

**FAX / EMAIL YOUR INTAKE FORMS AHEAD OF TIME FOR BETTER INDIVIDUAL CARE**

**ADULT INTAKE FORM**

**PATIENT INFORMATION**

Please note that all the information that you provide will be held absolutely confidential.

Today's Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Care Card Number (PHN): \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth (M/D/Y): \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone # (home): \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Email address: \_\_\_\_\_

Do you wish to receive our seasonal e-newsletter? Y  N

Can Dr. Zurekova contact you via email regarding your care? Y  N

How did you hear about this clinic? \_\_\_\_\_

If you were referred, please indicate whom we may thank: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Emergency contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you see a medical doctor? Y  N

Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Other types of health care: (ie. Chiropractor, massage therapy, physiotherapist) \_\_\_\_\_

Do you have extended coverage Y  N

Do you receive MSP premium assistance Y  N

What are your main health concerns? List as many as you can in order of importance.

1) \_\_\_\_\_ When did this start? \_\_\_\_\_

2) \_\_\_\_\_ When did this start? \_\_\_\_\_

3) \_\_\_\_\_ When did this start? \_\_\_\_\_

4) \_\_\_\_\_ When did this start? \_\_\_\_\_

**CONTEXT OF CARE QUESTIONNAIRE**

*Why did you choose to come to this clinic?*

*What do you know about our approach?*

*What expectations do you have for **this visit** to our clinic?*

*What **long-term** expectations do you have from working with our clinic?*

*What is your **present level of commitment** to address any underlying causes of your health concerns?*

0%    10    20    30    40    50    60    70    80    90    100%

*What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?*

## HEALTH HISTORY INFORMATION

### FAMILY HISTORY

Does anyone in your family have a history of any of the following? Note maternal (M) or paternal (P) side of the family

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> M <input type="checkbox"/> P Cancer              | <input type="checkbox"/> M <input type="checkbox"/> P Arthritis        | <input type="checkbox"/> M <input type="checkbox"/> P Asthma                |
| <input type="checkbox"/> M <input type="checkbox"/> P Diabetes            | <input type="checkbox"/> M <input type="checkbox"/> P Kidney disease   | <input type="checkbox"/> M <input type="checkbox"/> P Epilepsy              |
| <input type="checkbox"/> M <input type="checkbox"/> P Heart disease       | <input type="checkbox"/> M <input type="checkbox"/> P Liver disease    | <input type="checkbox"/> M <input type="checkbox"/> P Anxiety/Depression    |
| <input type="checkbox"/> M <input type="checkbox"/> P High blood pressure | <input type="checkbox"/> M <input type="checkbox"/> P Anemia           | <input type="checkbox"/> M <input type="checkbox"/> P Eating Disorder       |
| <input type="checkbox"/> M <input type="checkbox"/> P Stroke              | <input type="checkbox"/> M <input type="checkbox"/> P Autoimmune       | <input type="checkbox"/> M <input type="checkbox"/> P Addiction             |
| <input type="checkbox"/> M <input type="checkbox"/> P Glaucoma            | <input type="checkbox"/> M <input type="checkbox"/> P Thyroid disease  | <input type="checkbox"/> M <input type="checkbox"/> P Neurological disorder |
| <input type="checkbox"/> M <input type="checkbox"/> P Osteoporosis        | <input type="checkbox"/> M <input type="checkbox"/> P Allergies/ Hives | <input type="checkbox"/> M <input type="checkbox"/> P Skin disorder         |

Other relevant family history? \_\_\_\_\_

Family Heritage: \_\_\_\_\_

### PAST MEDICAL HISTORY

Please check if you had any of the following as a child:

- |  |                                     |  |   |
|--|-------------------------------------|--|---|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Mumps      | <input type="checkbox"/> Chicken pox   | Other: _____                            |

### VACCINATIONS

Have you received all scheduled vaccinations? Y  N

If no, please specify which you have had:

- |                                       |  |                                      |                                     |
|---------------------------------------|--|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Polio        | <input type="checkbox"/> MMR (Measles/Mumps/Rubella) | <input type="checkbox"/> Pertussis   | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Tetanus Shot | <input type="checkbox"/> Hepatitis A                 | <input type="checkbox"/> Hepatitis B | Other: _____                        |

### HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, significant trauma, diagnostic testing (X-ray, CAT scan, MRI, EEG, EKG, etc...) have you had?

_____ year _____	_____ year _____
_____ year _____	_____ year _____
_____ year _____	_____ year _____

Major accidents/trauma (fall, motor vehicle accident, loss of loved one, etc.)

### CURRENT MEDICAL INFORMATION

Do you have any known contagious diseases at this time? Y  N  If yes, what? \_\_\_\_\_

### ALLERGIES/SENSITIVITIES

Any medication/drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental, chemical or other? \_\_\_\_\_

**CURRENT MEDICATIONS OR SUPPLEMENTS** Please list any prescription medications, over the counter medications, or supplements (vitamins, minerals, herbal formulas, homeopathics, ...) you are taking.

- 1) \_\_\_\_\_ dose: \_\_\_\_\_ start date: \_\_\_\_\_
- 2) \_\_\_\_\_ dose: \_\_\_\_\_ start date: \_\_\_\_\_
- 3) \_\_\_\_\_ dose: \_\_\_\_\_ start date: \_\_\_\_\_
- 4) \_\_\_\_\_ dose: \_\_\_\_\_ start date: \_\_\_\_\_
- 5) \_\_\_\_\_ dose: \_\_\_\_\_ start date: \_\_\_\_\_

## GENERAL HEALTH HISTORY

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_

Energy level 1-10: \_\_\_\_\_ When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

Level of stress: 1-10 \_\_\_\_\_ Main cause? \_\_\_\_\_

Main interests and hobbies: \_\_\_\_\_

Exercise: Y  N  If so, what kind and how often: \_\_\_\_\_

## TYPICAL FOOD INTAKE

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

Are you or have you ever been on a restricted diet? If so, what kind? \_\_\_\_\_

Alcohol consumption:  None  Once a month  Once a week  Every day  Multiple times a dayCaffeine consumption:  None  Once a month  Once a week  Every day  Multiple times a day

## PLEASE CHECK IF THE FOLLOWING IS A CURRENT OR RECURRING SYMPTOM:

### GENERAL

Hours of sleep? \_\_\_\_\_ Awake rested? Y  N  Spend time outside? Y  N I sleep primarily on: Do you eat out often? Y  N my back  my side  my stomach  Cravings? Y  N Have supportive relationship? Y  N  Do you eat refined sugar? Y  N Treated for addiction/dependence? Y  N  Do you add salt to your food? Y  N Use tobacco currently or in past? Y  N  Toxic exposure (at home or work)? Y  N Do you enjoy your work? Y  N  How many root canals do you have? \_\_\_\_\_Take vacations? Y  N 

### IMMUNE

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Reactions to immunizations | <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Chills            |
| <input type="checkbox"/> Chronically swollen glands | <input type="checkbox"/> Night sweats             | <input type="checkbox"/> Fever             |
| <input type="checkbox"/> Slow wound healing         | <input type="checkbox"/> Chronic infections       | <input type="checkbox"/> Frequent cold/flu |

### SKIN/HAIR

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Rashes                       | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Perpetual hair loss |
| <input type="checkbox"/> Acne/boils                   | <input type="checkbox"/> Hives/Itching | <input type="checkbox"/> Dandruff            |
| <input type="checkbox"/> Change in skin color/texture | <input type="checkbox"/> Recent moles  | <input type="checkbox"/> Sweat easily        |

### HEAD, EYES, EARS, NOSE, THROAT

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Recent change in vision      | <input type="checkbox"/> Headaches/migraines       | <input type="checkbox"/> Pain or stiffness in neck |
| <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Head injury               | <input type="checkbox"/> Frequent sore throat      |
| <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Jaw or TMJ problems       | <input type="checkbox"/> Sores on tongue or lips   |
| <input type="checkbox"/> Spots in vision              | <input type="checkbox"/> Sinus problems/congestion | <input type="checkbox"/> Hoarseness                |
| <input type="checkbox"/> Redness or itching of eyes   | <input type="checkbox"/> Nose bleeds               | <input type="checkbox"/> Teeth grinding            |
| <input type="checkbox"/> Eye pain, tearing or dryness | <input type="checkbox"/> Hay fever                 | <input type="checkbox"/> Gum problems              |
| <input type="checkbox"/> Loss of hearing              | <input type="checkbox"/> Loss of smell             | <input type="checkbox"/> Dental cavities           |
| <input type="checkbox"/> Ringing in ears              | <input type="checkbox"/> Lumps in neck             | <input type="checkbox"/> Facial pain               |
| <input type="checkbox"/> Ear infection/pain           | <input type="checkbox"/> Difficulty swallowing     | <input type="checkbox"/> Loss of sense of taste    |

### RESPIRATORY

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Cough <input type="checkbox"/> Phlegm (Colour?) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Emphysema    |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Pain in breathing   | <input type="checkbox"/> Bronchitis   |
| <input type="checkbox"/> Wheezing  | <input type="checkbox"/> Coughing up blood   | <input type="checkbox"/> Tuberculosis |

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## HEART AND CIRCULATION

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Irregular heart beat       | <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Varicose veins             |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> Blood clots/thrombosis/DVT |
| <input type="checkbox"/> Dizziness/Fainting         | <input type="checkbox"/> Deep leg pain             | <input type="checkbox"/> Swelling of extremities    |
| <input type="checkbox"/> Chest pain                 |  |   |

## ENDOCRINE

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hypothyroid                | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Hypoglycemia               | <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Difficulty exercising |
| <input type="checkbox"/> Excessive hunger or thirst | <input type="checkbox"/> Hyperthyroid             | <input type="checkbox"/> Goiter                |

## DIGESTION AND ELIMINATION

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Change in appetite/thirst     | <input type="checkbox"/> Heartburn                | Bowel movement frequency: _____   |
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Abdominal pain or cramps | Is this a change? Y <input type="checkbox"/> N <input type="checkbox"/> |
| <input type="checkbox"/> Nausea/vomiting               | <input type="checkbox"/> Belching or passing gas  | <input type="checkbox"/> Black stools                                   |
| <input type="checkbox"/> Ulcer                         | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Blood in stools                                |
| <input type="checkbox"/> Gall bladder or Liver disease | <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Hemorrhoids                                    |
| <input type="checkbox"/> Pancreatitis                  | <input type="checkbox"/> Chronic laxative use     | <input type="checkbox"/> Rectal pain                                    |

## GENITO-URINARY

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Frequent or urgent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Sores on genitals                             |
| <input type="checkbox"/> Inability to hold urine      | <input type="checkbox"/> Frequent UTI's | <input type="checkbox"/> Sexually transmitted disease:<br>Which: _____ |
| <input type="checkbox"/> Painful urination            | <input type="checkbox"/> Kidney stones  |  |

## FEMALE REPRODUCTIVE

- |  |  |  |
|--|--|--|
| Age of first menses: _____   | <input type="checkbox"/> Bleeding between cycles                               | <input type="checkbox"/> Difficulty conceiving   |
| Length of cycle: _____ days  | <input type="checkbox"/> Endometriosis   | How long? _____  |
| Duration of menses: _____ days   | <input type="checkbox"/> Ovarian cysts   | Number of pregnancies: _____   |
| Date of last menses: _____   | <input type="checkbox"/> Fibroids  | Number of live births: _____   |
| Are your cycles regular? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Vaginal discharge/odor                                | Number of miscarriages: _____  |
| <input type="checkbox"/> Painful menses  | Date of last papsmear: _____   | Number of abortions: _____   |
| <input type="checkbox"/> Heavy or excessive flow                               | <input type="checkbox"/> Abnormal PAP  | Do you perform monthly self-breast<br>exams? <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Clots   | <input type="checkbox"/> Cervical dysplasia                                    | <input type="checkbox"/> Breast pain/tenderness  |
| <input type="checkbox"/> PMS   | Are you sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Breast lumps/nipple discharge   |
| Symptoms: _____  | Birth control? <input type="checkbox"/> Y <input type="checkbox"/> N           | <input type="checkbox"/> Menopausal symptoms? _____  |
| _____  | Type: _____  | _____  |
| _____  | How long: _____  | _____  |
|  | <input type="checkbox"/> Pain during intercourse                               | _____  |
|  | <input type="checkbox"/> Libido level 1-10: _____                              | _____  |

## MALE REPRODUCTIVE

- |  |  |   |
|--|--|---|
| Are you sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Hernias                   | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Discharge or sores                                    | <input type="checkbox"/> Testicular masses or pain | <input type="checkbox"/> Impotence        |

## MENTAL/EMOTIONAL

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Treated for emotional problem | <input type="checkbox"/> Easily stressed         | <input type="checkbox"/> Attempted suicide   |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Quick temper/irritable  | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Anxiety or nervousness        | <input type="checkbox"/> Do you have mood swings | <input type="checkbox"/> Memory problems     |
| <input type="checkbox"/> Poor concentration            | <input type="checkbox"/> Considered suicide      | <input type="checkbox"/> Seasonal depression |

## NEUROLOGICAL

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Seizures        | <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Loss of balance/coordination |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Paralysis            | <input type="checkbox"/> Nerve pain/Sciatica          |
| <input type="checkbox"/> Loss of memory  | <input type="checkbox"/> Numbness or tingling |   |

## MUSCULOSKELETAL

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Joint pain or stiffness | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Muscle spasms or cramps |
| Indicate which areas: _____                      | <input type="checkbox"/> Bone pain       | Indicate which areas: _____                      |
| _____  | <input type="checkbox"/> Muscle weakness | _____  |
| _____  |  | _____  |

## ACUPUNCTURE INTAKE FORM

**SYMPTOMS – \*\*NOTE\*\*:** For each symptom you currently have, rate its severity from 1- 5  
(5 being the worst). LEAVE BLANK IF NOT APPLICABLE.

### LIVER / GALLBLADDER

Irritability / Anger  
 Depression / Stress  
 Headaches / Migraines  
 Visual Problems  
 Red / Dry / Itchy Eyes  
 Gall Stones  
 Dizziness  
 Blurred Vision  
 Feeling of Lump in Throat  
 Clenching of Teeth at Night  
 Muscle Cramping / Twitching  
 Tension  
 Joints/Neck/Shoulder  
 Pain/Tight  
 Poor Circulation  
 Soft / Brittle Nails  
 Emotional Eater

### KIDNEY / URINARY BLADDER

Urinary Problems  
 Bladder Infection  
 Lack of Bladder Control  
 Weakness / Pain in Lower  
 Back  
 Decrease Bone Density  
 Feel Cold Easily  
 Low Sex Drive  
 Excess Sexual Desire  
 Poor Memory  
 Loss of Hair  
 Hearing Problems  
 Cavities  
 Craving / Avoiding Salty Foods  
 Fear  
 Hot Flush / Night Sweating

### HEART / SMALL INTESTINES

Heart Palpitations  
 Chest Pain  
 Insomnia / Sleep Problems  
 Easily Startled  
 Restlessness / Agitation  
 Vivid Dreams  
 Lack of Joy in Life

### LUNG / LARGE INTESTINE

Dry Cough  
 Cough with Sputum  
 Nasal Discharge  
 Post-Nasal Drip  
 Sinus Infection / Congestion  
 Itchy, Red or Painful Throat  
 Dry Mouth / Throat / Nose  
 Skin Rashes / Hives  
 Snoring  
 Grief / Sadness  
 Shortness of Breath  
 Allergies / Asthma  
 Low Resistance to Colds or  
 Flu  
 Sneezing  
 Mild Fever Comes & Goes  
 Smoke Cigarettes

### BODY TEMPERATURE

Please check all that apply:

Cold entire body  
 Cold extremities  
 Hot all day  
 Hot only in afternoon  
 Hot only at night  
 Normal

### SPLEEN / STOMACH

Heaviness Anywhere in Body  
 Fatigue / Worse After Eating  
 Hard to Get Up in the Morning  
 Edema (Swelling)  
 Muscles Feel Tired Often  
 Easily Bruising & Bleeding  
 Bad Breath  
 Decreased / Increased Appetite  
 Crave Sweets  
 Hypoglycemia  
 Difficulty Digesting Oily Foods  
 Nausea / Vomiting  
 Gas / Belching  
 Insulin Sensitivity  
 Hemorrhoids  
 Constipation  
 Diarrhea  
 Abdominal Pain  
 Indigestion / Heartburn  
 Over-Thinking  
 Tendency to Gain Weight  
 Brain Foggy

**ENERGY LEVEL – Please circle:**

Low 1 2 3 4 5 6 7 8 9 10 High

Thank you & Welcome! Looking forward to working with you on your path to better health!

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## INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE & ACUPUNCTURE

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I, \_\_\_\_\_, hereby request and consent to examination and treatment by Helena Zurekova, ND, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

**I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Zurekova, and/or with the allied health care provider, providing backup:**

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done

**I understand that a Naturopathic evaluation and treatment may include, but are not limited to:**

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including pap smears, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including naturopathic/osseous manipulation of the spine and extremities)
- Dietary advice and therapeutic nutrition (including food, nutritional supplements, or intravenous injection of nutrients)
- Traditional Oriental medicine- including acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface), moxa and cupping.
- Botanical/ herbal medicines
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Lifestyle counseling (including but not limited to visualization for improved lifestyle strategies)
- Bowen therapy (gentle physical therapy)
- Prescribed medication (which are within the naturopathic scope of practice in BC)
- Intravenous/Chelation/Intramuscular therapy which may include Vitamins, Minerals, Antioxidants, Amino Acids, Chelating agents, etc)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat, hydrotherapies; allergic reaction to prescribed herbs, supplements and medications; soft tissue or bony injury from physical manipulation; aggravation of pre-existing symptoms; pain at the injection site, fainting, fatigue, muscle cramps, nerve/tendon/ligament damage, lowering of blood sugar (hypoglycemia), mineral loss, and flu-like symptoms - And very rare risks: shock, infection, inflammation of the vein used for injection, phlebitis, circulatory overload, severe allergic reaction, anaphylaxis, cardiac arrest, kidney problems, liver problems Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief or pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace makers, and/or cancer: For your safety it is vital to alert your provider, Helena Zurekova, ND, of these conditions.

I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs and supplements. I understand the information provided on this form and agree to the foregoing, and authorize and consent to the performance of the procedures.

# DR. HELENA ZUREKOVA, ND

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I do not expect Helena Zurekova, ND and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Zurekova explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

\*I understand that I require to provide 24 hr notice for cancelling my appointment, otherwise I will be charged \$50 for late cancellation and full visit fee for missing my appointment (without prior notice).

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date