

Instructions:

1. Fill Out All Three Forms Below:
 - a. Confidential Patient Symptom Profile
 - b. NATUROPATH TREATMENT ACKNOWLEDGEMENT AND AGREEMENT
 - c. Credit Card Authorization Form

2. Mail or Fax the Forms to Dr. Strande
 - a. Mailing Address
Healing P.A.
2670 S. Gessner Drive
Houston, TX. 77063

 - b. Dr. Strande has 2 Fax Numbers

713 660-1426

713 660-1427

3. Any questions call Healing P.A.

713 660-1420 or

EMail info@simplyhealingclinic.com

CONFIDENTIAL PATIENT SYMPTOM PROFILE

Name _____ Date _____

Address _____

Age _____ Date of Birth _____ Male/Female _____

Occupation _____ Children (Ages) _____

Previous Illnesses _____

Current Medications and/or Treatments (include the specific condition being treated)

Family History (circle if yes): Heart Disease Diabetes Cancer Obesity

Alcohol/Drug Addiction Mental or Emotional Problems

Other _____

Do you get cold hands and/or feet (circle)? Often Sometimes Never

Please Circle One

- | | | | |
|--|-------|-----------|-------|
| Do you find it difficult to sustain concentration or forget things easily? | Often | Sometimes | Never |
| Do you get weepy, depressed and find it hard to motivate yourself? | Often | Sometimes | Never |
| Do you get anxious, panicky or shaky inside? | Often | Sometimes | Never |
| Do you become impatient, irritable or aggressive too easily? | Often | Sometimes | Never |
| Do you crave sugar or sugary products? | Often | Sometimes | Never |
| Do you sigh and yawn a lot? | Often | Sometimes | Never |
| Do you suffer sharp shooting pains in the body? | Often | Sometimes | Never |
| Do you experience twitching of the face or eye muscle? | Often | Sometimes | Never |
| Do you experience any heart palpitations? | Often | Sometimes | Never |
| Do you wake up feeling tired? | Often | Sometimes | Never |
| Do you get stiff or painful joints? | Often | Sometimes | Never |
| Do you suffer from a sexually transmitted disease? | | Yes | No |
| Does your head feel fuzzy, as if it's full of cotton? | | Yes | No |
| Do you suffer from headaches? | Often | Sometimes | Never |
| Do you have excessive hair loss or split ends? | Often | Sometimes | Never |
| Are your fingernails soft or do they flake or crack? | Often | Sometimes | Never |
| Do you catch colds or infections easily? | Often | Sometimes | Never |
| Do you suffer from yeast infections or thrush? | Often | Sometimes | Never |
| Do you suffer from blocked sinuses or sinus headaches? | Often | Sometimes | Never |
| Do you have any post-nasal throat or chest mucus that is green or yellow?
in color? | Often | Sometimes | Never |
| Do you have respiratory mucus that is white in color? | Often | Sometimes | Never |
| Does the skin or your lips, hands or feet crack? | Often | Sometimes | Never |
| Do rich foods disagree with you? | Often | Sometimes | Never |
| Do you feel a tight band around your chest, head, throat or abdomen? | Often | Sometimes | Never |
| Do you suffer from hernia, hemorrhoids or varicose veins? | | Yes | No |
| Do you suffer from cystitis or urethritis? | Often | Sometimes | Never |
| Do you bruise easily or do cuts take a long time to heal? | Often | Sometimes | Never |

Your signature _____ **Date** _____

Please print name _____

NATUROPATH TREATMENT ACKNOWLEDGEMENT AND AGREEMENT

This agreement("Agreement") is entered into on _____, 201__ between Aleksander Strande, MS., Ph.D., and the corporation in which Dr. Strande conducts his practice, Healing, P.A. (together "Healing, P.A. unless otherwise noted) and _____("Patient"). The purpose of this Agreement is to confirm certain understandings and agreements, and confirm certain information provided to Patient by Healing P.A.

1. Patient understands that Dr. Strande is a Board Certified Naturopath by the Board of Examiners of American Naturopathic Medical Certification & Accreditation Board, Inc. (Committee on Naturopathic Medical Education, Washington, and District of Columbia) and licensed as a Naturopath by the Department of Health, Washington, District of Columbia. He is a member of the following organizations: The American Naturopathic Medical Association, The Association of Nutritional Consultants, American Association of Drugless Practitioners, American Holistic Association and American Herbalists Guild.
2. Patient understands that Dr. Strande is not a licensed physician. He has a Ph.D. Degree in Naturopathy, a MS. Degree in Microbiology, a Diploma of Herbal Medicine, and Diploma of professional Homeopathic Prescribing and a Postgraduate Diploma in Clinical Nutrition. As a Naturopath, he does not diagnose disease, treat illness or prescribe medicine. As a Naturopath, he assists in recovery from ill health and in maintaining well-being. Services provided are predicated on the enhancement and support of the inherent healing capacity of the individual body by using natural means. The treatment provided by Healing, P.A. is alternative or complimentary to healing arts services licensed by the State. However, the services provided are not licensed by the state of Texas.
3. It is the patient's choice to use any exercise or to purchase or use any supplements (i.e. Vitamins and minerals), herbs, homeopathic preparations, foods amino acids, and skin creams, discussed with, referred by or sold by Healing, P.A., or to buy any books, videotapes, or related materials that are recommended.
4. Patient will consult his/her primary physician if he/she so chooses or whenever deemed necessary. Patient will seek the advice of a doctor or specialist if advised by Healing, Inc. or Patient determines to be prudent or necessary for any reason.
5. Patient acknowledges that no representations or guarantees have been made by Healing, P.A. to Patient regarding the success or outcome of a consultation with or recommendations made by Dr. Strande.
6. Patient represents that all information that he/she has provided to Healing, P.A. is true and accurate and agrees that if there is a material change in the information provided; Patient will promptly notify Healing, P.A. of the change.

7. Patient agrees that if 24-hour notice is not given for the cancellation of any appointment consultation, Patient will be charged and agrees to pay for the full appointment fee.
8. Patient acknowledges and agrees that no refunds will be given for consultations, freight of supplements, liquid herbs and powdered amino acids as well as open bottles of other supplements.
9. Patient agrees to pay in full for all services and supplements at the time of consultation. If Patient uses another individual's credit card or check for payment, Patient represents that it is done with the permission of the individual's and Healing is not responsible to verify such permission.
10. This Agreement constitutes the entire understanding and final expression of the agreement between the parties regarding the subject matter of the Agreement and supercedes any and all prior or contemporaneous communications, all of which are merged into this Agreement. This Agreement shall not be modified, amended, supplemented or altered, except by an instrument signed by both parties. This Agreement is intended to cover services provided both before and after the date of this Agreement.
11. All disputes or claims arising out of, or in connection with the treatments or advice provided by or through Healing P.A. shall be settled under the rules of the American Arbitration Association by one arbitrator appointed in accordance with the rules. The place for the arbitration shall be Houston. The parties agree to submit themselves to the jurisdiction of the AAA in Houston, Texas.
12. This Agreement is intended to be valid and enforceable to the fullest extent permitted. If any provision is held invalid or unenforceable, such judicial findings shall not affect the validity or enforceability of any provisions.

THE SIGNATURE BELOW ACKNOWLEDGES THAT THE UNDERSIGNED HAS RECEIVED THE INFORMATION CONTAINED IN SECTIONS 1 AND 2.

DATED: _____

HEALING P.A.

By: _____

Aleksander Strande, MS., Ph.D.

DATED: _____

PATIENT

By _____

Signature

Print Name

Healing P.A.

2670 S. Gessner Rd.
Houston, TX. 77063

Name: _____

Address: _____

Home Phone: _____ Cell: _____

Credit Card: _____ Exp.Date _____

I authorize Healing P.A. to use this credit card number. I understand that payment for services are paid in full at the time services are rendered. I understand that all sales are final.

Signature: _____