



DUGGARWELLNESS
Functional Medicine & Transformational Nutrition

New Patient Intake Packet

Intake Packet Instructions

Please read these instructions carefully

1. This form must be printed and filled out manually or by using a PDF program like Adobe. Do NOT fill this out in your web browser.
2. Please give yourself enough time to fill this packet out completely. It is very comprehensive and may take an hour or more.
3. Take your time telling your story. The more we know, the better we can help.
4. If you are not sure how to answer, leave a question mark next to the question.
5. When you are done, please scan and email this form back to our office 24 hours prior to your initial appointment with Dr. Duggar. Emails can be sent to info@duggarwellness.com

Demographic Information

Date: _____

Name _____
First Middle Last

Preferred Name _____

Date of Birth _____ Place of Birth _____

Age _____ Gender Male Female

Primary Address _____

Primary Phone _____ Secondary Phone _____
Cell, Home, Work (circle) Cell, Home, Work (circle)

Email Address _____

Emergency Contact _____
Name Relation Phone number

Primary Care Doctor _____
Name Phone FAX

Marital Status Single Married Divorced Widow(er) Partnership

Genetic Background African European Native American Mediterranean
 Asian Ashkenazi Middle Eastern Caucasian
 Other: _____

Highest Education level High School Under-Graduate Post Graduate

Occupation _____ Hours per week _____

Nature of Business _____

How did you learn about our office? _____

Have you attended a presentation by Dr. Duggar or Tammie? Yes No

Have you signed up for any free programs on our website? Yes No

Are you already receiving our practice email newsletters? Yes No

Establishing Your Health and Wellness Goals

After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated or distracted and failed in their attempt to get well. After careful review, I have discovered several reasons why some people succeed and why others fail. The most important determining factors are a clear and powerful desire to improve and specific goals and action steps to accomplish those goals. When you have decided to change and you know your reasons, you create an internal power that can propel you past perceived obstacles to achieving health and wellness.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve by seeking care in our office? _____

If you could permanently eliminate three health problems, what would they be?

1. _____
2. _____
3. _____

What activities have you been unable to do due to your present symptoms? _____

When was the last time you remember feeling well? _____

On a scale of: 5 (very willing) to 1 (not willing), how willing are you to:

	5	4	3	2	1
Significantly change your diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take nutritional supplements daily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keep a record of everything you eat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Modify your lifestyle (e.g. work demands, sleep habits)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Practice relaxation techniques	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Engage in regular exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have periodic lab tests to assess progress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are there any specific obstacles that you foresee that would stand in your way of making lifestyle changes that will favor healing? _____

Current Health Concerns

Please provide us with current and ongoing problems

SYMPTOM	DATE OF ONSET	SEVERITY/FREQUENCY	TREATMENT	RESULTS
EX: Headaches	May 2016	2 x per week	Ibuprofen	No improvement

What diagnoses or explanations have you received for any of these issues? _____

What treatments/providers have you seen/tried for your conditions?

- Western medicine Chiropractic Massage Yoga Acupuncture
- Nutritional therapy Homeopathy Reiki Iridology Biofeedback
- Chinese medicine Essential Oils Colonics Foot Zone Physical Therapy

Have you lost time from work or school in the past year due to these conditions? _____

What treatments have improved your health? _____

What treatments have worsened your health? _____

What do you consider a realistic window of time to see changes in your health under our care? _____

What are you looking for in a healthcare practitioner? _____

Medical History

Diseases/Diagnosis/Conditions – Check all appropriate boxes and provide dates of onset (mm/yyyy)

Past	Now	Gastrointestinal System
		Irritable Bowel Syndrome
		Inflammatory Bowel Disease
		Crohn's
		Ulcerative Colitis
		Gastritis or Peptic Ulcer Disease
		GERD (reflux)
		Celiac Disease
		Gallstones
		Other

Past	Now	Cancer
		Lung Cancer
		Breast Cancer
		Colon Cancer
		Ovarian Cancer
		Prostate Cancer
		Skin Cancer
		Brain Cancer
		Lymphoma
		Other

Past	Now	Cardiovascular System
		Heart Attack
		Heart Disease
		Stroke
		Elevated Cholesterol
		Arrhythmia (irregular heartbeat)
		Hypertension (high blood pressure)
		Rheumatic Fever
		Mitral Valve Prolapse
		Other

Past	Now	Genital & Urinary System
		Kidney Stones
		Gout
		Interstitial Cystitis
		Frequent Urinary Tract Infections
		Frequent Yeast Infections
		Erectile Dysfunction/ Sexual Dysfunction
		Other

Past	Now	Metabolic/Endocrine System
		Type 1 Diabetes
		Type 2 Diabetes
		Hypoglycemia
		Insulin Resistance/Pre-Diabetes
		Hypothyroid (Low thyroid)
		Hyperthyroid (Overactive thyroid)
		Polycystic Ovary Syndrome (PCOS)
		Infertility
		Weight Gain
		Weight Loss
		Frequent Weight fluctuations
		Bulimia
		Anorexia
		Binge Eating Disorder
		Night Eating Disorder
		Other Eating Disorder
		Other

Past	Now	Musculoskeletal System
		Osteoarthritis
		Fibromyalgia
		Chronic Pain
		Back Injury
		Neck Injury
		Scoliosis
		Shoulder Injury
		Knee Injury
		Other Joint Injury
		Other

Past	Now	Skin
		Eczema
		Psoriasis
		Acne
		Other

Past	Now	Neurological/Mood
		Depression
		Anxiety
		Bipolar Disorder
		Schizophrenia
		Headaches
		Migraines
		ADD/ADHD
		Autism Spectrum Disorder
		Mild Cognitive Impairment
		Memory Problems
		Alzheimer's
		Parkinson's
		Multiple Sclerosis
		ALS

Medical History (continued)

Past	Now	Immune/Inflammatory
		Chronic Fatigue Syndrome
		Autoimmune Disease
		Rheumatoid Arthritis
		Lupus
		Immune Deficiency Disease
		Sexually Transmitted Disease
		Frequent Infections
		Food Allergies
		Environmental Allergies
		Multiple Chemical Sensitivities
		Latex Allergy
		Hepatitis
		Mononucleosis
		Epstein Barr Virus
		Lyme's Disease
		Chicken Pox
		German Measles
		Measles
		Mumps
		Whooping Cough
		Other

Past	Now	Respiratory System
		Asthma
		Chronic Sinusitis
		Bronchitis
		Emphysema
		Pneumonia
		Tuberculosis
		Sleep Apnea
		Other

Preventative/Diagnostic Tests	
	Full Physical Exam
	Bone Density Test
	Colonoscopy
	Cardiac Stress Test
	EBT Heart Scan
	EKG
	Hemoccult Test (blood in stool)
	MRI
	CT Scan
	Upper Endoscopy
	Upper GI Series
	Ultrasound
	Mammogram
	Thermography
	X-Ray
	Other

Surgeries	
	Appendectomy
	Tonsillectomy
	Gall Bladder
	Hernia
	Hysterectomy +/- Ovaries
	Joint Replacement (knee/hip)
	Heart Surgery
	Angioplasty (Stent)
	Pacemaker
	Breast Augmentation/Reduction
	Liposuction
	C-Section
	Prostate
	Other

Gynecological History

For Women Only

Obstetric History (check box if "yes" and provide # of events)

<input type="checkbox"/>	Pregnancies	<input type="checkbox"/>	Post-Partum Depression
<input type="checkbox"/>	Caesarian	<input type="checkbox"/>	Toxemia
<input type="checkbox"/>	Vaginal Deliveries	<input type="checkbox"/>	Gestational Diabetes
<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Baby over 8 lbs.
<input type="checkbox"/>	Abortion	<input type="checkbox"/>	Breast Feeding
<input type="checkbox"/>	Living Children	<input type="checkbox"/>	How Long?

Menstrual History and Contraception

Age at First Period _____ Menses Length _____ Length of Menstrual Cycle _____

Do you often skip periods? Yes No If yes, how long? _____

Typically Painful? Yes No Typically Clotting Yes No

Contraception methods in use: Birth Control Pills Hormone Patch Nuva Ring
 Partner Sterilized Condom/Diaphragm IUD

Women's Disorders/ Hormones Imbalances

Do you experience breast tenderness, water retention, irritability or other PMS symptoms in the second half of your cycle? Yes No

Do you experience: Infertility Fibrocystic Breasts Endometriosis
 Fibroids Painful Periods Heavy Bleeding
 PMS

Last Mammogram _____ Breast biopsy? Yes No Normal Abnormal

Last PAP test _____ Normal Abnormal

Last Bone Density _____ Normal Abnormal (Osteoporosis/Osteopenia)

Are you in Menopause? Yes No If so, age at menopause _____

Do you experience: Hot Flashes Mood Swings Memory Problems
 Vaginal Dryness Low Libido Weight Gain
 Incontinence Palpitations Headaches

Use of hormone replacement therapy (HRT): Currently In the past Never

If so, what type? Progesterone Estrogen Ogen Estrace
 Premarin Provera Other _____

Men's Health History

For Men Only

Have you had a PSA test Yes No Last PSA test date _____

PSA Level: 0-2 2-4 4-10 >10

Do you experience:

- Prostate Enlargement Prostate Infection Change in Libido
- Impotence Difficulty Obtaining Erection Difficulty Maintaining Erection
- Blood in Urine Blood in Semen
- Urgency/Hesitancy/Loss of bladder control
- Urination at night Yes No If yes, how many times a night? _____

5 Key Systems Questionnaire

Structural Health

Was your birth process complicated? _____

Have you had any significant falls or accidents in your life? _____

Do you play sports currently or did you as a youth? _____

Have you ever sprained a joint or fractured a bone? _____

Have you ever been diagnosed with scoliosis, osteoporosis, disc degeneration, arthritis or any other bone or joint disease? _____

Have you had any surgeries on your bones or joints? _____

Have you had any car accidents (even minor ones)? _____

Do you sit or stand for prolonged periods of time? _____

Over the past 3-4 months, have you felt:

0 = No, does not occur

2 = Yes, moderate, occasional (weekly)

1 = Yes, minor, rare (monthly)

3 = Yes, severe, frequent (daily)

	0	1	2	3
Neck pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Upper or mid-back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Joints or muscles stiff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult to pick something up from the floor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painful joint motion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult to open jars that were previously easy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Joint swelling or stiffness in fingers, hands, wrists, elbows or shoulders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Joint swelling or stiffness in toes, feet, ankles, knees or hips	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult or painful going from sitting to standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prolonged sitting increases pain or symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shooting/aching/tingling sensations down one or both legs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning/throbbing/stabbing muscle pains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle cramps or spasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Points on your body are extra sore and tender to touch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tension or headaches that start in the back of your neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jaw clicking or popping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult to open your mouth and chew	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Numbness in hands or wrists	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Limping or favoring one leg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Structural system symptom score _____

5 Key Systems Questionnaire (continued)

Neurological/Mental Health

Have you ever suffered a concussion (even minor)? _____

Have you ever suffered bouts of prolonged depression? _____

Have you ever suffered bouts of prolonged anxiety? _____

Have you ever needed medication to manage a mental illness? _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? _____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it so that we can support you and optimize your treatment outcomes

Over the past 3-4 months, have you felt:

0 = No, does not occur

1 = Yes, minor, rare (monthly)

2 = Yes, moderate, occasional (weekly)

3 = Yes, severe, frequent (daily)

	0	1	2	3
Memory noticeably declining	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty learning new things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty with concentration and focus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Temperament generally getting worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High stress levels in any area of your life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of time for yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feelings of loss of direction or purpose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling that you are undeserving of good things in your life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feelings of sadness or depression for no reason	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feelings of inner rage or anger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feelings of hopelessness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-destructive feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preference to isolate yourself from others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of your temper when under stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feelings of panic or anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feelings of dread or impending doom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knots in your stomach	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty turning off your mind and relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Negative feelings about yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of interest in creative hobbies/pursuits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Neurological system symptom score _____

5 Key Systems Questionnaire (continued)

Hormonal Health

Are you currently overweight? _____

When was the last time you were at your ideal weight? _____

Have you repeatedly gained and lost weight on diets? _____

Over the past 3-4 months, have you felt:

0 = No, does not occur

1 = Yes, minor, rare (monthly)

2 = Yes, moderate, occasional (weekly)

3 = Yes, severe, frequent (daily)

	0	1	2	3
Fatigue that is relieved by eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleepiness in the afternoon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Awaken at night, hard to get back to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritable or shaky before meals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequent thirst and urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Easily fatigued with minor exertion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty falling asleep at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Slow starter in the morning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clench or grind teeth at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lightheaded when standing up suddenly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult gaining or losing weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intolerance to high temperatures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel cold or chilled when others are fine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss or thinning of outer 1/3 of eyebrows	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coarse, dry hair or dry skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Females only				
Mood changes associated with menstrual cycle (PMS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast tenderness associated with menstrual cycle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Variations in menstrual cycle (length, flow, cramps)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of sexual desire	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Males only				
Urgency/Hesitation or other difficulty with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decreased sexual function	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of sexual desire	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of lean muscle/ increase in belly fat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decreased physical stamina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Hormonal system symptom score _____

5 Key Systems Questionnaire (continued)

Digestive Health

How often have you traveled to a foreign country? _____

How often do you camp in the wilderness? _____

Bowel Habits

Frequency: > 3/week 1-3/day 4-6/day 2-3/day <2/week

Consistency: Soft, well-formed Often floats Difficult to pass Diarrhea

Thin, narrow Small, hard Loose, not watery

Color: Medium brown Very dark/Black Greenish Blood visible

Greasy, shiny appearance

Over the past 3-4 months, have you felt:

0 = No, does not occur

1 = Yes, minor, rare (monthly)

2 = Yes, moderate, occasional (weekly)

3 = Yes, severe, frequent (daily)

	0	1	2	3
Heartburn or acid reflux	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bloating and belching after eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bad breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach upset by taking vitamins	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel better when you don't eat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleepy after meals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Undigested food visible in stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food sensitivities to wheat, dairy or other foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have strong food cravings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternating periods of diarrhea and constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma, sinus infections or stuffy nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Environmental allergies, hay fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Itching around anus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tongue has whitish coating on the back	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fungal or yeast infections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Symptoms increase with intake of sugar, starches or alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Less than one bowel movement per day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stools are not well formed (loose)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood in stool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive lower bowel gas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Digestive system symptom score _____

5 Key Systems Questionnaire (continued)

Detoxification/Environmental Health

Do you consume diet or regular carbonated soft drinks or energy drinks on a weekly basis? _____

Do you smoke or chew tobacco? If so, how much? _____

Do you drink alcohol? If so, how much? _____

Do you get your house treated for bugs or have your lawn chemically treated? _____

Do you have "silver" amalgam fillings in your teeth? _____

Do you drink from plastic containers or unfiltered tap water? _____

Are you exposed to chemicals in the workplace? _____

Over the past 3-4 months, have you felt:

0 = No, does not occur

1 = Yes, minor, rare (monthly)

2 = Yes, moderate, occasional (weekly)

3 = Yes, severe, frequent (daily)

	0	1	2	3
Pain between the shoulder blades after eating fatty foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach upset by greasy foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequent or persistent nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gall bladder attacks (if gall bladder has been removed, mark 3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain under right side of ribs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bitter taste in mouth, especially after meals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine or cluster headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bags or dark circles under eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive mucus formation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic cough or need to clear throat often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overweight or obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water retention and/or edema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequent illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of drug or alcohol abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of hepatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Long-term use of prescription/recreational drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitive to chemicals (perfumes, cleaners, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitive to tobacco smoke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitive to MSG, Aspartame, Caffeine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic fatigue or fibromyalgia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Detoxification system symptom score _____

7 Pillars Lifestyle Questionnaire

Nutrition

Height (feet/inches) _____ Current Weight _____ Desired Weight _____

Highest Adult Weight _____ Lowest Adult Weight _____ Body Fat % _____

How often do you weight yourself? Daily Weekly Monthly Rarely/Never

Do you grocery shop? Yes No If no, who does the shopping? _____

Do you cook? Yes No If no, who does the cooking? _____

Do you read food labels? Yes No

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals/week

Have you made any changes in your eating habits because of your health? Yes No

Do you currently follow a special diet or nutritional program? Yes No

Gluten-Free Diabetic Dairy restricted Vegetarian Vegan

Paleo Other: _____

Please tell us if there is anything special about your diet that we should know _____

Check all the behaviors or beliefs that apply to your current lifestyle and eating habits

<input type="checkbox"/>	Erratic eating patterns	<input type="checkbox"/>	Love to eat
<input type="checkbox"/>	Fast eater	<input type="checkbox"/>	Eat only because I have to
<input type="checkbox"/>	Late night eating	<input type="checkbox"/>	Have a negative relationship with food
<input type="checkbox"/>	Dislike healthy food	<input type="checkbox"/>	Struggle with eating issues
<input type="checkbox"/>	Spouse or family doesn't like healthy food	<input type="checkbox"/>	Emotional eater (sad, lonely, depressed etc.)
<input type="checkbox"/>	More than 50% of meals away from home	<input type="checkbox"/>	Eat too much when under stress
<input type="checkbox"/>	Travel frequently	<input type="checkbox"/>	Eat too little when under stress
<input type="checkbox"/>	Non-availability of healthy foods	<input type="checkbox"/>	Don't care to cook
<input type="checkbox"/>	Do not plan meals or menus	<input type="checkbox"/>	Eating in the middle of the night
<input type="checkbox"/>	Reliance of convenience	<input type="checkbox"/>	Confused by nutrition advice
<input type="checkbox"/>	Poor snack choices	<input type="checkbox"/>	Family members have special dietary needs
<input type="checkbox"/>	Time constraints	<input type="checkbox"/>	Eat too much

Nutrition – Food Diary

Food	Freq.	Often	Occas.	Seldom	Never
Alcoholic beverages	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat out at restaurants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pastries, cookies, candy, ice cream etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White flour: bread, pasta, pancakes etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Added sugar to coffee, tea, cereals etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sodas or soft drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diet soft drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fruit juices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial sweeteners (Nutrasweet, saccharin, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Natural sweeteners (honey, maple syrup, agave etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breakfast cereals (hot or cold)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Packaged foods: chips, crackers, puffs etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vegetable oils (sunflower, safflower, canola, corn, soy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Margarine or tub vegetable oil spreads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deep-fried foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Olive oil	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avocados	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saturated fats (butter, ghee, lard, coconut, palm, tallow)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatty fish (salmon, mackerel, sardines, herring)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nuts and seeds (including nut/seed butters)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasteurized dairy (Check: <input type="checkbox"/> nonfat, <input type="checkbox"/> low-fat, <input type="checkbox"/> whole)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Raw dairy (Check: <input type="checkbox"/> nonfat, <input type="checkbox"/> low-fat, <input type="checkbox"/> whole)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fermented dairy (yoghurt, kefir, cheese)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eggs (Check: <input type="checkbox"/> free-range, <input type="checkbox"/> pastured <input type="checkbox"/> organic, <input type="checkbox"/> conventional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poultry or fowl (chicken, turkey, duck etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pork	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red meat (beef, lamb)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Processed meats (bacon, sausage etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Organ meats (liver, kidney, sweetbreads, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soy products (tofu, tempeh, soy milk, edamame)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salads, uncooked vegetables	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Fermented vegetables (sauerkraut, kimchi, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-starchy vegetables (greens, squash, carrots)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Starchy vegetables (potatoes, yams, sweet potatoes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fresh fruits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beans and legumes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Whole grains with gluten (wheat, rye, barley)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternative grains (quinoa, buckwheat etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Herbs and spices (fresh or dried)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chocolate (Check <input type="checkbox"/> milk <input type="checkbox"/> dark)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Herbal teas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee (Check <input type="checkbox"/> regular <input type="checkbox"/> decaffeinated)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caffeinated teas (Check <input type="checkbox"/> black <input type="checkbox"/> green)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salt (Check <input type="checkbox"/> iodized <input type="checkbox"/> sea salt)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Exercise

Do you exercise regularly? Yes No

Current exercise program: (List activity, intensity, number of sessions per week and duration)

Activity	Type/Intensity	Frequency per week	Duration in minutes
Walking/Jogging			
Cardio/Aerobics			
Strength training			
Yoga/Pilates			
Dance/Zumba			
Sports or leisure activities			
Other: (List below)			

What's your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? _____

Do you usually sweat when exercise? Yes No

Informed Consent for Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and hot/cold packs, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a clot with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one per one million to two million cervical adjustments.

It is also important to that you understand that there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter medications, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current of future recommendation to receive chiropractic care and nutritional and lifestyle advice as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Signature of patient or patient representative
patient

Date

Indicate relationship if signing for

Signature of office representative

Date

Financial Policies

To maintain compliance with various state and federal regulations, we have adopted the following financial policies.

- Our clinic has established a single fee schedule that applies to all patients for each service provided.
- You may be entitled to a network or contractual discount under the following circumstances:
 - You are covered by a State or Federal program with a mandated fee schedule i.e. Medicare
 - You are a member of our Wellness Circle Program or any other Discount Medical Plan Organization our office participates with.
- If you do not meet any of the circumstances above, you will be required to pay the full fee at the time of service unless we have approved in advance to accept a partial payment.
- Missed Appointments - Failing to provide adequate notice (24- hours) of your inability to keep an appointment will incur a charge equal to 50% of the scheduled service.
- A \$25 charge will be applied in the event of a check returned with Not Sufficient Funds.
- Refunds – There are no refunds extended for services that have already been received. If you have elected to pre-pay for any part of your care, unused portions of your care MAY be eligible for a refund. The conditions for a refund will be carefully explained prior to your agreement to receive “pre-pay eligible” services.
 - Refunds for supplements must meet the following criteria:
 - The bottle or package must be unopened.
 - The return must be within 30 days of purchase and the product must not have passed its expiration date.
 - A 15% handling fee will be applied unless the product is being exchanged for another product at that time.
 - Refunds for lab testing must be requested within 30 days of obtaining test kits, otherwise refund will be awarded as in-office credit.
- If your account is not paid within 30 days of the date of service and no financial arrangements have been agreed upon in writing, a finance charge of 2% per month (annual percentage rate 24%) of the unpaid balance will be added monthly. Should the balance remain unpaid for 60 days after the date of service the balance will be sent to collections and the responsible party agrees to pay all collection fees and all legal fees, with or without suit, including attorney fees and court costs.
- Special information for Auto Accidents: Our office will submit claims for you if you have been injured in an Auto Accident. Utah Personal Injury Protection Benefits include a minimum of \$3,000 for initial health care expenses. Once this limit is reached, patients will be required to pay for all services at the time they are received. It is the patient's responsibility to fill out and return their PIP benefits application to their insurance company in a timely manner. Your insurance company will not pay on claims until this application has been received. Since we are unaware of other health services you may have received, we cannot be responsible to keep track of your PIP balance/benefits.
- If this is a personal injury case, signing this agreement acts as a lien and all parties will be paid on services rendered.
- I hereby assign all health eligible insurance benefits to which I am entitled to Dr. Jerald W. Duggar, 140 N Main St. Bountiful, UT 84010. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax Transmittal, e--mail or hard copy. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my insurance status.

Signature of Responsible Party: _____ Date: _____

HIPAA Privacy Policies

At Duggar Wellness we understand that your medical and health information is private. We know that respect for that privacy is a critical part of our relationship. We are committed to protecting the privacy of your protected health information that is in our possession. We follow strict federal and state laws that require us to maintain confidentiality of your health information. This “Notice of Privacy Practices” was created to help you understand our legal duties to protect your health information, as well as your rights in regards to your health information.

How We May Use Your Health Information

When you receive care at our office we may use your health information for treating you, billing for services rendered and conducting our normal business operations. The following are examples of how we use and disclose your health information: Treatment - We keep records of the care and services provided to you. We use these records to deliver quality care to meet your needs. We may share your health information with a specialist or representative who will assist in your treatment. Payment- We keep billing records that include payment information and documentation of services provided to you. Your information may be used to obtain payment from your insurance company or any third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that need prior notice or authorization. Health Care Operations- We use health information to continually improve the quality and effectiveness the health care services we provide. We may use your health information to train staff and students, provide customer services, and conduct required business duties.

We may also use your health information to: Recommend treatment alternatives, tell you about health services and products that may benefit you, share information with family or friends who are involved in your care or payment for your care and share information with third parties who assist us with treatment, payment and health care operations.

Specific Agreements (Please Circle)

Y / N - I agree to allow Duggar Wellness to call my home and/or work to remind me of appointments or advise me of issues related to my care.

Y / N - I agree to allow Duggar Wellness to correspond to me via email regarding my personal health matters (lab reports etc.) as well as other information regarding general health issues.

We may share your health information: For public health purposes such as reporting communicable diseases, work--related illness and injuries, or other diseases and injuries permitted by law; reporting deaths; and reporting reactions to drugs or problems with medical devices, to protect victims of abuse, neglect or domestic violence, for lawsuits and similar proceedings, when requested by law enforcement as required by law or court order, for Workers' Compensation or other similar programs if you are injured at work. Our office will obtain your written authorization before using or disclosing your health information other than those instances listed above (or as otherwise permitted and required by law). You may revoke your authorization at any time with a written statement.

Our Privacy Responsibilities: We are required by law to do the following: Maintain the privacy or your health information, provide this notice that describes the ways we may use and share your health information, follow the terms of the notice currently in effect.

Your Individual Rights: You may request restrictions on how we use and share your information. (However, we may not be required by law to honor these requests.) You may inspect and request a copy of your health information (Fees may apply). You may make a written request for corrections or additions to your health information. You may request and additional copy of this notice. You may request an accounting of certain disclosures of your health information made by

us. This would exclude an accounting of disclosures made for treatment, payment or health care operations. This excludes disclosures prior to April 14, 2007.

We at Duggar Wellness take the matters described in this "Notice of Privacy Practices" very seriously because of our relationship with you and the legal requirements that we comply with this notice. We reserve the right to update and make changes to this notice at any time. You may request a copy of this notice from any employee at our office.

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, please feel free to contact our Privacy Coordinator:

Tammie Duggar
(801)-677-7878

I have received/reviewed a copy of this office's Notice of Privacy Practices.

Signature of patient or guardian _____ Date _____

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 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 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.

Signature of patient or patient representative Date Indicate relationship if signing for patient

Signature of office representative Date