WELCOME TO INFINITY WELLNESS CENTER

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Dr. Tenesha Wards ❖ Dr. Amanda Massey ❖ Dr. Danny VanNoy

PERMISSION AND AUTHORIZATION FORM

I specifically authorize the natural health practitioner at Infinity Wellness Center to perform a neurological spinal exam and a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include spinal adjustments, acupuncture, dietary guidelines, and nutritional supplements in order to assist me in improving my health and not for the treatment or 'cure' of any diseases.

I understand the Nutritional Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalances in these areas could cause or contribute to various health problems.

I understand that the practitioner is not using a method for 'diagnosing' or 'treating' any disease and that no promise or guarantee has been made regarding the result of Nutritional Response Testing or any natural health, nutritional, or dietary programs recommended.

I understand that there are risks associated with chiropractic manipulations and myofascial release which may include fractures, strokes, bruising, muscular soreness, and ligamentous sprain. The ML 830 cold laser system is a Class IIIb laser that is contraindicated in areas of the body with aberrant sensation and analgesia. Class IIIb laser treatments are meant for optimizing the healing process of soft tissue injuries and are not to be used for any other condition.

Cancellation Policy: No fee is charged if 24 hour notice is given for a cancellation. We understand emergencies happen and give one grace for a missed appointment without 24 hour notice. There will be a $50 charge for a second missed appointment and a credit card will be needed on file to book a follow up appointment thereafter.

I also understand that Infinity Wellness Center does NOT bill insurance companies directly nor do they accept Medicare. Infinity Wellness Center does provide a Super Bill with diagnostic codes to submit for reimbursement.

I understand that entering my name on the signature line constitutes a legal signature confirming that I acknowledge and agree to the terms above. This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Signature: _____

(Signature of parent or guardian required for minors.)

What to Expect on Your First Few Visits

Visit #1 - The initial visit will take 40 minutes to an hour; thorough history and exam is taken and may include a neurological and kinesiology exam using nutrition response testing. We will take this information and determine if your case is a good fit for us. If it is, we will order any necessary lab testing and formulate a program designed on your exam findings.

Visit #2 - This is my favorite day; it will ideally be a week or two after your initial visit. This is when you will receive a Report of Findings (ROF), lab results and treatment plan that is specific to you. We will map out the meridian points, organ systems, and spinal levels that need to be addressed and corrected.

If you agree with the treatment plan and choose to accept care, we will start your treatment this day.

Treatments will include one or a combination of the following techniques:

- Nutritional Response Testing (determining which supplements are best for you)
- Acupuncture or Acupressure
- Chiropractic
- Neuro-Emotional Technique (NET)
- Webster Technique/Prenatal Care
- Cold Laser
- Myofascial Release
- Cranial Sacral Therapy
- Flexion Distraction

Subsequent Visits will entail a combination of the above treatments. Treatments are determined by what your body needs to keep moving forward in the healing process.

HIPAA PRIVACY DISCLOSURE CONSENT

Privacy of your personal information is an important part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Uses and Disclosures

1. Your doctor or a staff member may have to disclose your health information up to and including all of your clinical records to another health care provider if it is necessary to refer you to them for treatment of your health condition.
2. It may be necessary for the doctor and members of the staff to use your health information, examination, and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
3. Your doctor and members of the practice staff may need to use your information (ex. name, address, email, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. Appointment reminders will be sent by email to the email address you provided to us or by calling the phone number provided and leaving a message on your voicemail if there is no answer.
4. As our patient, you possess the right to refuse to give us the authority to contact you regarding the above-mentioned circumstances.

Your Right to Limit Uses or Disclosures

1. You have the right to request that this office restricts how your personal information is used and/or disclosed.
2. If there are health care providers, hospitals, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information.
3. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restrictions would have to be in writing and the restrictions will be binding on this office.

Your Right to Revoke Your Authorization

1. You have the right to revoke your consent at any time as long as we have a written statement. This revocation will not apply to any action already taken by the office before receiving the formal written notice.

I have read and understand the above notice. I understand that entering my name on the signature line constitutes a legal signature confirming that I acknowledge and agree to the terms above.

_____ _____

Name of patient/guardian Signature of patient/guardian

_____

Date

NEW CLIENT EVALUATION

INFINITY WELLNESS CENTER

Today's Date: _____ How did you hear about us? _____

Name: _____ M ○ F ○ Birthdate: ____/____/____ Age: _____

Mailing Address: _____

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

Marital Status: S ○ M ○ D ○ W ○ Weight: _____ Height: _____ No. of Children: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Blood Type: _____

Complaints: Please tell us the main reason why you are here. _____

_____

_____

Secondary Complaints: Please let us know any other health concerns. _____

_____

_____

Previous Treatment for these Complaints: _____

_____

_____

Major Illnesses: _____

_____

Surgeries: _____

_____

Injuries: _____

_____

NEW CLIENT EVALUATION

INFINITY WELLNESS CENTER

WOMEN ONLY

Are you pregnant? Yes ☐ No ☐ Are you nursing? Yes ☐ No ☐

Date of onset of last menstrual cycle: _____

Any gynecologic surgeries (ie. hysterectomy, endometriosis, ovarian cysts)? _____

_____

Menstrual Cycle Do you have regular monthly periods? _____

Select any of the following symptoms you experience associated with your period:

Cramping☐ Bloating☐ Moody☐ Cravings☐ Heavy Bleeding☐ Back Pain☐ Headaches☐ Clots☐

Sleep - please select: Trouble Falling Asleep☐ Can't Stay Asleep☐ Bad Dreams☐ Night Sweats☐

Any other sleep problems? _____

Pets: Any pets? Y☐N☐If so, what kind and how many? _____

Exercise: What kind of exercise do you do? _____

How often? _____ Duration: _____

Allergies List (Including Food) _____

_____

Food Cravings: Please mark an answer for each of the questions below about food cravings, regardless of whether or not you let yourself eat these foods.

If you could have any breakfast that you wanted, which would you choose?

- ○ *Poached eggs with hollandaise sauce*
- ○ *Bacon and eggs*
- ○ *Granola and yogurt*
- ○ *Toast and oatmeal and coffee or tea*

If you could have any lunch you wanted, which would you choose?

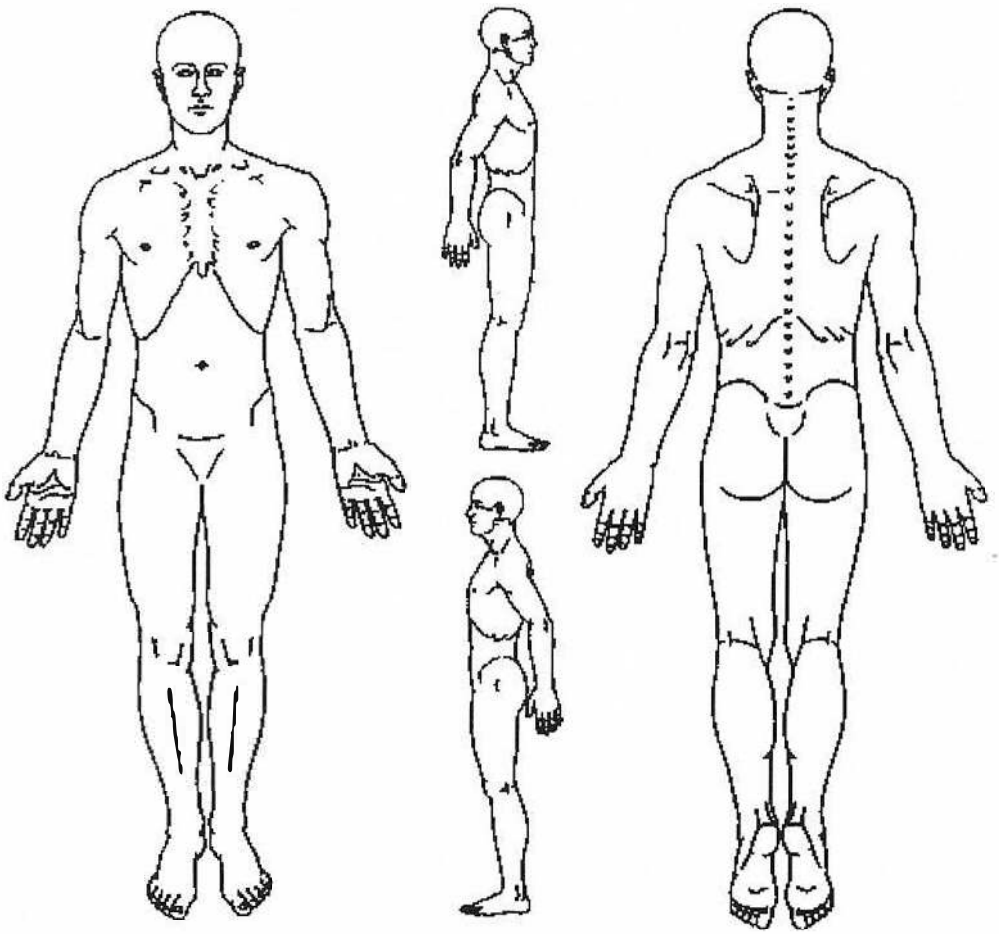
- ○ *Barbecued ribs or teriyaki and chips*
- ○ *Hamburger and French fries*
- ○ *A cheese sandwich and/or a milkshake*
- ○ *A sandwich, pretzels, and a soda or coffee*

If you could have any dinner you wanted, which would you choose?

- ○ *Thai food*
- ○ *A nice steak*
- ○ *Pizza*
- ○ *Pasta with sauce*

TRAUMA HISTORY

INFINITY WELLNESS CENTER



For online form, please type information into the appropriate area.

↯	**Scars**	Please note areas where you have scars, even if they are very old or difficult to see. Don't forget C-sections, episiotomies, vaccination scars, surgeries, body piercings, tattoos, cosmetic surgeries, vasectomies, stretch marks, etc. Please note the approximate age you were when you got each scar.
○	**Surgery**	Please note the location of any surgeries, including exploratory surgeries, laparoscopies etc. Please write the year of the surgery on the drawing.
□	**Internal Metal**	Please note areas where there are any internal metal objects, such as surgical pins, metal plates, hip replacements etc.

Name:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a Clinical Purification™ program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Note the corresponding number for questions16a-16f below and enter the total.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

Total: _____

17. Note the corresponding number for questions 17a-17b below and enter the total.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no, noting the corresponding number for questions 18a-18d and enter the total.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a Clinical Purification™ program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.