Dr. Jeff Hanson, ND.
Personal Patient Information

Name _____Today's Date _____

Mailing Address_____

City _____ State _____ Zip Code _____

Phone (cell)_____

Phone (other) _____

Is it ok to communicate to you via: Texting? ☐Yes ☐No E-mail? ☐Yes ☐No

E-Mail Address _____

Date of Birth _____Age _____Gender: ☐Male ☐Female

Marital Status ☐Married ☐Single Height _____ Weight _____

Occupation _____ Employer _____

How did you hear about Dr. Jeff Hanson, ND.?

☐Website ☐ Word of Mouth ☐Referral ☐ Other _____

Who referred you? _____

Emergency Contact Person _____

Phone Number _____ Relationship To You _____

Agreement and Payment Policy

By signing below, I understand that full payment for all services and products I receive at Embody Wellness is required at the time of service.

Signature _____

Dr. Jeff Hanson, ND.
Initial Health History Questionnaire

Name _____ **Date** _____

Reason For Visit _____

_____

Chronic Medical Problems (Check all that apply) ☐ None

☐Diabetes	☐Kidney Disorder	☐Headaches
☐High Blood Pressure	☐Sleep Disorder	☐Skin Disorder
☐Cancer	☐Fibromyalgia	☐Memory Loss
☐Autoimmune Disorder	☐Prostate problems	☐Gallbladder Disease
☐Depression	☐Dementia	☐Crohn's/Colitis
☐Allergies	☐Lung Disorder	☐Heartburn
☐Anxiety	☐Overweight	☐IBS
☐Liver Disease	☐Urination Disorder	☐Stomach Ulcers
☐Thyroid Disorder	☐Constipation	☐ED
☐Osteoporosis	☐Diarrhea	☐PMS

Other / Specifics _____

_____

Medications (List current Rx medications, OTC, Hormones that you take) ☐ None

_____

_____

Drug Allergies ☐ No Known Drug Allergies

Medications (Rx, OTC) _____

What is reaction to drug? _____

Supplements (List what you take most days) ☐ None

_____

_____

_____

Dr. Jeff Hanson, ND.
Initial Health History Questionnaire

Screening Tests/Exams (Most Recent)

☐ Blood Testing	Year _____	☐ PSA Test	Year _____
☐ Colonoscopy	Year _____	☐ Prostate Exam	Year _____
☐ PAP/GYN exam	Year _____	☐ Annual Physical	Year _____
☐ Mammogram	Year _____	☐ Cardiac Stress Test	Year _____
☐ Bone Density	Year _____	☐ Skin Cancer Screen	Year _____
☐ Chest X-Ray	Year _____	☐ CT/MRI	Year _____

Surgeries ☐ None

Year **Surgery**

_____ _____

_____ _____

_____ _____

_____ _____

Family History (What major diseases are found in your family) _____

_____

Doctors (List other doctors or health professionals currently seeing?) ☐ None

_____

_____

Personal Habits

Alcohol use: ☐ Social drinker ☐ Daily ☐ History of Abuse | Type of Alcohol: _____
Tobacco use: ☐ Never ☐ Past use ☐ Daily ☐ Second Hand Smoke Exposure ☐Smokeless Tobacco

How many packs per day? _____ How long been Smoking? _____

When did you stop smoking? _____

Dr. Jeff Hanson ND.
Informed Consent for Treatment

This document is a binding agreement (the "Agreement") between Dr. Jeff Hanson, ND (ND defined as Naturopathic Doctor) and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services which may be provided to you by Dr. Jeff Hanson, ND at the present and at all times in the future. You agree as follows (your agreement indicated by placing your initials on the lines following each section and by signing in the space provided):

1. **Consent For Treatment.** You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize Dr. Jeff Hanson, ND to provide You with health care treatment which, depending on Your health conditions, may include one or more of the following procedures: Naturopathic Medicine, Intravenous Infusions, Intramuscular Injections, Hormonal Replacement Therapy, Herbal Medicine, Intra-Articular and Extra-Articular Injection Therapy, Hcg Weight loss Diet Program, Dietary and Nutritional Consultation, Prolozone, Platelet Rich Plasma Injections, Low Dose Antigen Therapy, and Chelation Therapy; together the "Treatments" administered by Dr. Jeff Hanson, ND. You acknowledge that Dr. Jeff Hanson, ND has not made any guarantees or promises as to the outcome or the safety and efficacy of the above listed Treatments. (Initials) _____
2. **Experimental Nature of Treatments.** You acknowledge and agree that the Treatments may consist in whole or part of experimental procedures and methods, in which no governmental (including the U.S. Food and Drug Administration), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. Dr. Jeff Hanson, ND has informed You that the Treatments may alter, address, or decrease Your pain, symptoms, or complaints, but also may have no effect (Initials) _____
3. **Intravenous Therapy, Prolozone, Injection Therapy Risks, Side Effects, Complications.** Dr. Jeff Hanson, ND hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation swelling, severe pain, bleeding, dizziness, numbness, scarring, allergic reactions, itching, headaches, soreness, inflammation, bruising, phlebitis, vomiting, fainting, metabolic disturbances. Treatments may very rarely cause infection, injury to nerves, Pneumothorax (temporary lung collapse), the need for additional surgery or hospitalization, or other serious or debilitating injuries or death. (Initials) _____
4. **Description of Treatments.** The exact procedure, as well as the recommended sequence of Treatments, will be explained to you when Dr. Jeff Hanson, ND actually administer the Treatments. You acknowledge that any of the Treatments may involve insertion of needles into Your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicine, chelation agents, and FDA approved prescriptive medicines, local anesthetic (i.e. Procaine), concentrated sugar water (Dextrose), concentrates of your own blood (platelet rich plasma) and, on occasion, other substances which will be explained to You before injections. (Initials) _____
5. **Information You Provide Dr. Jeff Hanson.** You have provided Dr. Jeff Hanson, ND., with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements, or medical treatments of any kind. You agree to update Embody Wellness periodically should this list change. (Initials) _____

Continued on next page

6. **Assumption of Risk.** You hereby, acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement of the Treatment that you have, You are willing to assume any and all risks associate with the Treatments, including without limitation those described in the Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may/or could arise from the Treatments, but that by initialing and signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed. (Initials) _____
7. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. (Initials) _____
8. **Independent Practitioner.** All treatments and procedures provided are between Dr. Hanson and patient. Dr. Hanson is not an employee at Embody Wellness and is providing care at this facility as an Independent practitioner. (Initials) _____
9. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and Dr. Jeff Hanson, ND. regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by you. This Agreement shall be binding on You and Your successors, heirs, legal representative and assigns. In case anyone of the provisions of this Agreement is held invalid or illegal, such provisions shall be curtailed, limited, or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the State of California without regard to any choice of law principal. (Initials) _____

By signing this Agreement, You indicate that You have read, understood and agree to its terms, You have received a copy of this Agreement, and that You are the patient, Guarantor, the patient's legal representative or legally authorized to sign this Agreement and accept its terms.

Patient Name (Print) _____ Legal Guardian Name _____

Signature _____ Signature _____

Date _____ Date _____

Naturopathic Doctor Certification: I Dr. Jeff Hanson, ND, nearby certify that I have explained to the patient or authorized person the nature of the proposed treatments, the medically significant alternatives, and in lay terms the purpose, likelihood of success, benefits, and reasonably foreseeable risks, complications, and consequences of treatment. The patient or person authorized has had the opportunity to ask questions and has stated that no further explanation was desired.

Naturopathic Doctor Signature (Jeff Hanson, ND) _____ Date _____