Chrysalis Health Solutions

The Butterfly Effect

Patient Consent Form

Please complete and submit to:

Dr. Julie Johnson
2812 32nd. Ave. Dr.
Moline, IL 61265

t: 563.505.7582
f: 815.331.0700

drjohnson@myhealthsolution.org

When a patient seeks alternative health care and Dr. Johnson accepts a patient for such care, it is essential for both to be working toward the same objective. Lab analysis of any kind has only one goal: to identify dysfunction and provide a baseline to determine methods of care.

Lab analysis may include:

- Hair Follicle Analysis
- Female Hormone Panel
- Post Menopause Hormone Panel
- Male Hormone Panel
- Adrenal Stress Index Test
- GI Health Panel
- Food Intolerance Panel

Dr. Johnson does not offer to diagnose or treat any disease or condition. However, if during the course of a consultation, she encounters unusual findings, she will advise you immediately. If you desire advice, diagnosis or treatment for those findings Dr. Johnson will recommend that you seek an additional health care provider to work with you.

I, the undersigned, have been informed of the nature and purpose of care, the possible consequences of the care and the risks of the care, including the risk that care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care I am about to receive.

I have read the section above and I understand the information provided. This information has been explained to me and all questions, which I have asked, have been answered to my satisfaction.

Having this knowledge, I knowingly authorize Dr. Johnson to proceed with care.

Dated this ______ day of _____________ 20 _____.

____
Patient's Signature

____
Dr. Johnson's Signature

Consent To Evaluate And Consult With A Minor

I, ____being a parent or legal guardian of _________________________________ have read and fully understand the above terms of acceptance and hereby grant permission for this minor to receive care.

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HIPPA Compliance

Please complete and submit to:

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The Health Insurance Portability and Accountability Act of 1996, (HIPAA), was signed into law by President Clinton on August 21, 1996. The HIPAA Act is also known as the Kennedy Kassebaum bill. This law includes important new protections for millions of working Americans and their families who have preexisting medical conditions or who might suffer discrimination in health coverage based on a factor that relates to the individual's health. HIPAA's provisions amend Title I of the Employee Retirement Income Security Act of 1974 (ERISA), as well as the Internal Revenue Code and the Public Health Service Act, and places requirements on employer-sponsored group health plans, insurance companies and health maintenance organizations (HMOs).

The Benefits of HIPAA: The proposed rules should bring long term benefits to clinical information systems and computer based patient records: consistent provider identifiers, more consistent coding for services and diagnoses, greater efficiency for administrative transactions leading to more resources for clinical systems, and greater incentive to computerize health care operations.

Security Standards:

- Administrative procedures to guard data integrity, confidentiality and availability
- Physical safeguards over data integrity, confidentiality and availability
- Technical security services, guarding data integrity, confidentiality and availability
- Technical security mechanisms to guard against unauthorized access to data that is transmitted over a communications network

Chrysalis Health Solutions appreciates your understanding and cooperation with these guidelines. We support the spirit of the intentions of the HIPAA Act and strive to maintain the strictest confidence and integrity of information that pertains to any patient. We thank you for your signature on this document and invite any questions that you may have about the HIPAA rules and regulations.

____

Patient Signature Date

____

Doctor/Authorized Chrysalis Health Solutions Representative Signature Date

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Please complete all questions to the best of your ability. PLEASE PRINT.

Patient Name: ______________________________ Date: ____/____/____ Age ____ DOB: ____/____/____

Gender: Male [ ] Female [ ] Marital Status: S M W D No. of Children & Ages ______________________

Height: __________ Weight: __________ Blood Type (If Known): ______________________________

Email Address:______________________ Home Address: ______________________________

Home Phone: ( ) __________________Work Phone: ( ) ________________ Fax: ( ) ____________

Emergency Contact (Name of relative or close friend not living with you):

Name: ____ Phone: ( ) ________________

Address: ____

Name/Address of current medical physician: ______________________________________

____

Whom can we thank for referring you:______________________________________

What is the primary reason that you are seeking alternative health care? ______________________

____

Please list all current symptoms that you are experiencing: ______________________________

____

____

Drugs you currently take (prescription/over the counter):
[ ] Nerve Pills [ ] Pain Killers [ ] Muscle Relaxers [ ] "Pep" Pills [ ] Tranquilizers
[ ] Birth Control Pills [ ] High Blood Pressure [ ] HRT [ ] Antidepressants [ ] Sleep Aids
[ ] Others: ____

Do you take vitamins or minerals? _____ Yes _____ No
Please describe: ____

____

Do you think you may need vitamins or minerals? _____ Yes _____ No
Why? ____

Do you have an allergy to any drug/herb? _____ Yes _____ No
Please list:____

____

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HABITS	Heavy	Moderate	Light	None	Frequency Per Day/Week
Alcohol	[ ]	[ ]	[ ]	[ ]	____________________
Coffee/Soda	[ ]	[ ]	[ ]	[ ]	____________________
Tobacco	[ ]	[ ]	[ ]	[ ]	____________________
Drugs	[ ]	[ ]	[ ]	[ ]	____________________
Exercise	[ ]	[ ]	[ ]	[ ]	____________________
Sleep	[ ]	[ ]	[ ]	[ ]	____________________
Appetite/Meals	[ ]	[ ]	[ ]	[ ]	____________________

	CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:								
	Abortion		Breast Lump		Head/Spine Injury		Miscarriage		Retinal Detachment
	Abuse (Physical, Mental, Emotional)		Breast Cancer		Heart Disease		Multiple Sclerosis		Rheumatic Fever
	AIDS/HIV		Bulimia		Herniated Disc		Mumps		Scarlet Fever
	Alcoholism		Cancer		High Cholesterol		Osteoporosis		Stroke
	Anemia		Diabetes		Influenza		Parkinson's Disease		Testicular Pain
	Anorexia		Eczema		Lumbago		Pleurisy		Tuberculosis
	Appendicitis		Emphysema		Malaria		PMS		Ulcers
	Bleeding Disorders		Epilepsy		Mastectomy		Pneumonia		Vaccinations
	Blood in Urine/Stool		Goiter		Measles		Polio		Venereal Disease
	Burning/Painful Urination		Gout		Migraine Headaches		Prostate Problems		Other: __________

List past surgeries (include year) and illnesses: ____

____

Have you been in an auto accident: [ ] Past Year [ ] Past 5 Years [ ] Over 5 Years [ ] Never

Have you ever had any mental or emotional disorders? _____ Yes _____ No When?____________________

Have any others in your family had such disorders? _____ Yes _____ No When?____________________

Have you ever been knocked unconscious? _____ Yes _____ No When?____________________

Used a cane, crutch, or other support device? _____ Yes _____ No When?____________________

Been treated for a spine or nerve disorder? _____ Yes _____ No When?____________________

Been treated for a spine or nerve disorder? _____ Yes _____ No When?____________________

Fractured a bone? _____ Yes _____ No When?____________________

Been hospitalized for anything other than a surgery? _____ Yes _____ No When?____________________

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Date of Last:	Less than 6 months	6-18 months	Over 18 months	Never
Physical Exam	[ ]	[ ]	[ ]	[ ]
Spinal X-Ray	[ ]	[ ]	[ ]	[ ]
Blood Test	[ ]	[ ]	[ ]	[ ]
Urine Test	[ ]	[ ]	[ ]	[ ]
Spinal Exam	[ ]	[ ]	[ ]	[ ]
Chest X-Ray	[ ]	[ ]	[ ]	[ ]
Dental Exam	[ ]	[ ]	[ ]	[ ]
Mammogram *If applicable	[ ]	[ ]	[ ]	[ ]

Pregnancies (include date of pregnancy & outcome- vaginal vs. caesarian, difficulties) *If applicable only: __________

Please define job description & work schedule: __________

Describe lifestyle (hobbies, diet): __________

With specificity, write what it is you hope to achieve upon learning the results of the alternative testing: __________

Describe the steps you are willing to take to achieve any lifestyle changes or health goal(s): __________

List individuals who will be helpful and supportive to you during your quest for better health, naturally: __________

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Confidential Patient Health History

Please complete this questionnaire. Check the appropriate box for any of the following symptoms that you have now or have had in the past. (O- Occasional, F – Frequent, C – Constant)

O	F	C		O	F	C		O	F	C	
GENERAL							Constipation				Hardening of arteries
			Allergy (Shots)				Diarrhea				High blood pressure
			Insomnia				Difficult digestion				Low blood pressure
			Convulsions/Seizures				Distension of abdomen				Pain over heart
			Dizziness/Fainting				Excessive hunger				Poor circulation
			Difficulty Walking				Gall bladder trouble				Rapid heart beat
			Fatigue				Hemorrhoids				Slow heart beat
			Fever				Ulcers				Swelling of ankles
			Headache				Jaundice	RESPIRATORY			
			Loss of Sleep				Liver trouble				Chest pain
			Loss of weight				Nausea				Chronic cough
			Nervousness/Depression				Pain over stomach				Difficult breathing
			Neuralgia				Poor appetite				Spitting up blood
			Numbness/Tingling				Vomiting				Spitting up phlegm
			Sweats				Vomiting of blood				Wheezing
			Tremors					SKIN			
MUSCLE & JOINT				EENT							Boils
			Arthritis				Asthma				Bruise Easily
			Bursitis				Colds				Slow to Heal
			Foot Trouble				Crossed eyes				Hives or allergy
			Hernia				Deafness				Itching/Dry Skin
			Lumbago				Dental decay				Skin eruptions (rash)
			Neck pain or stiffness				Earache				Varicose veins
			Pain between shoulders				Ear discharge	GENITO-URINARY			
			Pain or Numbness in:				Ear noises				Bed-wetting
			Shoulders				Enlarged glands				Blood in urine
			Arms				Enlarged thyroid				Frequent urination
			Elbows				Eye pain				Incontinence/Dribbling
			Hands				Failing vision				Kidney infection or stones
			Hips				Far sightedness				Painful urination
			Legs				Gum trouble				Prostate trouble
			Knees				Hay fever				Pus in urine

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O	F	C		O	F	C		O	F	C	
MUSCLE & JOINT - CONT.				EENT - CONT.				FOR WOMEN ONLY			
			Feet				Hoarseness				Lymphedema
			Painful tail bone				Nasal obstruction				Cramps or backache
			Poor posture				Near sightedness				Excessive menstrual flow
			Sciatica				Nosebleeds				Hot flashes
			Spinal curvature				Sinus infection				Irregular cycle
			Swollen joints				Sore throat				Menopausal symptoms
GASTRO-INTESTINAL							Tonsillitis				Painful menstruation
			Belching or Gas	CARDIO-VASCULAR							Vaginal discharge/infection
			Colitis				Palpitation of heart		Y	N	Are you pregnant?
			Colon trouble				Pacemaker				

For Hair Follicle Analysis Patients Only:

Have you had hair analysis done previously? ______ Yes ______ No

If yes, are those test results available for review? ______ Yes ______No

Please check the following if it is currently present in your fingernails:

______ White Spots
______ Longitudinal Ridging
______ Deep Grooves

Do you have brittle hair & nails? ______ Yes ______ No

Have you been exposed to any environmental toxins that you are aware of at any time? ______ Yes ______ No

Have you ever worked in a job that required exposure to hazardous chemicals/materials? ______ Yes ______ No

Have you recently permed, colored or applied any salon/home process to your hair? ______ Yes ______ No

If yes, approximately how long ago? ____

Do you use any of the following products:

___ Grecian Formula
___ Selsun Blue
___ Head & Shoulders

Do you have a water softener? ______ Yes ______ No

Do you frequently swim in a chlorine pool? ______ Yes ______ No

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For Hormone Balancing Patients Only:

Are you seeking hormone balancing for fertility reasons? ______ Yes ______ No
If yes, how long have you been attempting to conceive? ________________________________

Have you had other forms of hormone testing done to date? ______ Yes ______ No
If yes, are those test results available for review? ______ Yes ______ No

Are you currently taking any form of hormone therapy? ______ Yes ______No
If yes, what is it? ____
How long have you been taking it? ____

For cycling women, please check any of the following that apply to you:

_______ Weight Gain
_______ Functional Infertility
_______ Osteoporosis
_______ Endometriosis
_______ Ovarian Cysts
_______ Fibroids
_______ Fibrocystic Breasts
_______ Increased Risk of Breast Cancer
_______ PMS
_______ Migraine Headaches
_______ Breast Tenderness
_______ Emotional Issues
_______ Insomnia
_______ Spotting
_______ Difficulty with emotions/thinking

For non-cycling women, please check any of the following that apply to you:

_______ Hot Flashes
_______ Low Libido
________ Mood Swings
_______ Depression
_______ Headaches
_______ Irritability
_______ Insomnia
_______ Memory Problems
_______ Bleeding Irregularities
_______ Osteoporosis
_______ Altered Lipid Metabolism
_______ Atherosclerosis
_______ Night Sweats
_______ Vaginal Dryness
_______ Nervousness

For men, please check any of the following that apply to you:

_______ Decreased Muscle Mass
_______ Decreased Strength
_______ Decreased Libido
_______ Insomnia
_______ Nervousness
_______ Depression
_______ Hair Loss
_______ Erectile Dysfunction
_______ Fat accumulation around waist
_______ Urinary Symptoms
_______ Increase in LDL cholesterol
_______ Decrease in (HDL) cholesterol

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For Gastro-Intestinal Panel Patients Only:

Have you ever had any form of stool testing before? ______ Yes ______No
If yes, what? ____________________

Do you frequently travel outside of the U.S.? ______ Yes ______No
If yes, where? ____________________
How recently? ____________________

Do you frequently travel within the U.S. ______ Yes ______No

Do you frequently eat out? ______ Yes ______No

Do your children go to daycare centers? ______ Yes ______No

Do you live in a dormitory or other residential housing? ______ Yes ______No

Do you prepare food for others at restaurants, homes, schools? ______ Yes ______No

Do you handle food that is transported to others? ______ Yes ______No

Do you work at a hospital or other healthcare facility? ______ Yes ______No

Have you had any previous parasitic infections? ______ Yes ______No
If yes, what & when? ____________________

Do you observe strict personal hygiene practices? ______ Yes ______No

Do you enforce strict personal hygiene practices with your children? ______ Yes ______No

Do you ensure that your food is thoroughly cooked? ______ Yes ______No

Do you eat raw meat of any kind? ______ Yes ______No

Do you wash your hands after touching pets? ______ Yes ______No

Do you restrict pets to certain parts of the home? ______ Yes ______No

Do you wash fresh fruits & vegetables? ______ Yes ______No

Do you have any concern about a potentially contaminated water source? ______ Yes ______No

Do you experience chronic & vague GI symptoms such as frequent bloating, gas, cramping and constipation? ______ Yes ______No

Do you have frequent diarrhea? ______ Yes ______No

For Adrenal Stress Index Patients Only:

Do you have excessive feelings of tiredness & an inability to cope? _______ Yes _______ No

Do you have cravings for sugary foods? Coffee? _______ Yes _______ No

Have you had a lack of vitality & energy? _______Yes _______ No

Do you have migraine headaches? _______ Yes _______ No

Do you have a low sex drive? _______ Yes _______ No

Have you had sleep disturbances? _______ Yes _______ No

Do you have muscle & joint pain? _______ Yes _______ No

Have you noticed poor memory? _______ Yes _______ No

Do you have an intolerance to alcohol? _______ Yes _______ No

Have you suffered from chronic stress & related health problems? _______ Yes _______ No

Do you have a low body temperature? _______ Yes _______ No

Have you been diagnosed with osteoporosis? _______ Yes _______ No

Has you immune system health been poor? _______ Yes _______ No

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Please carefully review the conditions listed below and place a check mark in the areas that are ***current*** health problems of a family member. Do not respond in any spaces that do not apply. If you wish to elaborate on any of your responses, please use the back of this form. **Also, please circle the responses that apply to relatives that live in your area, as there are certain conditions that are affected by similar climate conditions.**

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN		
	AGE [ ]	AGE [ ]	AGE [ ]	AGE [ ]	AGE [ ]	AGE [ ]	AGE [ ]	AGE [ ]	AGE [ ]	AGE [ ]
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Blood in Urine/Stools										
Breast Cancer										
Cancer										
Constipation										
Depression										
Diabetes										
Disc Problems										
Eczema										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Problems										
Liver Problems										
Migraine Headaches										
Nervousness										
Pinched Nerve										
PMS										
Scoliosis										
Sinus Trouble										
Stroke										
Stomach Trouble										
Other:										

Financial Requirements

The patient is responsible for the cost of the lab fees, in addition to any shipping and handling fees. These are to be payable directly to the lab.

Initial Consultation/Report of Findings & supplemental educational materials: $165
Follow-up Consultation with Repeat Testing & Updated Report of Findings: $100
Follow-up 30-minute phone consultation: $50

**Any supplementation or product recommended will be from the following companies exclusively available to health care practitioners and available at wholesale prices with the option for direct drop shipping:
Standard Process, MediHerb and Bezwecken.

Information on any of these organizations is available upon request.

I agree to pay for the fees for treatment as indicated:

[ ] Payment in full prior to each appointment with cash or check. Your cash or check will not be deposited until services are rendered.

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor on any changes in my health status.

Signature of Patient/ Guardian____ Date _______________

For Office Use Only

_____ Reg. Pre Menopause Female Hormone Panel (FHP)
_____ Expanded Pre Menopause Female Hormone Panel (eFHP)
_____ Short Post Menopause Hormone Panel (PHP1)
_____ Expanded Post Menopause Hormone Panel (ePHP1)
_____ Long Post Menopause Hormone Panel (PHP2)
_____ Regular Male Hormone Panel (MHP)
_____ Expanded Male Hormone Panel (eMHP)
_____ Short Thyroid Panel (STP)
_____ Expanded Gastrointestinal Health Panel
_____ Food Intolerance Panel
_____ Comprehensive Ova & Parasites Panel (GP9-S)
_____ Extended Ova & Parasites Panel
_____ Hair Analysis
_____ Regular Adrenal Stress Index (ASI)
_____ Expanded Adrenal Stress Index (eASI)
_____Bone Health Markers (DPD)
_____ Yeast Panel (CS8)
_____ Regular Gastrointestinal Health Panel (GI-1)