



Ozark Herbalist, LLC

608 E. South Street, Ozark, Mo 65721 (417)581-HERB(4372)

PERSONAL

INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____ Date Of Birth _____ Age _____

Height _____ Weight (Now) _____ Weight (1 Year Ago) _____ Weight (5 Years Ago) _____

Occupation _____ Employer _____

Name Of Spouse _____ Spouse's Occupation _____

Referred By _____

CURRENT HEALTH CONDITION

Purpose Of This Appointment:

Today's Condition Started When? _____

What Activities Aggravate Your Condition? _____

What Activities Lessen Your Condition? _____

Other Doctors Seen For This Condition _____

When? _____

Type Of Treatment _____ Results _____

Health Habits

Alcohol: Type _____
Amount _____
Frequency _____

Smoking: Packs daily _____
How long _____
Interested in stopping? _____

Water consumption
_____glasses/day

Caffeine: Coffee/tea,
Cups/daily _____

Carbonated drinks: _____cans/day
Favorite drink _____

Mixed food diet (animal & plant)

Vegan

Vegetarian

Lactose intolerant

Gluten intolerant

Egg/Albumen allergy

Corn/Soy intolerance

Special diet _____

Favorite snack _____

Sleep:

Difficulty falling asleep

Continuity disturbances

Early morning awakenings

Daytime drowsiness

Exercise

Regularly _____x/wk

Over 30 min per session

Walk, run, aerobics

Weight training

Other _____

Nutrition & Diet Habits:

Diet: **Salt** intake _____

Fat intake _____

Sugar intake _____

Eating Habits:

Skip meals

No breakfast

Two meals/day

One meal/day

Three meals/day

Eat for comfort

I like to snack

Do you use artificial sweeteners? If so, which ones:

- Aspartame (NutraSweet, Equal)
- Saccharin (Sweet N Low, Sugar Twin)
- Acesulfame (Sunett, Sweet One)
- Sucralose (Splenda)

Do you use any sugar substitutes?

Agave ___ Honey ___ Truvia ___

CURRENT PRESCRIPTION MEDICATIONS:

HERBS, VITAMINS, MINERALS, FOOD AND DIETARY SUPPLEMENTS:

DRUG or FOOD ALLERGIES

MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Ringing In Your Ears | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Adult Ear Infections | <input type="checkbox"/> Loss Of Bladder Control | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Decrease In Force/Flow | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Failing Vision | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Adult Eye Infections | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Significant Childhood Diseases |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Urethral Discharge | |
| <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Chronic Fatigue | |
| <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Weight Loss ____# | <i>Females Only</i> |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Weight Gain ____# | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Planning Pregnancy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Menstrual Flow |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Regular |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Irregular |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Heavy |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Days Of Flow_____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tremors | <input type="checkbox"/> Length Of Cycle_____ |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> 1 st Day Of Last Period |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Hands Shaking | _____ |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Pain/Bleeding During Or After |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Numbness | Sex |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tingling Sensations | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Loss Of Appetite | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Persistent Hunger | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Difficult Swallowing | <input type="checkbox"/> Muscle Pain | |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Osteoporosis | <i>Number Of:</i> |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Back Pain | Pregnancies ____ Abortions ____ |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bone Fracture | Miscarriages ____ Live Births ____ |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Joint Injury | <input type="checkbox"/> Birth Control Method |
| <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Gout | _____ |
| <input type="checkbox"/> Yellow Skin | <input type="checkbox"/> Foot Pain | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cold Numb Toes | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Change In Bowel Habits | <input type="checkbox"/> Rashes/Hives | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Psoriasis/Eczema | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abnormal PAP |
| <input type="checkbox"/> Bloody Or Black Stools | <input type="checkbox"/> Phobias | <input type="checkbox"/> Abnormal Breast Exam |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Depression | <input type="checkbox"/> Surgical Menopause |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Freq. Urine Infections | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Blood In Urine | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Overnight Urination | <input type="checkbox"/> Prostate Problems | |

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

Please Give The Following Information About Your Immediate Family:

Have Any Blood Relatives Had The Following Illnesses? If So, Please Indicate Relationship:

Relationship	Age If Living	Age At Death	State Of Health Or Cause Of Death	Illness	Family Member
Father				Diabetes	
Mother				Cancer	
Brothers And Sisters				Blood Disease Glaucoma Epilepsy	
Spouse				Rheumatoid Arthritis	
Children				Tuberculosis Gout High Blood Pressure Heart Disease Back Problems	

SIGNIFICANT LIFE EVENTS:

Please list appropriate dates and describe the nature of any traumatic experiences you have had in the past 7 years. (divorce, injury, loss of job, change of residence, death of a loved one, etc.)

Please use this space to add any other information about yourself that you think would be helpful:

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the visit. I also agree to the \$20 returned check charge in the event that my check is returned. In the case of credit card payment, arbitration of the balance due will be negotiated at the time of charge. Accounts payable in excess of 60 days will be surrendered to Collections. Any outstanding balance must have proportional payments monthly.

CONSENT, DISCLOSURE, AND DISCLAIMER

I request that **Ozark Herbalist, LLC**, perform a Health Evaluation and/or BioCommunication assessment and recommend a program for the purpose of improving my health and well-being. I understand that this assessment and/or therapies are not intended as diagnosis, prescription, treatment or cures for any specific disease, physical or mental. It is not intended as a substitute for regular medical care.

NINTH AMENDMENT DECLARATION

Under the Ninth Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care. This includes the right to choose my diet, and to obtain, purchase and use any therapy recommended by the therapist, doctor, or any practitioner of my choice.

CONSTRUCTIVE NOTICE

Notice is hereby given to any person who receives a copy of this Declaration and who, acting under the color of the law, intentionally interferes with the free exercise of the rights retained by me under the Ninth Amendment, as enumerated in this declaration, that they be in violation of my civil and constitutional rights. Title 42, U.S.C. 1983 et seq. and Title 18, Section 241

ALL INFORMATION ABIDES BY THE **FEDERAL HIPAA** (privacy and confidentiality) REGULATIONS. IF YOU WISH US TO ALLOW ANY OTHER PERSON(S) TO **ACCESS YOUR HEALTH INFORMATION** or **PICK UP SUPPLEMENTS**, PLEASE LIST THEIR NAMES BELOW:

Signature _____ Date _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** _____ (Date)
(Or Patient Representative) _____ (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** _____ (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE