COUNTRY HEALTH CLINIC

CARING NATURALLY, ONE PERSON AT A TIME

Name _____ Date_____ Phone (___)_____

Address _____ City _____ State _____ Zip_____

Date of Birth _____M_____ F_____ Age _____ Height _____Weight _____

Email _____Referred by_____

Employer_____ Work Phone_____

Spouse _____ Spouse Phone (___)_____

Nearest Relative Not Living With You_____ Phone (___)_____

Present/Previous Diagnosis:_____

_____

Treatments Received for Diagnosis:_____

Current Prescriptions:_____

Dental Work (metal fillings, root canals, implants, etc)_____

_____

When year Dental work was done:_____

At present, what is your chief complaint?_____

How long have you had these conditions?_____

Is this condition getting worse? Yes_____ No_____

Have you been on a nutritional program before? Yes_____ No _____

Please list any foods you choose not to partake of that may affect supplement choice for example pork, fish, etc_____

Circle which form of nutritional supplements you prefer: Capsules Liquid/Powder

Circle if you wear: Glasses Contacts Hearing Aid

Circle if you use: Tobacco Alcohol Coffee (more than two cups daily)

Allergies_____

Surgeries_____

If female, are you pregnant or nursing? Yes_____ No_____

1465 Bannock Hwy
Pocatello ID 83204

Telephone: 208-397-4156
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Website: www.drscountryhealth.com
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COUNTRY HEALTH CLINIC

CARING NATURALLY, ONE PERSON AT A TIME

CONFIDENTIAL HEALTH QUESTIONAIRE

Name: _____ Date: _____ Phone: _____

Address: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: M F

Instructions: Circle the number which best describes the intensity of your symptoms. If a question does not apply to you, leave it blank.

1 = Mild 2 = Moderate 3 = Severe

Note: Questions 13 – 21 circle appropriate symptom and intensity

1.	Chills	1	2	3	45.	Poor circulation	1	2	3
2.	Depression	1	2	3	46.	Rapid heartbeat	1	2	3
3.	Dizziness	1	2	3	47.	Swelling of ankles	1	2	3
4.	Fainting	1	2	3	48.	Varicose veins	1	2	3
5.	Fever	1	2	3	49.	Bleeding gums	1	2	3
6.	Forgetfulness	1	2	3	50.	Blurred vision	1	2	3
7.	Headache	1	2	3	51.	Crossed eyes	1	2	3
8.	Loss of sleep	1	2	3	52.	Difficulty swallowing	1	2	3
9.	Loss of weight	1	2	3	53.	Double vision	1	2	3
10.	Nervousness	1	2	3	54.	Earaches	1	2	3
11.	Numbness	1	2	3	55.	Ear discharge	1	2	3
12.	Sweats	1	2	3	56.	Hay fever	1	2	3
13.	Arms: Pain Weakness Numbness	1	2	3	57.	Hoarseness	1	2	3
14.	Back: Pain Weakness Numbness	1	2	3	58.	Loss of hearing	1	2	3
15.	Feet: Pain Weakness Numbness	1	2	3	59.	Nosebleeds	1	2	3
16.	Hands: Pain Weakness Numbness	1	2	3	60.	Persistent cough	1	2	3
17.	Hips: Pain Weakness Numbness	1	2	3	61.	Ringing in ears	1	2	3
18.	Legs: Pain Weakness Numbness	1	2	3	62.	Sinus problems	1	2	3
19.	Neck: Pain Weakness Numbness	1	2	3	63.	Vision—flashes	1	2	3
20.	Shoulders: Pain Weakness Numbness	1	2	3	64.	Vision—halos	1	2	3
21.	Allergies: Food or Airborne	1	2	3	65.	Bruise easily	1	2	3
22.	Blood in urine	1	2	3	66.	Hives	1	2	3
23.	Frequent urination	1	2	3	67.	Itching	1	2	3
24.	Lack of bladder control	1	2	3	68.	Change in moles	1	2	3
25.	Painful urination	1	2	3	69.	Rash	1	2	3
26.	Appetite poor	1	2	3	70.	Scars	1	2	3
27.	Bloating	1	2	3	71.	Sore that won't heal	1	2	3
28.	Bowel changes	1	2	3		MEN ONLY			
29.	Constipation	1	2	3	72.	Breast lump	1	2	3
30.	Diarrhea	1	2	3	73.	Erection difficulties	1	2	3
31.	Excessive hunger	1	2	3	74.	Lump in testicles	1	2	3
32.	Excessive thirst	1	2	3	75.	Penis discharge	1	2	3
33.	Gas	1	2	3	76.	Sore on penis	1	2	3
34.	Hemorrhoids	1	2	3		WOMEN ONLY			
35.	Indigestion	1	2	3	77.	Abnormal pap smear	1	2	3
36.	Nausea	1	2	3	78.	Bleeding between periods	1	2	3
37.	Rectal bleeding	1	2	3	79.	Breast lump	1	2	3
38.	Stomach pain	1	2	3	80..	Extreme menstrual pain	1	2	3
39.	Vomiting	1	2	3	81.	Hot flashes	1	2	3
40	Vomiting blood	1	2	3	82.	Nipple discharge	1	2	3
41.	Chest pain	1	2	3	83.	Painful intercourse	1	2	3
42.	High blood pressure	1	2	3	84.	Vaginal discharge	1	2	3
43.	Irregular heartbeat	1	2	3	85.	Shortness of breath	1	2	3
44	Low blood pressure	1	2	3	86.	Fibroids or Cysts	1	2	3

CONFIDENTIAL HEALTH HISTORY

Instructions: If you have had one of these conditions in the past put a "P". If you currently have one of these conditions, put a "C". Please mark only those conditions that apply to you and/or your health.

1.	Acid Reflux		31.	HIV Positive	
2.	Alcoholism		32.	Irritable Bowel Syndrome	
3.	Anemia		33.	Kidney Disease	
4.	Anorexia		34.	Liver Disease	
5.	Appendicitis		35.	Measles	
6.	Arthritis		36.	Migraine Headaches	
7.	Asthma		37.	Miscarriage	
8.	Auto Immune Disorder		38.	Mononucleosis	
9.	Bleeding Disorders		39.	Multiple Sclerosis	
10.	Breast Lump		40.	Mumps	
11.	Bronchitis		41.	Pacemaker	
12.	Bulimia		42.	Pneumonia	
13.	Cancer		43.	Polio	
14.	Cataracts		44.	Prostate Problem	
15.	Chemical Dependency		45.	Psychiatric Care	
16.	Chicken Pox		46.	Rheumatic Fever	
17.	COPD or Pulmonary Disease		47.	Scarlet Fever	
18.	Crohs Disease		48.	Shingles	
19.	Diabetes		49.	Smoker	
20.	Diverticulitis		50.	Soft Drinks (1 or more per day)	
21.	Emphysema		51.	Soft Drinks (Diet) (1 or more per day)	
22.	Epilepsy		52.	Stroke	
23.	Glaucoma		53.	Suicidal Thoughts	
24.	Goiter		54.	Thyroid Problems	
25.	Gout		55.	Tonsillitis	
26.	Heart Disease		56.	Tuberculosis	
27.	Hepatitis		57.	Typhoid Fever	
28.	Hernia		58.	Ulcers	
29.	Herpes		59.	Vaginal Infections	
30.	High Cholesterol		60.	Venereal Disease	

Dental work such as root canals, implants, metal fillings, etc. and year it was done_____

Other Condition and/or Diseases:_____

I have answered the above questions to the best of my knowledge.

Signed: _____

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DECLARATION OF INFORMED CONSENT TO SERVICES, CONTRACT AND STIPULATIONS REGARDING ALL EMPLOYEES OF COUNTRY HEALTH CLINIC
Effective January 2023

Clinic Treatment(s)
This document is a binding agreement (the "Agreement") between the Country Health Clinic, our practitioners, and/or ("We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows:

1. Consent for Treatment and Experimental Nature of Treatment. You understand and acknowledge that our practitioners, nor any other providers and/or employees of the Country Health Clinic do not guarantee the treatments will cure me of any disease or affliction (including cancer). You believe it is within your constitutional rights to seek any form of diagnosis and treatment, whether orthodox or unorthodox (not recommended by the AMA). It is your choice whether or not to accept such diagnosis and treatment. By Your signature, You attest that You have not engaged the service of those employed by the Country Health Clinic to file a malpractice suit or further any investigation or prosecution by any government entity or medical association. Your sole purpose and intent in seeking the services of our practitioners, and the Country Health Clinic is to get help for Your personal health problems.

You understand that Country Health Clinic and our practitioners, and /or Colleagues' treatment program includes but is not limited to: Naturopathic Medicine, Reflexology, Live and Dry Blood Appraisals, Intravenous Micronutrient Therapy, Ultraviolet Blood Irradiation, Manual Therapies, Ozone Therapy, Spinal Touch, Massage, Acupuncture, Applied Kinesiology, PTSD Treatments, Chelation, Prolozone, Nutritional Guidance and Counseling on which no governmental (including the U.S. Food and Drug Administration ("FDA")), scientific or medical authority has issued any guidelines or statements as to the safety or efficacy thereof. You also understand that the treatment may be unconventional or experimental. You understand that the practice of health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You acknowledge that we have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment. You agree to hold neither our practitioners nor any colleague and/or employee of the Country Health Clinic harmless and blameless from any untoward result. You acknowledge that Your acceptance of their services binds You to pay the fee and that such fee reflects their knowledge, education and years of experience. You acknowledge that We have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment. We have informed You that the Treatments MAY alter, address or decrease your pain, symptoms or complaints, but also may have not effect.

2. Risks, Side Effects, Complication. We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including but not limited to infection; swelling; increased pain; bleeding; vein irritation and hardening; temporary numbness; lightheadedness; nausea; dizziness; allergic or anaphylactic reaction; bruising; pain at IV site; acute vs. chronic liver or kidney dysfunction; scarring; headaches; gastrointestinal upset; shortness of breath; chest tightness; transient blindness; blood clots; embolism; fluid overload; a flushed feeling; warmth in the body; low or high blood pressure; low or high blood sugar; temporary or permanent alteration in sensation; discoloration; the need for additional surgery; soreness, itching, injury to nerves; spinal cord injuries, Pneumothorax (air on the outside of the lung); paralysis; no benefit from Treatments; or other serious or debilitating injuries or death. You understand that other complications and risks are possible and that healing does not always proceed in a predictable manner and may take many weeks or months to experience full effect.

3. Description of Treatments. You acknowledge that the Treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, homeopathic medicines, and FDA approved prescriptive medicines, local anesthetic (Procaine or Lidocaine), sugar water or dextrose, and, on occasion ozone therapy and local subcutaneous anesthetic infiltration. The exact solution and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to you when we actually administer the Treatments.

4. Health Care Staff. You are aware that among those who attend you on our behalf may be medical, nursing, and other health care personnel in training, who unless requested otherwise, may participate in patient care as part of their education. You further consent to the presence of service representatives and/or technicians from manufacturers of equipment or devices to assist in performing and/or operation of such equipment and/or devices during operation, procedure and Treatments.

5. Information You provide Us. You have provided Us with a complete list of all prescription and nonprescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided us with 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 covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 5, is true, accurate, complete and up-to-date to the best of Your knowledge.

6. Assumption of Risk and Alternatives. You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any question about this Agreement or the Treatments that you have, you are willing to assume any and all risks associated with the Treatments, including without limitation those described in this 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 signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed. You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications, and taking no action. You further acknowledge that You have not been advised against seeking any other medical examinations or treatments.

7. Miscellaneous. You agree that this Agreement constitutes the entire agreement between You and Us 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 representatives and assigns. In case any one of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidly. This Agreement shall be governed by the laws of the state of Idaho without regard to any choice of law principal. Any dispute between you and Us shall be adjudicated in state of federal court and You submit to the jurisdiction of any such court.

8. Dry Blood Appraisal/Live Blood Appraisal (DBA/LBA): If you wish to partake in the blood appraisal comparison program, it will be necessary for you to fill out completely the forms, including the Metabolic Assessment form. An appraisal will not be done without the Metabolic Assessment form and/or a comparison modality (such as conventional medical reports or lab work). We may also give you a prescription to have other conventional tests/labs done if desired or needed to assist with the comparison and assessing of your health condition. When doing so you acknowledged you have provided us with a complete list of all prescription and nonprescription medications you are currently taking. You understand that our practitioners, and the staff do the (HLB) DBA/LBA blood research comparison appraisals and were trained under Dr. Harold Klassen. This is used to help gather data for future reference and appraisal using this type of test. The DBA detects morphological changes which are pathological conditions. However, many of these morphological changes appear similar, particularly in early stages. It is not intended for diagnostic purposes.

9. Email Consent: I consent to receive communications sent from Country Health Clinic and/or Colleagues, staff members, via U.S. mail and/or email. I understand that I may unsubscribe from any automated communications at any time.

You understand that Dr. Lee is a licensed Naturopathic Physician in the State of Idaho #NAT-19 and a licensed Chiropractor in the State of Idaho #CHIA 408, but is not a licensed MD or DO. You also understand that Randy Vawdrey is a licensed Nurse Practitioner (NP-659A) in the State of Idaho. Also, Karen Dickerson is a certified Physicians Assistant (PA-566) in the State of Idaho. Their advice and treatment is based on their training, experience and education reflecting their professional judgment in how to help me in the fullest. In good faith, You accept and engage the service of those employed by the Country Health Clinic and do hold them harmless for the services they have or will render. You understand that our practitioners, and our colleagues, are not Medicare or Medicaid providers and that your receipt is **not** to be submitted to Medicare or Medicaid. By Your signature, You attest to the fact that no one may view my records except the Country Health Clinic and myself without written permission from me. Payments for services are due at the time service is rendered, unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover, or American Express. We do not accept assignment.

10. Provider Notice of Privacy Practices: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of the treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods. You have the right to look at or get a copy of health information about yourself and/or your minor children that we use to make decisions about you or them. We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this declaration.

11. Acknowledgement and Voluntary Consent to Seek Services: I have read (or have had read to me) the Declaration of Informed Consent to Services, contract and stipulations, and agree to be bound by the terms therein. I have not signed this declaration without first reading it or having it read to me and I may ask any questions useful in helping me to understand it. I further understand my agreement to the provision of this declaration is an entirely voluntary and informed choice to which my signature attests.

_____ _____

PATIENT OR GUARDIAN SIGNATURE WITNESS SIGNATURE