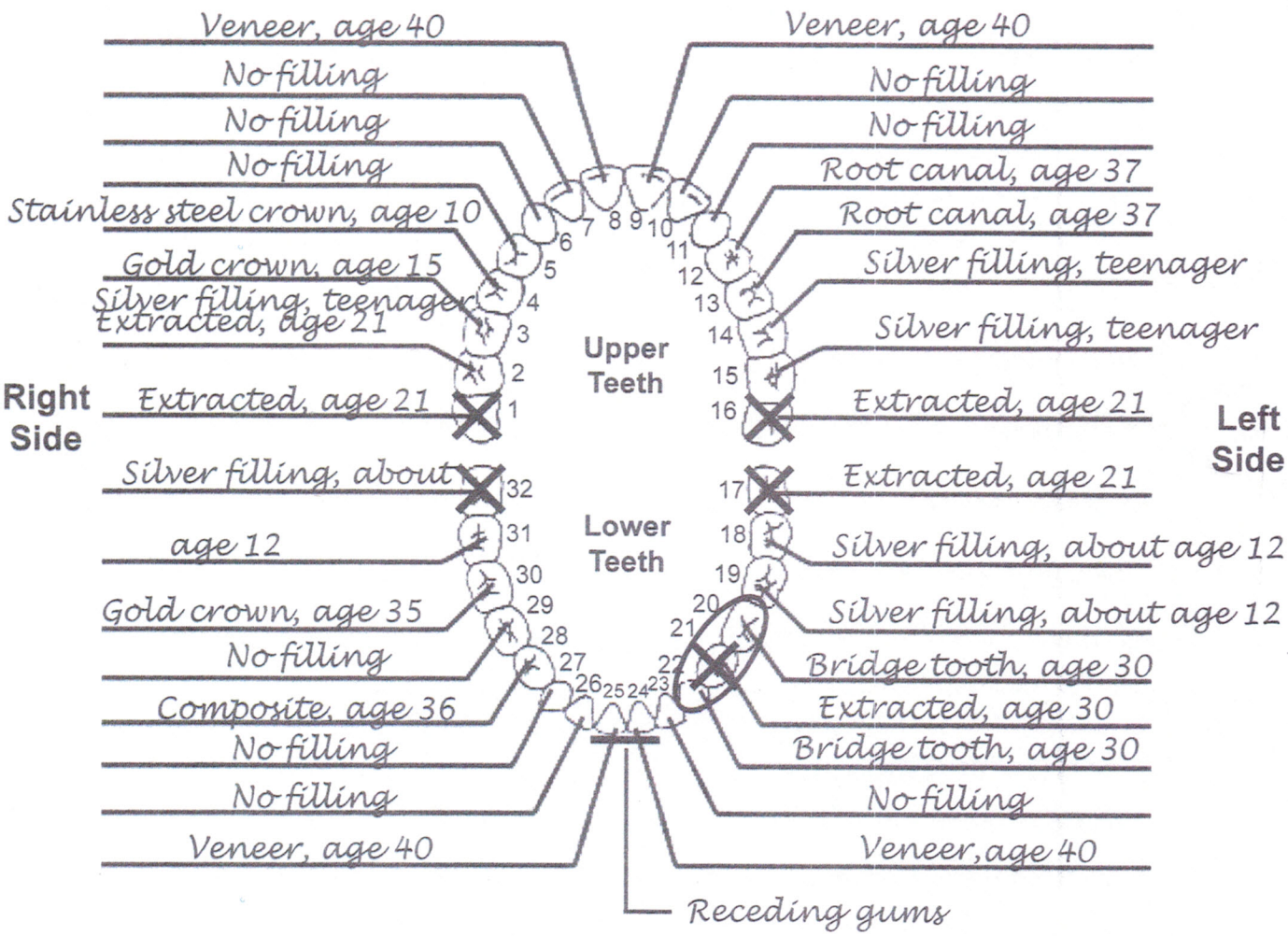
- Silver filling
- Composite filling *(plastic-like filling)*
- Gold crown
- Stainless steel crown
- Root canal
- Post (in root canal)
- Veneers
- Bridge *(circle teeth with bridge attached)*
- Partial denture
- Full denture
- Extracted tooth *(write next to X'd out tooth)*
- No filling

Gum Concerns: please make a line at the base of any teeth that have gum problems and indicate what type of concern, such as deep pockets, receding gums, bleeding gums, etc.



Example Dental Chart

Name: Den Tall Date: 01-01-2011



R06-0201

The Three Body Types
Questionnaire

Identifying Your Constitution

To learn your basic Ayurvedic constitution type (called a "dosha"), please rate the following traits as they have pertained to you in the last 2 to 3 years.

Answer each number and be sure to put a number in all 3 blanks per line, even if it is "0".

0 = Doesn't describe me at all
1 = Describes me a little
2 = Describes me quite well
3 = Describes me almost perfectly

	VATA	PITTA	KAPHA
1. My hair texture tends to be:	____ Dry, curly wavy, shiny	____ Straight or fine	____ Thick or full bodied
2. My hair color is:	____ Medium or or light brown	____ Blond or reddish tone or early gray	____ Dark brown or black
3. My skin tends to be:	____ On the dry side	____ Delicate or sensitive	____ Oily or smooth
4. My complexion (when compared with others of my race) is:	____ Darker	____ More reddish or freckled	____ Lighter
5. Compared with others of my height, I have:	____ Smaller bones	____ Average-size bones	____ Larger bones
6. My weight is:	____ Thin; I don't gain weight	____ Average	____ Heavy
7. My energy level:	____ Tends to fluctuate, may be high or low	____ Is moderate to high; I can push myself too hard	____ Is steady
SUBTOTALS:	VATA = _____	PITTA = _____	KAPHA = _____

0 = Doesn't describe me at all
1 = Describes me a little
2 = Describes me quite well
3 = Describes me almost perfectly

	VATA	PITTA	KAPHA
8. Regarding temperature, I:	____ Dislike cold; am comfortable in heat	____ Dislike heat, perspire easily, like cool temperatures	____ Dislike damp and cold, can tolerate extremes well
9. My typical hunger level:	____ Can vary from excessive to no interest in food	____ Is intense; I need regular meals	____ Is usually low but can be emotionally driven
10. I prefer my food/drinks:	____ Warm or moist or oily	____ Cold	____ Warm or dry
11. I generally eat:	____ Quickly	____ Moderately fast	____ Slowly
12. My sleep is most often:	____ Interrupted, light	____ Sound, moderate	____ Deep, long
13. My sexual interest is:	____ Strong when romantically involved; low to moderate otherwise	____ Moderate to strong	____ Slow to awaken but then is sustained
14. My emotional moods:	____ Change easily; I'm very responsive	____ Are intense; I'm quick-tempered	____ Are even; I'm slow to anger
15. My general reaction to stress is:	____ Anxious, fearful	____ Irritated	____ Mostly calm
16. With regard to money, I:	____ Am easy and impulsive	____ Am careful, but I spend	____ Tend to save, accumulate

SUBTOTALS: **VATA =** _____ **PITTA =** _____ **KAPHA =** _____

	VATA	PITTA	KAPHA
17. My way of learning is:	____ To learn quickly, enjoy more than one thing at a time	____ To focus sharply, discriminate	____ To take my time
18. With regard to tasks, I may:	____ Start a task, but not finish	____ Finish what I start	____ Tend to be methodical
19. My memory is:	____ Best in the short term	____ Good overall	____ Best in the long term
20. My way of speaking is:	____ Quick, often imaginative or excessive	____ Clear, precise detailed, well-organized	____ Soothing, calm
21. If there was one trait to best describe me, it would be:	____ Vivacious	____ Determined	____ Easygoing
22. Regarding my relationships, I:	____ Easily adapt to different kinds	____ Often choose friends on the basis of their values	____ Am slow to make new friends, but then I am loyal
23. My family and friends might prefer me to be more:	____ Settled	____ Tolerant	____ Enthusiastic

SUBTOTALS: **VATA =** _____ **PITTA =** _____ **KAPHA =** _____

Add each of the subtotals together for each dosha, then enter in the grand total for each one.

GRAND TOTAL **VATA =** _____ **PITTA =** _____ **KAPHA =** _____

ASSESSING YOUR SCORE

If one column total is 15 or more points higher than the other two column totals, this is clearly your dominant constitutional type -- vata, pitta or kapha.

If two of the column totals are 0 to 15 points apart, you are a dual-dosha constitutional type -- vata-pitta (or pitta-vata), pitta-kapha (or kapha-pitta), or vata-kapha (or kapha-vata).

If all three column totals are within 0 to 10 points of each other, you are a tri-dosha constitutional type (the most balanced type).

Birth Dosha: To determine your original constitutional type, take this test again, only answer the questions as they would have pertained to you as a child. Compare your present (acquired dosha) with your birth dosha.