

NeuroWellness

Adult Intake Form

Last Name _____ First Name _____

Date of Birth ____/____/____ E-mail _____

Address _____

City _____ ST _____ Zip _____

Home Phone _____ Work Phone _____

Other Phone _____ Fax _____

Emergency Contact _____ Relationship _____

Emergency Contact Home Phone _____ Work Phone _____

How did you learn about NeuroWellness? _____

What is/are the principal health concern(s) for which you are coming to see us?

Migraines Weight control High stress level Arthritis

ADHD Exhaustion Focus/mental clarity PMS

Depression Fibromyalgia Chronic fatigue Anxiety

Low energy Poor memory Allergies/Asthma Sleep

Blood Pressure Cholesterol Digestion Bowel

Do you have other health concerns you would be interested in addressing?

Age _____ Height _____ Weight _____ Marital Status _____

Children at home/ages _____ Other children/ages _____

Occupation _____ How many hours per week? _____

Existing medical problems:

How many sick days did you take in the past year due to these conditions? _____

Past medical problems: _____

Please list any surgeries and their dates: _____

NeuroWellness, Inc.

CLIENT CONSENT

This Client Consent (“Consent”) will enable the Client to make a written confirmation of some of the more significant information NeuroWellness has provided regarding its health services.

- 1. Services:** Client understands that NeuroWellness, Inc. (NW) is a nutrition-based neuroscience company comprised of Ph.D.s and other trained practitioners. NW does not prescribe medication nor are any of its practitioners, protocols or products developed to diagnose, treat, cure or prevent any disease. As such, clients may or may not work directly with a physician while working with NW. However, when amino acid protocols are used, the initial dosage and any recommended modifications are provided by CHK Labs of Duluth, MN, and Dr. Marty Hinz[t1], MD. Many NW clients choose the natural, healthy protocols offered by NW because they desire alternative solutions to their health challenges without the often negative side-effects of prescription drugs. The NW protocols are designed to strengthen the body’s immune and restorative systems, as well as increase neurotransmitter production.
- 2. Risks/Benefits:** Dr. Marty Hinz, MD, the patent holder of the amino acid formulas, has designated NW as an authorized caregiver. Dr. Hinz and his NeuroResearch, Inc. have performed extensive testing on the risks associated with amino acid supplementation. As is documented on his website, www.neuroassist.com, amino acid supplementation produces fewer negative side effects than a sugar pill (placebo). The potential benefits are many, including elimination of negative symptoms associated with many neurotransmitter deficiencies. All products sold by NW are nutritional supplements manufactured by 3rd party contractors who have performed their own extensive safety and quality control research.
- 3. Complications; Unforeseen Conditions; Results:** Client is aware that his/her body is unique and the nutritional protocols used by NW may not be effective or may take time and effort before they become effective. The NW products and protocols may not be better than, or even as good as, alternative approaches. I further acknowledge that no guarantees or promises have been made to me concerning the results of the Services described in Part 1 above.
- 4. Release:** Client, having received and acknowledged this Consent, holds harmless, releases and forever discharges NeuroWellness, Inc., its shareholders, officers, directors, advisors, managers, members, employees, agents, affiliates, successors, professionals and assign’s heirs, successors, agents and assigns, from and against any and all damages, injuries, claims, demands, costs, expenses, debts, liabilities, judgments, actions and causes of action of whatever kind and nature arising out of, resulting from, or in any way related to the Services as set forth in this Consent, including, but not limited to, all claims for contract damages, tort damages, breach of duty, conversion, special, general, direct and consequential damages, compensatory damages, loss of profits, injury to persons or property, punitive damages, attorney fees and any and all other damages of any kind or nature.
- 5. Acknowledgments:** The Services, including the potential benefits and risks associated therewith, have been explained to Client. Client understands what has been discussed as well as the contents of this Consent. Client has been given the opportunity to ask questions, and has received satisfactory answers.
- 6. Consent to Services:** Having read this form and talked with the professionals involved, Client’s signature below acknowledges that Client does hereby voluntarily give his/her authorization and consent to the performance of the Services described in Paragraph 1 above. The NW and/or its associates, assisted by personnel and other trained persons, are responsible for the Services rendered. Client also consents to any blood and urine testing done in support of the Services. Client understands that personal information about Client will be kept strictly confidential unless Client authorizes otherwise in writing.

Date: ___/___/___

Staff Name (printed)

Client Name (printed)

Staff Signature

Client Signature