Vitalized Performance Group

## Demographic Information

Today's Date: _____

*Please bring in your valid Government issue ID and hand it to your provider*

Name: _____ Date of Birth: _____

Address: _____ Email: _____

City, State: _____ Cell Phone: _____

Zip Code: _____ Home Phone: _____

Emergency Contact: _____ Contact's Phone: _____

Gender _____ Pronoun Preference _____

Reason for today's visit: How long have you had this issue? Have you seen anyone else address this issue? What other treatments have you received? _____ _____ Are you under the routine care of a physician? If yes Name/Town_____

Physician's /PCP's name and contact info: _____

**How did you hear about us? Help us thank them.**

- Physician (who and where?) _____
- Friend/Family Member/Other _____
- VPG Client _____
- Radio/TV Ad (what channel?) _____
- Coupon (where?) _____
- Sign (where?) _____
- Internet search (what were your search terms?) _____ _____

# HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. Vitalized Performance Group is a collaborative practice and by signing this form you give each one of us permission to look at your file and discuss amongst each other your medical condition and treatment plan.

The notice contains a patient's rights section describing your rights under the law. You confirm with your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potential anonymous use in publication. You have the right to revoke this consent in writing, signed by you.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed only by law.
- The practice has the right to restrict the information, but the practice does not have to agree with those restrictions.
- The patient has the right to revoke this consent in writing at any time and the full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Our Email: **vpgwaves@vpgwaves.com** is a HIPAA COMPLIANT 3RD PARTY ENCRYPTED EMAIL GOING OUT: PLEASE USE THIS ALL PROVIDERS HAVE ACCESS TO THIS EMAIL. We understand that many households use shared e-mail addresses. You give us permission to send emails where others can potentially access the information. With today's advances in technology and the busy lifestyles that people lead, email is often preferred over other forms of communication when it comes to confirming appointments or sending lab test results. However, patients/clients should be aware that even despite extensive efforts on the part of the healthcare provider to protect sensitive information, no email is 100% safe.

May we phone, email, or text you to confirm appointments? Yes,

No May we leave a message on your answering machine or cell Yes

No

May we discuss your medical condition with any member of your family or other medical establishment: Yes No

If YES, please provide the names of members allowed:

_____

_____

This consent was signed by client/patient (PRINT NAME): _____

Sign _____

If patient/client is under 18 or other incapable (legal guardian/ Print/Sign): _____ Date_____

**List all your Surgeries & Hospitalizations, including date they occurred:**

_____

_____

_____

_____

**List all allergies to medications, food, and environment:**

_____

_____

_____

**List your health concerns in order of importance:**

| | |
|---|---|
| **1)** | **4)** |
| **2)** | **5)** |
| **3)** | **6)** |

**List all prescription medicines & nutrients/supplement/herbs that you are taking and including brand name and dosage:**

_____

**HEAD**

| | | | |
|---|---|---|---|
| Headache: | Y N P | Migraines: | Y N P |
| Dandruff: | Y N P | Head injury: | Y N P |
| Oily/dry hair: | Y N P | Hair loss: | Y N P |

**NECK**

| | | | |
|---|---|---|---|
| Stiffness: | Y N P | Swollen glands: | Y N P |
| Restricted movement: | Y N P | Tightness: | Y N P |

**RESPIRATORY**

| | | | |
|---|---|---|---|
| Cough: | Y N P | Tuberculosis: | Y N P |
| Shortness of breath on | Y N P | Bronchitis: | Y N P |
| Shortness of breath while | Y N P | Pneumonia: | Y N P |
| Shortness of breath while | Y N P | Asthma: | Y N P |
| Wheezing: | Y N P | Painful breathing: | Y N P |

**CARDIOVASCULAR**

| | | | |
|---|---|---|---|
| High blood pressure: | Y N P | Rheumatic fever: | Y N P |
| Low blood pressure: | Y N P | Murmur: | Y N P |
| Arrythmia: | Y N P | Palpitations: | Y N P |
| Edema: | Y N P | Chest pain: | Y N P |

**URINARY TRACT**

| | | | |
|---|---|---|---|
| Incontinence: | Y N P | Painful urination: | Y N P |
| Frequent infections: | Y N P | Kidney Stones: | Y N P |
| Urgency: | Y N P | Discharge/blood: | Y N P |

**GASTROINTESTINAL**

| | | | |
|---|---|---|---|
| Heartburn: | Y N P | Bowel movement frequency: | _____x/day |
| Indigestion: | Y N P | Recent BM change: | Y N P |
| Bloating: | Y N P | Diarrhea/constipation: | Y N P |
| Nausea: | Y N P | Hemorrhoids: | Y N P |
| Vomiting: | Y N P | Gall bladder disease: | Y N P |
| Change in appetite: | Y N P | Liver disease: | Y N P |
| Pancreatitis: | Y N P | Ulcer: | Y N P |

**MUSCULOSKELETAL**

| | | | |
|---|---|---|---|
| Weakness: | Y N P | Arthritis: | Y N P |
| Stiffness: | Y N P | Leg cramps: | Y N P |
| Tremors: | Y N P | Pain: | Y N P |

**NERVOUS**

| | | | |
|---|---|---|---|
| Paralysis: | Y N P | Sciatica: | Y N P |
| Tingling/numbness: | Y N P | Carpal tunnel syndrome: | Y N P |
| Seizures: | Y N P | Fainting: | Y N P |

**MENTAL/EMOTIONAL**

| | | | |
|---|---|---|---|
| Depression: | Y N P | Anger/irritability: | Y N P |
| Suicidal: | Y N P | High-strung/tense: | Y N P |
| Anxiety: | Y N P | Fear/panic: | Y N P |
| Eating disorder: | Y N P | Psychiatric treatment: | Y N P |

**SKIN**

| | | | |
|---|---|---|---|
| Rashes: | Y N P | Color change: | Y N P |
| Hives: | Y N P | Lump(s): | Y N P |
| Psoriasis/eczema: | Y N P | Itchiness: | Y N P |
| Dryness: | Y N P | Warts/moles: | Y N P |
| Cancer/type: _____ | Y N P | Perspiration: | Y N P |

## MALE REPRODUCTIVE

| | | | |
|---|---|---|---|
| Testicular pain/swelling: | Y N P | Sexually active: | Y N P |
| Hernia: | Y N P | STD/STI: | Y N P |
| Discharge: | Y N P | Prostate | Y N P |
| Impotence: | Y N P | Sexual orientation: | |

## FEMALE REPRODUCTIVE

| | | | |
|---|---|---|---|
| Age period began: | | Days in menstrual cycle: | |
| How long period lasts: | | Heavy bleeding: | Y N P |
| Menstrual cramping: | Y N P | Menstrual pain: | Y N P |
| PMS: | Y N P | Food cravings | Y N P |
| Number of pregnancies: | | Number of births: | |
| Miscarriages: | | Terminations: | |
| Last pap smear: | | Sexual orientation: | |
| Abnormal pap smear(s) | Y N P | When was result | |
| Menopausal since: | | Hormone use: | Y N P |
| Type of hormones used: | | Healthy libido: | Y N P |
| Vaginal dryness: | Y N P | Sexually active: | Y N P |
| Painful intercourse: | Y N P | Vaginitis: | Y N P |
| STD/STI: | Y N P | Mammography: | Y N P |
| Bone density test: | Y N P | Bone density results: | |

Current Weight _____ Height_____

Weight one year ago: _____ Maximum weight: _____(when: _____) Ideal weight: _____

Do you have good or adequate or low energy? _____

Do you experience fatigue? _____

Does fatigue affect you most in the morning ____, afternoon ____, or evening ____?

Does fatigue prevent you from necessary activity? _____

**Questions/Concerns/Comments:**

If anything circled/checked Y or P FOR Past, please explain. Would you like a more in-depth consultation regarding the above wellness concerns?

Health History Questionnaire for Colon Hydrotherapy

***What is a Contraindication?*** *(con·tra·in·di·ca·tion)* A contraindication is a specific health condition for which a Drug, Disease, Procedure, Treatment or Surgery is inadvisable as it may be harmful to the health of the client/patient.

Mark (x) any contraindications and note the dates of diagnosis or experience. ONLY MARK CURRENT CONDITIONS

| | | | |
|---|---|---|---|
| | Abdominal hernia: Date: | | Dialysis: Y N Past if past explain |
| | Abdominal surgery: Date/ type: | | Diverticulosis or diverticulitis |
| | Abdominal distension | | Fissures or fistulas |
| | Acute liver failure | | Hemorrhaging |
| | Anemia Severe needing blood transfusion | | Hemorrhoidectomy |
| | Aneurysm (all types) | | Intestinal perforation |
| | Cancer - specify type: Date: | | Lupus |
| | Cardiac condition | | Pregnant – due date: |
| | Crohn's disease | | Rectal/colon surgery |
| | Colitis | | Renal insufficiencies (kidney disease) |

If you have ***NOT*** been diagnosed with any of the above listed contraindications to colon hydrotherapy,

please initial here: _____date: _____

Please mark (x) all that apply to you: These are not contraindication to colonics. Note current inflamed/bleeding hemorrhoids colonics not recommended until the flare is healed.

| | | | | | |
|---|---|---|---|---|---|
| | Recent colonoscopy (date: ) | | Hemorrhoids (internal / external) | | BM difficult or painful |
| | Blood in stool | | Rectal bleeding | | Burning or itching anus |
| | Constipation or diarrhea | | Laxative use | | Vomiting |
| | Bloating | | High blood pressure | | Infectious disease |
| | Last menstrual cycle date: | | UTI/bladder infection | | Latex allergy |

I am aware that this clinic uses FDA Colon Hydrotherapy Devices, and the trained therapist is *not* required to be state licensed. This clinic does have a Licensed Medical Director who may NOT be on site at the time of your appointment. No studies have been conducted for this alternative and complementary modality. I am aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon hydrotherapy devices and/or enema kits. Should I experience resistance during my nozzle insertion, I will immediately stop my session. If during the session, I experience discomfort or pain, I am responsible for immediately stopping my session. If you are taking Medications that may increase the risk for potential side effects, then you should consult with your physician before proceeding with your colonic. Please initial to confirm: _____

**I have reviewed and discussed with the LIBBE Device Trained Therapist that I *do not* have any diseases, contraindications or other health concerns that prevent me from safely receiving colonics and I wish to proceed with my colon hydrotherapy sessions:**

**Signature: _____Date: _____**

**As a Trained Therapist, I will always follow the LIBBE Manufacture operation, use & maintenance guidelines. I have reviewed and discussed this form with the above client.**

**Therapist Signature: X_____**

I, _____, have decided to undergo a Colon Hydrotherapy session.

Colon Hydrotherapy is intended to irrigate the large intestine with the use of the FDA-approved colon hydrotherapy LIBBE system. I understand there may be benefits resulting from this session; however, I understand and agree that no warranties have been made as to the effectiveness or outcome of this session.

- We do not diagnose.
- We make no attempt to cure any condition.
- We make no claim or imply any claim that suggestions are given to cure any condition.
- We do not claim that any supplemental material that we discuss will cure any condition or that its purpose is to treat any condition.

I understand that I will insert a tube/speculum into my rectum and agree that I will witness that the tubing the certified therapist is using a sterile from a new, sealed container. _____(Initial Here)

I understand that all the therapists here are not attempting to portray or conduct the activities of a medical doctor and I waive any liability on behalf of the certified therapist. _____(Initial Here)

I confirm that I am not a woman who is pregnant as this would make me an unsuitable candidate for this session. _____(Initial Here)

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment. I hereby give consent for this Colon Hydrotherapy treatment and release the certified therapist, the person performing the Colon Hydrotherapy session and the facility from liability associated with this and all subsequent treatments with the above understood.

**Consent for Colon Hydrotherapy:**

I am aware of the possible adverse events that may occur during Colon Hydrotherapy including perforation, redness, or tenderness at the insertion point. Should I experience resistance during my nozzle insertion, I will immediately stop my session. If during if during the session I experience any discomfort or pain, I will stop my session immediately and notify the Practitioner. I have notified my Practitioner of any allergies that I may have included an allergy to latex and any prescription drugs or supplements that I am currently taking. I have reviewed and discussed my medical history with my LIBBE device trained therapist and I do not have any diseases, contraindications or any other health concerns that may affect my treatment. I also understand the possible side effects including but not limited to increased or decreased energy, nausea, vomiting, cramping, lightheadedness, gas and bloating, overheating, diarrhea, headache, body and joint aches, hemorrhoids (which may become irritated, inflamed or bleed.)

I also consent for Naturopathic/Dr/Md/APRN Provider to view this form. I consent to any consultations if the provider requires it to receive a needed written prescription form for colon hydrotherapy sessions.

_____Signature of Patient and Date

ALL CONSENTS MUST BE READ AND SIGNED TO BE ABLE SUBMIT FORM. THIS IS TO ASSURE ALL PAPERWORK IS COMPLETE, AND LAST MINUTE ADD ON TREATMENTS WILL BE COVERED.

**Patient Consents to all providers and services and agrees to follow regimen to their best abilities for 6 months during treatment and after completion of treatments. Initial here: _____ OPTIONAL, THIS PROMISE TO ONE-SELF HELPS KEEP THEM ACCOUNTABLE FOR THEIR HEALTH GOALS.**

**IMMEDIATELY INFORM YOUR PRACTITIONER IF YOU HAVE THE FOLLOWING:** ***Contraindications: Heat Sensitivity, Pacemaker or other electromagnetism, Heart transplant or any open sores, blood clots and or blood thinners.***

**Consent for GAINSWave/FemiWave/AcuteWave/Shock wave for pain and all other issues:**

(**Please inform your medical practitioner if you have a blood clot or clotting or bleeding disorder or are taking blood thinners as these may be contraindications to the GAINSWave Procedure**)

I authorize the practitioner to treat my condition. I understand the purpose of the therapy procedures to be: Extracorporeal Shock Wave Therapy (ESWT) with an FDA cleared medical device to those areas the Practitioner believes will be the most effective in optimizing my condition/conditions. Although ESWT has been performed on thousands of patients and the risks are very low, I understand that common risks associated with the procedure are swelling, reddening of the skin, soreness, hematomas or bruising and petechiae (minor broken blood vessels). I also understand that there may be risks or complications from both unknown and known causes from treatments. I am aware that there is no guarantee of treatment outcome. I have informed the practitioner of any known allergies to drugs or other substances and any past reactions to any anesthetics. I have informed the practitioner of all current medications and supplements I am taking.

_____ Signature of Patient and Date

**Consent for Acupuncture/ Chinese Herbs/ Cupping and Gua Sha**

I understand that acupuncture is performed by the insertion of needles through the skin on or near the surface of the body in attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to regulate the body's physiological functions. I am aware of the possible side effects such as but not limited to local bruising, minor bleeding, fainting, pain or discomfort. I understand that *gua sha* and cupping therapy can lead to bruising, sore muscles, and aches. I am aware that Chinese Herbal Therapies or Homeopathic remedies which are used to normalize body function can lead to changes in bowel movements, abdominal pain or discomfort. All therapies can lead to possible aggravation of symptoms. Should I experience any side effects I will notify my practitioner. I have notified my practitioner of any allergies I may have as well as any drugs or supplements that I am taking. I have carefully read and understand all the information and am fully aware of what I am signing, and I consent to treatment.

_____ Signature of Patient and Date

***Consent for Any heat or Ionic Treatment***:

*IF PREGNATE MUST HAVE LESS THAN 1 HOUR SESSION AND LOWER HEAT SETTINGS.

. I understand that these procedures are for the purpose of cleansing/relaxation and are not intended to take the place of medical care or medications. I clearly confirm that I do not have any contraindications to the Ion Detox Therapy Foot Bath/and all heat therapies. I understand that I take full responsibility for my own health and well-being. I will discuss all health concerns with my provider before treatment to make sure these treatments are safe for me. I also understand I might be offered electrolytes/water after and during treatments.

_____ Client Signature/Date