PATIENT INFORMATION

Child's Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Parent/Guardian Names: _____

Address: _____
(Street) (City) (Postal Code)

Cell: _____ Home Ph. #: _____ Email: _____

# of Siblings: _____ Names and Ages: _____

How did you hear about us?_____

HEALTH CONCERNS

Please list, in order of importance, your chief concerns:

1. _____ 3. _____

2. _____ 4. _____

Have you seen any other doctors for the above concern(s)? Y N If so, then please describe treatment given:

_____

_____

PERSONAL HEALTH HISTORY

Does your child have now or has ever suffered from:

__Ear Infections	__Scoliosis	__Seizures
__Chronic Colds	__Digestive Problems	__Colic
__Asthma	__Allergies	__ADD/ADHD
__Recurring Fevers	__Bed Wetting	__Car Accident
__Sports Injury	__Growing Pains	__Other Pain
__Temper Tantrums	__Difficulty Sleeping	__Diabetes
__Slow Physical Development	__Slow Mental Development	__ Other

Vaccination status:_____

Adverse vaccine events: Y/N Reaction:_____

Has your child ever fallen from a high place? Hit his/her head? Concussion? Y N

Please list any and all traumas or injuries and the year they occurred.

_____

Please list hospitalizations, surgeries, major illnesses and/or medical procedures and the year they occurred.

_____

_____

Number of medications or antibiotics your child has taken in the past year: _____ Lifetime:_____

Please list the names of all prescription and over-the-counter medications and for what symptom:

1. _____ (Name) (Symptom)
2. _____ (Name) (Symptom)
3. _____ (Name) (Symptom)
4. _____ (Name) (Symptom)
5. _____ (Name) (Symptom)
6. _____ (Name) (Symptom)

DIET AND LIFESTYLE

Please describe your child's current diet. List any foods your avoiding and why.

_____

_____

List any real or suspected allergies/sensitivities to drugs, food, or environmental sources.

_____

_____

Does your child do any physical activity? Please describe what type and how often.

_____

PRENATAL & BIRTH HISTORY

Complications during pregnancy? Y N If yes, then please describe_____

Ultrasounds during pregnancy? Y N If yes, how many and which months_____

Any medications taken before or during delivery_____

Alcohol/Cigarettes/Drugs During Pregnancy? Y N Was your baby full term?_____

Location of Birth (Circle One): Hospital Home Birthing Center How long was the labor?_____

Birthing Interventions (Circle All That Apply): Epidural Forceps Vacuum Extraction VBAC C-Section

If C-Section, was it emergency or planned?_____

Any complications with delivery?_____

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely 0 1 2 3
Lower abdominal pain relieved by passing stool or gas 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Diarrhea 0 1 2 3
Constipation 0 1 2 3
Hard, dry, or small stool 0 1 2 3
Coated tongue or "fuzzy" debris on tongue 0 1 2 3
Pass large amount of foul-smelling gas 0 1 2 3
More than 3 bowel movements daily 0 1 2 3
Use laxatives frequently 0 1 2 3

Category II

Increasing frequency of food reactions 0 1 2 3
Unpredictable food reactions 0 1 2 3
Aches, pains, and swelling throughout the body 0 1 2 3
Unpredictable abdominal swelling 0 1 2 3
Frequent bloating and distention after eating 0 1 2 3

Category III

Intolerance to smells Intolerance to jewelry 0 1 2 3
Intolerance to shampoo, lotion, detergents, etc 0 1 2 3
Multiple smell and chemical sensitivities 0 1 2 3
Constant skin outbreaks 0 1 2 3

Category IV

Excessive belching, burping, or bloating 0 1 2 3
Gas immediately following a meal 0 1 2 3
Offensive breath 0 1 2 3
Difficult bowel movements 0 1 2 3
Sense of fullness during and after meals 0 1 2 3
Difficulty digesting proteins and meats; undigested food found in stools 0 1 2 3

Category V

Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3
Use of antacids 0 1 2 3
Feel hungry an hour or two after eating 0 1 2 3
Heartburn when lying down or bending forward 0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3
Digestive problems subside with rest and relaxation 0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3

Category VI

Difficulty digesting roughage and fiber 0 1 2 3
Indigestion and fullness last 2-4 hours after eating 0 1 2 3
Pain, tenderness, soreness on left side under rib cage 0 1 2 3
Excessive passage of gas 0 1 2 3
Nausea and/or vomiting 0 1 2 3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed 0 1 2 3
Frequent loss of appetite 0 1 2 3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar 0 1 2 3
Abdominal distention after certain probiotic or natural supplements 0 1 2 3
Decreased gastrointestinal motility, constipation 0 1 2 3
Increased gastrointestinal motility, diarrhea 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Suspicion of nutritional malabsorption 0 1 2 3
Frequent use of antacid medication 0 1 2 3

Category VIII

Greasy or high-fat foods cause distress 0 1 2 3
Lower bowel gas or bloating several hours after eating 0 1 2 3
Bitter metallic taste in mouth, especially in the morning 0 1 2 3
Burpy, fishy taste after consuming fish oils 0 1 2 3
Unexplained itchy skin 0 1 2 3
Yellowish cast to eyes 0 1 2 3
Stool color alternates from clay colored to normal brown 0 1 2 3
Reddened skin, especially palms 0 1 2 3
Dry or flaky skin and/or hair 0 1 2 3
History of gallbladder attacks or stones 0 1 2 3
Have you had your gallbladder removed? *YES NO*

Category IX

Acne and unhealthy skin 0 1 2 3
Excessive hair loss 0 1 2 3
Overall sense of bloating 0 1 2 3
Bodily swelling for no reason 0 1 2 3
Hormone imbalances 0 1 2 3
Weight gain 0 1 2 3
Poor bowel function 0 1 2 3
Excessively foul-smelling sweat 0 1 2 3

Category X

Crave sweets during the day 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep going/get started 0 1 2 3
Get light-headed if meals are missed 0 1 2 3
Eating relieves fatigue 0 1 2 3
Feel shaky, jittery, or have tremors 0 1 2 3
Agitated, easily upset, nervous 0 1 2 3
Poor memory, forgetful between meals 0 1 2 3
Blurred vision 0 1 2 3

Category XI

Fatigue after meals 0 1 2 3
Crave sweets during the day 0 1 2 3
Eating sweets does not relieve cravings for sugar 0 1 2 3
Must have sweets after meals 0 1 2 3
Waist girth is equal or larger than hip girth 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

Category XII

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category XIII

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under a high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category XIV

Edema and swelling in ankles and wrists	0 1 2 3
Muscle cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Frequent thirst	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel regularity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

Category XV

Tired/sluggish	0 1 2 3
Feel cold—hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XVI

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XVII (Males Only)

Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel emptying	0 1 2 3
Leg twitching at night	0 1 2 3

Category XVIII (Males Only)

Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Difficulty maintaining morning erections	0 1 2 3
Spells of mental fatigue Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decreased physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XIX (Menstruating Females Only)

Perimenopausal	0 1 2 3
Alternating menstrual cycle lengths	0 1 2 3
Extended menstrual cycle (greater than 32 days)	0 1 2 3
Shortened menstrual cycle (less than 24 days)	0 1 2 3
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XX (Menopausal Females Only)

How many years have you been menopausal?	_____ *Years*
Since menopause, do you ever have uterine bleeding?	*YES NO*
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness, or itching	0 1 2 3

Name_____ **DOB**: _____

Clinical Care Release

_____ has been accepted as a patient to be seen at Innovative Health and Wellness Group.

The patient and/or his/her guardian(s), or legally responsible person(s) desire to be examined by the licensed practitioners and the clinical staff. You the patient, upon signature, give permission/consent to any clinically appropriate examination and therapeutic procedures, as determined by the clinical staff and consented to.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that providers of many disciplines may be in attendance or participate in this clinical evaluation and care process. These individuals will potentially observe all examination and treatment procedures.

Clinical staff: (Please take the time to understand the staff, their roles, and feel free to ask about scope of practice with each one). We have a multi-disciplinary staff to accommodate you.

Staff:

Dr. Elizabeth Seymour, MD

- Medical Doctor
- Clinical Director

Dr. Erin Van Veldhuizen, DC, MSN, FNP, DACNB, DCBCN, DCN, CCCN, CCTT

Family nurse practitioner - Certified (Delegation with Elizabeth Seymour, MD)

- Chiropractor
- Diplomat, American Chiropractic Neurology Board
- Diplomat, Chiropractic Board of Clinical Nutrition
- Diplomat, Clinical Nutrition from American Association of Integrative Medicine
- Nutritional Therapy
- Certified Camera Thermographer, International Association of Camera Thermographers

Dr. Nisreen Tayebjee, DC

- Chiropractor
- Nutrition Therapy

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedures, including those used at Innovative Health and Wellness Group. The procedures ordered by the staff clinicians are recommended because the potential benefits are greater than the potential risks.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that NO promise or guarantee of a cure or outcome has been given. While the Innovative Health and Wellness Group staff will attempt to work with any patient we feel we can assist in recovery or improvement, we also reserve the right to deny or suspend care should the patient's condition warrant it.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that neither the patient or any assigns will hold Innovative Health and Wellness Group, its staff, or its volunteers liable for any actions, non-actions, or outcomes associated with the diagnosis, treatment, and recommendations of the staff.

_____ Date _____/_____/_____

Printed name of patient

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

Statement of Patient Financial Responsibility

Name: _____ DOB:_____

Innovative Health and Wellness Group appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies complete financial responsibility on your part.

The financial responsibility obligates you to ensure payment in full of our fees and the costs of all testing, including laboratory and other outside tests. We expect these payments at time of service.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that at no time will IHWG be obligated to communicate or bill any insurance company. We will provide you with a detailed statement of services provided should you wish to seek reimbursement independently.

While your specific treatment plan is determined by the clinical staff. The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that all costs specific to transportation, lodging, and travel expenses are to be borne by the patient and/or his/her guardian(s), or legally responsible person(s).

I have read the above policy regarding my financial responsibility to Innovative Health and Wellness Group, for providing services to myself or the above-named patient. I certify the information is, to the best of my knowledge, true and accurate. Payment in full and the entire amount of bill incurred by me or the above-named patient is due prior to service rendered.

_____ _____ Date _____/_____/_____

Signature of parent or guardian Printed name

Authorization to Release Information

I authorize Innovative Health and Wellness Group to release to appropriate agencies or persons, any information acquired in the course of my or the above-named patient's examination and treatment. This information may be stored and transmitted electronically using appropriate safeguards and/or data encryption.

For more information, please see the HIPAA authorization form and privacy notice, or feel free to ask a member of staff should you need clarification.

_____ _____ Date _____/_____/_____

Signature of parent or guardian Printed name

Cancellation/No Show Policy

We acknowledge there may be times when you miss an appointment due to emergencies or obligations to work or family; however, we urge you to call 24 hours prior to canceling your appointment.

Our opportunities to treat patients are limited by our treatment regime, therefore the patient and/or his/her guardian(s), or legally responsible person(s) also acknowledge that if the patient No Shows for more than two appointments that they may be dismissed from care. The Practice will notify you if you are discharged from care.

I have read and acknowledge the above policy, and I agree to the terms described.

_____ _____ Date _____/_____/_____

Signature of parent or guardian Printed name

Video and Photography Consent

Occasionally Innovative Health and Wellness Group will conduct filming and/or photography for promotional materials as well as for training purposes. The patient and/or their legal guardian is responsible for ensuring they are not incidentally recorded should they refuse this consent. The staff at this facility will never attempt to employ hidden or covert means to record any patient without their knowledge.

Educational Usage

In consideration that Innovative Health and Wellness Group partners with educational organizations, we request your consent to film or record various aspects of your treatment. We also request your consent to use information related to your condition or care in the training of staff and/or students. Any protected health information (PHI) will be removed or redacted from any documents used in this manner.

Promotional Usage

While relatively uncommon, we will ask to record patients for testimonials or photograph for promotional materials. General information may be shared such as a brief description of your condition, your first name and/or initials and statements you may wish to make. Should you be asked and agree to provide a testimonial, there will be no reimbursement and the product, including the rights to use your likeness, will become the sole property of IHWG.

You are free to refuse your consent to be recorded or photographed with **NO EFFECT** on your care.

I have read the above policies and wish to give my consent to:

__ Both educational and promotional usage.
__ Only educational usage.
__ None of the above.

_____ _____ Date _____/_____/_____

Signature of parent or guardian Printed name

Experimental Therapy Statement

Some of the devices and therapies used at Innovative Health and Wellness Group are proprietary and/or are in the process of gaining regulatory approval. While they are thought by our clinical staff and medical advisory board to have a positive effect, no claim is made that any of the devices listed below diagnose or treat any condition unless specifically evaluated and approved by the Food and Drug Administration for that usage.

- Compounded infusion formulas for the treatment of specific conditions.
- Various compounded medications and nutritional and dietary and supplemental usage combined with conventional medical care.

Additionally, the nutraceuticals and supplements offered may contain elements that have not been assessed by the Food and Drug Administration. While none of these, in the opinion of the clinical staff, pose an unbalanced risk or are inherently unsafe, we as healthcare providers feel you should be made aware that they may not have been proven effective in treating your specific condition.

I have read and acknowledge the above statement.

_____ _____ Date _____/_____/_____

Signature of parent or guardian Printed name

HIPAA Authorization Form

_____ _____/_____/_____ _____

Patient's full name Date of birth Telephone number

_____ _____

Name of legal guardian/representative Relationship to patient

I authorize Innovative Health and Wellness Group to access, use or disclose my protected health information in the manner described below.

1) IHWG may request and be provided with a copy of prior health records, including protected health information from your current or previous healthcare provider(s).
2) IHWG may communicate with your current or previous healthcare provider(s) in reference to your diagnosis, treatment and care.
3) IHWG staff may communicate internally regarding your case.
4) You have the right to authorize or disallow communication with outside non-clinical personnel (such as a family member) regarding your diagnosis, treatment or care of IWHG.

The following information may be disclosed to, from, or between outside medical personnel and IHWG as it is relevant to your care:

*Medical Records *All treatment records

*Records regarding communicable diseases *Chiropractic records

*Alcohol/Drug abuse treatment records *Any other information relating to your condition

*Mental Health records

All past, present and future periods of healthcare information may be shared for the period of this authorization.

The purpose of the use or disclosure of this information is to facilitate effective and accurate diagnosis and treatment at IHWG, and to comply with state and federal laws.

This authorization is valid beginning on _____/_____/_____ (today's date) and expires one year after the end of your care received at or from IHWG, including any follow-up care and consultations.

I acknowledge that the information used or disclosed under this authorization may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form; however, if I refuse to sign the staff of IHWG may refuse service if they are unable to gain access to previous medical records. If signed, I have the

right to revoke this authorization, in writing, at any time. I acknowledge that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Please see the HIPAA privacy notice for a more detailed outline of our privacy policy.

In the event I cannot be reached, IHWG may use the following methods to communicate important health information:

___ e-mail provide the email address: _____

___ voicemail at the following number (be aware work voicemails may not be secure): _____

___ standard mail at the following address: _____

Name of any person(s) allowed to communicate with IHWG and relation to patient:

_____

_____

_____ _____ Date _____/_____/_____

Signature of parent or guardian Printed name

Chiropractic Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

***Adjustment**: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.*

***Health**: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.*

***Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.*

We do not offer the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, _____ have read and fully understand the above statements.

(Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____

Signature Date

Disclosure(s) and Informed Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical, chiropractic or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to undergo the procedure or after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but recommended to you by us, as your providers.

Details of the diagnostic tests that we run at Innovative Health and Wellness Group are contained in the list at the end of this Disclosure and Informed Consent.

I understand that medical, chiropractic or diagnostic tests or procedure(s) may be necessary or advisable and I voluntarily consent and authorize such tests or procedure(s) as deemed necessary or advisable upon examination. The list of tests and procedure(s) to be performed, and their risk, benefits, is included below, and I have been informed that the risks/hazards of such test or procedure(s).

Just as there may be risks and hazards in continuing my present condition, with or without treatment or procedure(s), there are also risks and hazards related to the performance of medical, chiropractic, or diagnostic procedure(s) planned for me. I realize that common to medical, chiropractic and/or diagnostic procedure(s), is the potential for infection, allergic reaction(s) and, in very rare cases, even death due to severe systemic reaction.

While some of the devices and therapies used at Innovative Health and Wellness Group are thought by our clinical staff to have a positive effect on your condition, no claim is made that any of the devices listed below diagnose or treat any condition unless specifically evaluated and approved by the Food and Drug Administration for that usage.

Risks Associated with Diagnostic and Therapeutic Modalities

As with any healthcare procedure, there are certain complications that may arise during diagnostic procedure(s) and therapeutic intervention(s). The following procedure(s) and intervention(s) may or may not be used in your specific case. The complications are outlined below and include but are not limited to:

RPSS

Risks include pain, skin irritation, muscle spasms or minor electrical burn at the end point of contact

Gaze Stability

Risks for gaze stability exercises include temporary discomfort in the neck, changes to vision, dizziness, nausea, light-headedness, fatigue and headaches

Vibracussor, balance testing, NSI and other Neuromuscular Re-Education

Risks include local soreness, increase in symptoms, fatigue, headache, light-headedness and dizziness; rarely therapy may result in loss of balance with subsequent fall with injury.

OVARD:

Benefits: The patented Off Vertical Axis Rotational Device (OVARD) provides neurological rehabilitation to patients whose lives have been affected by concussions, physiological and neurological disorders, and other conditions that may benefit from brain-based therapy. It targets the vestibular system, which affects balance, spatial orientation and movement. This rotation stimulates the vestibular system to encourage neural activity in parts of the brain that have been affected by illness or injury.

Risks: Include temporary light-headedness, dizziness, nausea, anxiety, headache and malaise. Risks that are uncommonly encountered include fainting, changes to blood pressure and heart rate and death.

Chiropractic Manipulation and Manual Myofascial Therapy:

Reactions that are most commonly reported are local soreness/discomfort and bruising, headaches, fatigue, radiating discomfort, dizziness. The vast majority of the aforementioned conditions will resolved within 48 hours. Rare side effects include: fracture or joint injuries isolated cases with underlying physical defect, deformities or pathologists, muscle and ligament sprain, disc herniations, cauda equina syndrome, compromise of vertebrobasilar artery (i.e stroke).

Cold Laser Therapy, PTL II laser, and Qi5:

Benefits: Cold Laser Therapy is a pure from of light energy of a specific color and wavelength that does no increase thermal temperature of what it is contacting. The laser light interacts with tissue causing the occurrence of certain photochemical reactions and stimulating the neural biological process. It is a non-invasive procedure, meaning that it does not require a surgical incision. This means that there is no prolonged recovery time. Laser therapy also does not involve taking any medications, and many patients prefer to avoid taking medications.

Risks: Patients do no typically get full relief or resolution from their pain symptoms after the first treatment. It takes a series of days after treatments, but for most patient this sensations is short term, lasting for a couple of days.

Blood Draw:

The risks of taking blood include discomfort, local bruising, redness and swelling of the vein and the rare risks of fainting and infection.

IV Therapy:

The risks of taking blood and/or IV therapy include discomfort, local bruising, redness and swelling of the vein and the rare risks of fainting and infection. Severe reactions include allergic reaction, anaphylaxis, infection, cardiac arrest and death.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedure, including those used at Innovative Health and Wellness Group. The procedures order the staff clinicians are recommended because the potential benefits are greater than the potential risks.

The patient and/or his her/her guardian(s), or legally responsible person(s) acknowledge and agree that NO promise or guarantee of a cure or outcome has been given. While the Innovative Health and Wellness Group staff will attempt to work with any patient, we feel we can assist in the recovery or improvement, we also reserve the right to deny or suspend care should the patient's condition warrant it.

I have been given the opportunity to discuss with my medical provider, and to ask questions about my condition and treatment, risks of non-treatment and the medical, chiropractic or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such treatment and procedure(s), and I believe that I have sufficient information to give this informed consent. I acknowledge that this DISCLOSURE AND INFORMED CONSENT have been fully explained to me, that I have read it or have had it read to me and that I understand its contents.

The patient and or his/her guardian(s), or legally responsible person(s) desire to be examined by Innovative Health and Wellness Group staff. They give permission/consent to any clinically appropriate examination and therapeutic procedures as determined by the clinical staff.

_____ _____ *Date* _____/_____/_____

Signature of patient *Printed name*

_____ _____

Signature of Guardian, if patient is a minor or dependent *Relationship to patient*