NEW PATIENT INFORMATION

In order to receive the best possible results, it is important to read and understand the following:

- Some cases may require treating preliminary items that are contained within a substance, such as vitamins, minerals, phenolics and/or sugars. For example, sugar may need to be addressed before proceeding with fruit, grains or alcohol.
- After addressing any preliminary items, patients may choose what order remaining substances are treated.
- It is possible to treat numerous items in one session if they are all part of the same family. For example, all dairy products (milk, cheese and yogurt) and calcium may be treated together. But dairy and wheat, or tomatoes and pollens may not be addressed in the same session. If they are, the treatment will not be successful.
- We cannot guarantee how many sessions a substance will require to reduce the symptoms associated with it.
- When addressing a condition, instead of a single substance or family of substances, multiple items may be contributing to the symptoms. Therefore such conditions may require multiple sessions to relieve the symptoms of the condition.

Please adhere to the following guidelines:

- As a courtesy to our other patients who may have strong sensitivities, please do not smoke or wear perfume or fragrances prior to coming in to the clinic.
- Do not eat or chew gum during the session.

Office Policies

- The clinic has a 24-hour cancellation policy. Late cancellations or no-shows will incur a charge of _____.
- Please arrive 10 minutes prior to your appointment time. Late arrivals may be rescheduled and charged _____.
- Payment is due at the time services are rendered.

Initial Assessment for:
Patient's Name _____

	Amines		Grain / Wheat		Cats		Acids
	Caffeine		**Iron**		Cockroaches		Enzymes
	Calcium		Milk / Dairy		Dogs		
	Chicken		**Minerals**		Dust / Dust Mites		
	Chocolate		Protein		Flowers		
	Coffee		Salicylates		Fungus		
	Corn		Salts / Chlorides		Grasses		
	Eggs		Soy		Molds / Mildews		
	Food Coloring		**Sugar**		Plant Phenolics		
	Food Flavorings		**Vitamin A**		Plants		
	Food Phenolics		**Vitamin B**		Pollens		
	Food Preservatives		**Vitamin C**		Sinus Fungus		
	Glutamates		Yeast		Trees		
					Weeds		

PATIENT INFORMATION

Last Name _____ First Name _____ Date _____

Address _____ Zip Code _____

Telephone Home _____ Work _____ Cellular _____

Email Address: _____

Age _____ DOB _____ Occupation _____

Who to reach in case of an emergency _____ Contact # _____

How did you hear about our clinic? _____

Are you currently receiving health care? Please circle: Y N

If yes, name of physician: _____

Condition being treated: _____

What are your most important health concerns?

1 _____

2 _____

3 _____

Please list tested or suspected allergies or sensitivities and related symptoms:

Foods _____

Seasonal _____

Drug / other _____

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

_____

Daily Dosage _____

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)? _____

Do you smoke? Please circle: Y N

Are you currently receiving acupuncture or chiropractic treatments? _____

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the items listed on the New Patient Information form.

Signature _____ **Date** _____

(If under the age of 16, must be signed by Parent or Legal Guardian.)

WAIVER AND RELEASE

I _____ (the "Undersigned"), hereby consent to treatment at

Mahaya Health

I understand that such procedures are non-invasive.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results in the reduction of symptoms. The clinic cannot guarantee that new reactions will not develop in the future. While the treatment can address many symptoms associated with allergies and sensitivities some cases do not respond to the treatment.

I also understand that the only known risk factor with the treatment of symptoms associated with allergies or sensitivities, including immunotherapy, is the possibility of increased sensitivity. I assume all responsibility for unpredictable reactions which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention.

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

☐ **No, I do not have any life threatening allergies.**

☐ Yes, I have the following allergies that may cause anaphylaxis:

_____

_____

_____

I agree to pay the clinic the standard fee for any and all treatments administered.

IN WITNESS THEREOF, the undersigned executed the Agreement as of

DATE _____

_____ _____

Signature of Undersigned Signature of Practitioner

_____

Signature of Parent or Legal Guardian