Quantum ALTERNATIVE HEALTH
AN INTEGRATIVE FAMILY WELLNESS CLINIC

New Patient Paperwork

Patient Information

Name:				
Address:				
City:	Zip Code:			
Home Phone:				
Cell Phone:				
Email:				
Yes, I want to receive emails about specials! ___Yes / ___No				
Employer:				
Address:				
Work Phone:				
Position/Title:				
Date of Birth:	Age:			
Place of Birth:	Gender: M / F			
If minor, Mother's Name:				
Mother's Phone:				
If minor, Father's Name:				
Father's Phone:				
Emergency Contact Name:				
Emergency Contact Phone:				
Relationship to Patient:				
Marital Status:				
Children's Name(s):	Age(s):			
Spouse Name:				
Date of Birth:	Age:			
Employer:				
Position/Title:				
How did you hear about us?		☐ Internet	☐ Facebook	
☐ Drive by	☐ Flyer	☐ Friend	☐ Physician	
Referral's Name:				

Current health challenges and main concerns

Please list all here:				
When did problem begin?				
☐ Sharp	☐ Dull	☐ Tingling	☐ Numb	☐ Stabbing
☐ Constant	☐ Frequent	☐ Comes and goes		
Has this condition gotten worse or stayed constant?				
Does this concern interfere with:				
☐ Work	☐ Sleep	☐ Daily activities	☐ Other:	
Other doctors seen for this condition:				
When?				
Type of Treatment?				
Results?				
Home remedies?				

Medications/Supplements

Multi-vitamin:
Omega-3 Oils:
Probiotic:
Vitamin C, D, or E:
Minerals:
Herbs:
Cholesterol:
Blood Pressure:
Muscle relaxer:
Pain Killers:
Insulin:
Other:

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General Health Questionnaire:

Please answer the following general health questions, to help establish awareness for need of detoxification.

1. Number of organs removed? _____
2. Number of synthetic drugs currently taking? _____
3. Number of times you smoke in a day? _____
4. Number of steroid drugs used in the last year? _____
5. Number of silver fillings in your mouth? _____
6. Number of street drugs used each month? _____
7. Number of known allergies? _____
8. Number of unresolved emotional factors (anger, depression, anxiety, etc.)? _____
9. Rate how responsible you are for your body from 1-10 (1 is least, 10 is most): _____
10. Rate the amount of fat in your diet from 1-10 (3 is average): _____
11. Personal stress from 1-10 (1 is least, 10 is most): _____
12. Number of sugar-type products in a day? _____
13. Number of exercise sessions in one week? _____
14. Number of alcoholic drinks in one day? _____
15. Number of Caffeine products in a day (coffee, soda, tea, etc.)? _____
16. Number of toxic exposures per year (x-rays, chemicals, pesticides)? _____
17. Number of major injuries in the past (broken bones, accidents, surgeries)? _____
18. Number of major infections in the past (pneumonia, appendicitis, tonsillitis, etc.)? _____
19. Number of glasses of water per day? _____
20. How many pounds overweight? _____
21. **Do you have a pacemaker (circle one)? YES or NO**

*****If you have a pacemaker, the footbath and biofeedback is contraindicated for you. Lymphatic massage and/or the full spectrum infrared sauna may be more appropriate for your needs.**

Healthy Habits

Do you smoke?	Y / N	How much?
Do you drink alcohol?	Y / N	How much?
Coffee, tea or soda?	Y / N	How much?
Do you exercise?	Y / N	How much?
Prayer/Meditate/Yoga?	Y / N	How much?
Do you go out to eat?	Y / N	How much?

What do you like to do for fun?

Females Only

Are you pregnant?	Y / N	Due date:
Are you nursing?	Y / N	
Do you have breast implants?	Y / N	
Are you taking any hormones?	Y / N	Synthetic or Bio-identical?
Do you experience symptomatic periods?	Y / N	Date of last period:
Are you taking birth control?	Y / N	

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Health Conditions/Symptoms:

Please circle all that you experience now or have experienced in the past, as many health concerns other than pain affect the overall diagnosis and recommendations.

Asthma
Allergies
Arthritis
Bladder problems
Bronchitis
Chemotherapy
Chest pains
Circulation problems
Constipation
Colitis
Congestion
Cold hands or feet
Dizziness
Difficult concentration
Depression
Difficult breathing
Digestive problems
Diarrhea
Diabetes
Fatigue
Fainting
Gallbladder condition
Gastritis
Gas Pain
Hand numbness
Headache
Hearing difficulty
Heart defect
Heart disease
Heartburn
Hepatitis
High blood pressure
IBS
Irritability
Kidney disorder
Lower back pain
Low blood pressure
Memory problems
Menstrual problems
Migraines
Mid back pain
Neck pain or stiffness
Numbness
Pacemaker
Pneumonia
Ringing in ears
Radiating arm pain
Reproductive issues
Shingles
Sinus problems
Sore throat
Stiffness
Tension
Tuberculosis
Upset stomach
Ulcers
Vision Problems

Surgeries/Accidents:

Broken Bones:

Other medical disorders:

What does your current diet look like?

Give as much detail as possible, using the past 7 days as an example.

Breakfast:	Lunch:	Dinner:	Snacks:	Liquids:

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Current weight: _____ Weight 6 months ago: _____ One year ago: _____

Would you like for your weight to be different? Y / N If so, where would you want your weight to be?

What is your ancestry? _____ What is your blood type? _____

What role do sports and exercise play in your life?_____

What percentage of your food is fresh and home-cooked (not pre-packaged or from restaurants)? _____%

Where does the rest of your food come from? _____

Do you crave sugar, salt, coffee, cigarettes, alcohol, or have any major addictions? _____

At what point in your life did you feel at your best? _____

Consent to receive therapies:

First and foremost, it is our belief that it is each individual's inherent & inalienable human right to be able to take responsibility for their health and wellness. We also feel that the best care can be given when an integrative approach is pursued. With that in mind, we always recommend that if you are seeking better health and wellness by pursuing education on natural alternatives through our office, it is your responsibility to continue to utilize your Primary Care Physician for standard medical care. This is the most effective approach while you are choosing to maximize your wellness with natural supportive therapies that may improve your overall well-being and quality of life.

I understand that Carol Reese CTN, LMT, CBS, HHP and Justin E. Reese NMD, DTN, PHD, BCAMP is not licensed as a medical doctor, chiropractor, psychologist, or psychotherapist, and does not portray himself/herself as such. I understand that he/she will not diagnose, evaluate, treat, cure, mitigate any medical, psychological, or nutritional disease, disorder or condition. I further understand he/she will not advise me on any medical, emotional, or psychological treatment. I further understand that it is my responsibility to continue my medications as prescribed by my licensed medical doctor and remain under the care of my primary physician. I understand that he/she does not discourage me from any protocols medical doctors have prescribed. I am simply seeking wellness enhancing suggestions that could improve my health and wellness and help reduce my stress.

Credentials:

I understand that Justin E. Reese NMD, DTN, PHD, BCAMP is a Doctor of Natural Medicine, Doctor of Traditional Naturopathy, holds a PHD in Natural Medicine, and is a Board Certified Alternative Medical Practitioner. As such he is certified to work with alternatives like nutrition and homeopathic medicines, trained in biofeedback and Lower Level Laser therapy to reduce pain, stress, and to improve the quality of life and therefore my overall health and wellness. As a certified Homeopathic Therapeutic Consultant, he may recommend FDA registered homeopathic remedies that may help alleviate my concerns and improve my wellness.

I understand that Carol Reese BCTN, LMT, CBS, HHP is a Board Certified Traditional Naturopath, Licensed Massage Therapist in the states of New Mexico and Georgia, a Certified Biofeedback Specialist, and Holistic Health Practitioner. This means that Carol Reese may legally recommend FDA approved Homeopathic remedies, Nutritional Supplementation, and other dietary changes that could increase my health and wellness. She also has a license to identify and address soft tissue related issues related to massage therapy and soft tissue mobilization.

I, in sound mind and in good faith, understand that I am seeking a wellness consultation from this attending wellness consultant. I have solicited the attending practitioner's services in good faith, exercising my free will and following the dictates of my own conscience. I am fully aware and release the practitioner to run Biofeedback Stress Reduction Protocols. They have informed me that they are doing stress reduction protocols, relaxation techniques, pain management, as well as other wellness modalities within their scope of practice as trained in nutrition and homeopathics. I understand it is my responsibility to monitor the effects of biofeedback training and to continue the training as long as it is beneficial to me. I will tell me practitioner any time I detect discomfort during biofeedback training. I further understand that research suggests that while most people gain considerable benefit from biofeedback training, some individuals may not receive any benefit. I have every expectation that biofeedback will benefit me but I understand that there is no guarantee that I will.

If the undersigned is the custodial parent or legal guardian of a child and is seeking to have an EPFX Biofeedback session for said child, then said guardian hereby grants Carol Reese and/or Justin Reese express consent to give an EPFX Biofeedback session to said child and undertakes all above representations on behalf of said child. Said Custodial or legal guardian of child agrees to indemnify Carol Reese and Justin Reese, and hold him/her harmless from all damages and costs, including reasonable attorneys fees resulting from any abstinence of or defect in said custodial parent or legal guardianship relationship.

Arbitration:

I agree that in the event that Quantum Alternative Health, Inc. and I are unable to reach an amicable solution to any issues between us, we both agree to accept the decision of the attorney arbitrator of the Natural Therapies Arbitration Council and the final settlement of our differences. I understand that this service is provided through the Biofeedback Association of North America (800) 985-0819 at no cost to me. I further understand if the arbitrator finds against me, I will not be required to pay a penalty above whatever the amount the arbitrator finds equitable.

Client Warranty:

By signing below, I acknowledge that I have read and understand this document. I consent to receive therapies including Biofeedback Training from Quantum Alternative Health, Inc. I warrant I am not under any duress at this time and my consent is given voluntarily and without coercion. I further understand I may discontinue Biofeedback Training or any other therapies at any time and that I may refuse to participate in any particular therapy/training without penalty.

Missed Appointments:

Most patients require a minimum of two office visits to establish a comprehensive wellness plan. Regular follow-up appointments are important so that we can track your progress. If you are unable to make your scheduled appointment, we require 24 hours notice to change and/or cancel your appointment.

_____INITIAL HERE: If you are unable to provide 24-hours notice, there will be a $40 missed appointment fee charge to your account.

Health Care Authorization:

Every medical and non-medical doctor in the Unites States is required by law to have patients sign the following authorization form which protects the privacy of your personal health/medical records. This form is for your benefit. If you have any questions, please do not hesitate to ask the office manger.

_____ _____ / _____ / _____

Patient's Full Name Date of Birth

The patient identified above authorizes Quantum Alternative Health, Inc. to use and or disclose protected health information in accordance with the following:

Specific Authorizations

I give permission to Quantum Alternative Health Inc., to use my address, phone number and clinical records to contact me with appointment reminders and missed appointment notifications.

If Quantum Alternative Health, Inc. contacts me by phone at home, work, or on my cell phone, I give the office staff permission to leave a message on any answering machine or voicemail.

I give Quantum Alternative Health, Inc. permission to treat me in an open room where other patients may also be treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I ask to speak with a doctor at any time in private, the doctor will provide a room for these conversations at my request. I understand that I may choose treatment in a private room rather than in the open adjusting suite.

I give permission to Quantum Alternative Health, Inc. to speak to me about treatment or report of findings in front of my spouse or children if I choose to bring them to my appointments.

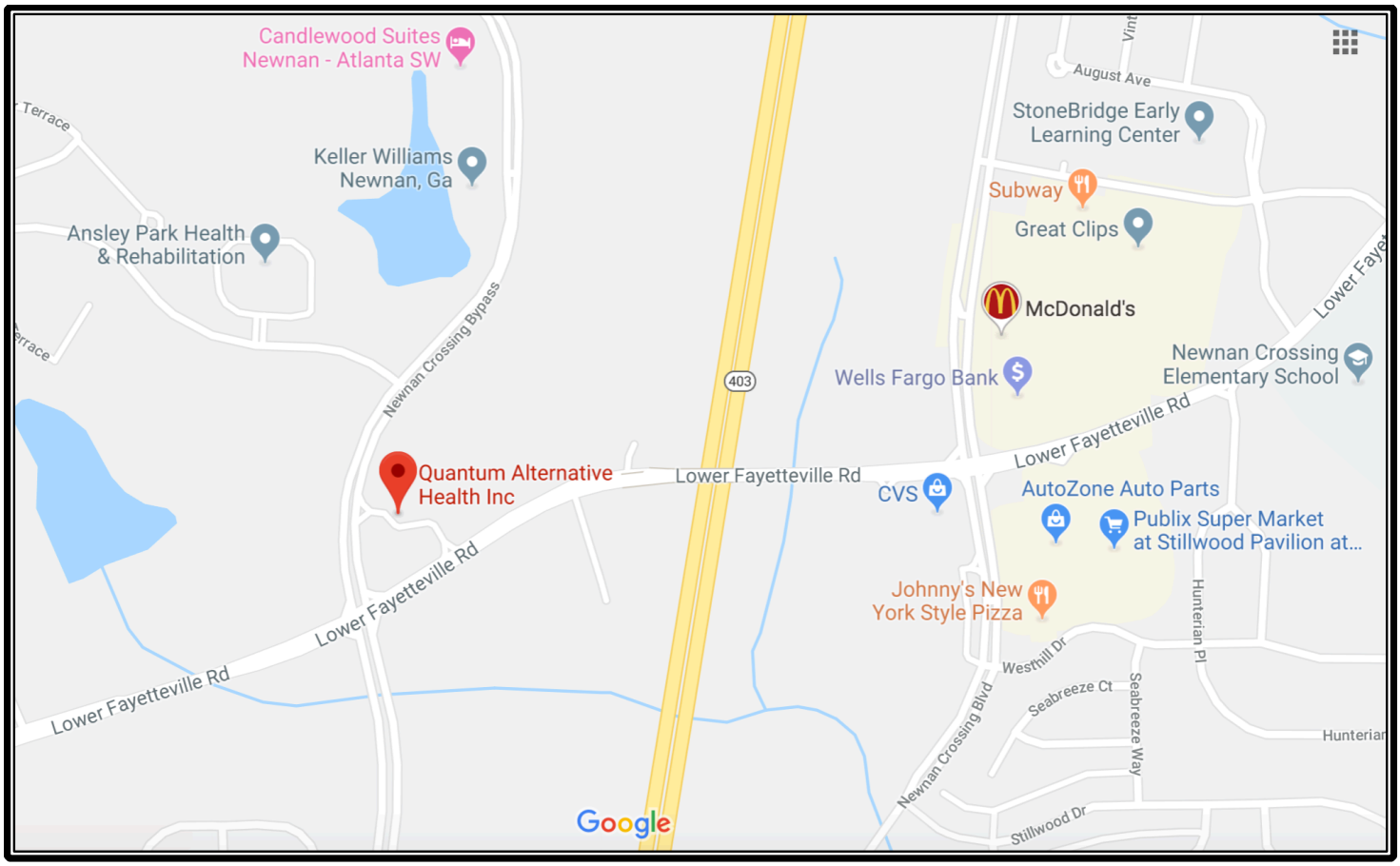
By signing this form, you are giving Quantum Alternative Health, Inc. permission to use and disclose your protected health information in accordance with the directives listed above.

_____

Patient Name (printed)

_____ _____ / _____ / _____

Patient Signature or Legal Guardian Signature Today's Date



Quantum Alternative Health, Inc.
802 Lower Fayetteville Rd.
Suite A
Newnan, GA 30265
(770) 755-6525