

Aysana
H E A L T H
Creating balance in your life

19 S. Main Street, Owasso, Ok 74055
Phone: 918. 274.1760.

63225 E 290 Road P.O. Box 6856 Grove, OK. 74344
Phone: 918.786.3686

“Voluntary Release of Claim and Treatment agreement for Traditional Naturopathy”

Last Name _____ First Name _____ Client’s File _____
Street _____ City _____ State _____
Zip Code _____ Phone _____ Other Phone _____
Date of Birth _____ Sex _____ Marital Status _____
Occupation _____ Email _____

I fully understand that I am seeking non-medical treatment with Dr. Paula Rochelle N.D. / Dr. Renee Beck N.D. for the purpose of supporting my healing and health through rejuvenation, nourishment and body system strengthening and cleansing. Dr. Paula Rochelle N.D. / Dr. Renee Beck practice out of the state of Oklahoma and work in Oklahoma as a Naturopathic Practitioners as a free lance consultant for clients of Aysana Health. I am fully informed as to all suggested protocols and am free and encouraged to ask any and all questions about my health care decisions when working with Dr. Paula Rochelle / Dr. Renee Beck. I understand that Dr. Paula Rochelle / Dr. Renee Beck are Naturopathic Practitioners not Medical Doctors (M.D.), and as such, will not diagnose or “treat” for specific named medical disease but will work within their scope of practice as a Naturopath. Holistic screenings and modalities used include, but are not limited to: Electro Interstitial Screening, Electro Dermal Screening, thermography, laboratory results, and other holistic screenings which DO NOT DIAGNOSE but lead the naturopath or practitioner on a path to better ones’ health. Alternative and complimentary therapies include, but are not limited to: herbology, craniosacral therapy, homeopathy and nutritional work. By giving advice, which I am free to accept or reject or therapies which I choose to do or not, overall it is my decision to do or take any of the above therapies or screenings and the risks and end results of the same. Overall, I understand Aysana Health and or Dr. Paula Rochelle / Dr. Renee Beck do not take the responsibility for any of my decisions or actions or the results of taking or receiving suggestions or therapies and I release any and all claims to the contrary of the above agreements.

Date: _____ Signature: _____

IMPORTANT NOTICE: THE CONTENTS AND PROCESS IN THIS PROGRAM ARE FOR EDUCATIONAL PURPOSES ONLY AND ARE NOT TO BE USED AS DIAGNOSTIC, PRESCRIPTION, OR MEDICAL TREATMENT. ONLY LICENSED DOCTORS CAN DIAGNOSE, PRESCRIBE, OR GIVE TREATMENTS. YOU ARE RESPONSIBLE TO FOLLOW OR NOT ANY SUGGESTIONS. THE PRODUCTS SUGGESTED ARE ONLY FOR THEIR NUTRITIONAL VALUE. THE SUGGESTIONS OF THESE PRODUCTS DO NOT SIGNIFY A PRESCRIPTION OR MEDICAL TREATMENT. IF YOU ARE UNDER TREATMENT, THERAPY, OR TAKING ANY MEDICATIONS PRESCRIBED BY YOUR DOCTOR – DO NOT DISCONTINUE THEM. CONSULT YOUR DOCTOR BEFORE YOU TAKE THESE PRODUCTS OR FOLLOW ANY SUGGESTIONS.

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Client's Interview

Referred By _____

Surgery (list type, date, and approximate age):

Present Complaints or Problems:

- | | | | |
|------------------------|------------------------|------------------------|---------------------------|
| Abdominal Pain _____ | Vision Problems _____ | Dizziness _____ | Hemorrhoids _____ |
| Back Problems _____ | Lack Patience _____ | Loss of Memory _____ | Nagging Cough _____ |
| Joint Pains _____ | Nervousness _____ | Headaches _____ | Shortness of Breath _____ |
| Constipation _____ | Temper Problems _____ | Cold Hands/Feet _____ | Sinus Problems _____ |
| Digestion _____ | Tire Easily _____ | Hearing Problems _____ | Skin Problems _____ |
| Belching _____ | Trouble Sleeping _____ | Ear-Aches _____ | Varicose Veins _____ |
| Bowels Irregular _____ | Others _____ | | |

Childhood History

- | | | | |
|-------------------|--------------------|----------------------|-------------------|
| Asthma _____ | Measles _____ | Tuberculosis _____ | Hay Fever _____ |
| Chicken Pox _____ | Pleurisy _____ | Typhoid _____ | Tonsillitis _____ |
| Colds _____ | Pneumonia _____ | Whooping Cough _____ | Hives _____ |
| Diphtheria _____ | Running Ears _____ | Scarlet Fever _____ | Other _____ |

How much do you consume a day?

- | | | |
|---------------|------------------|-------------------|
| Alcohol _____ | Junk Foods _____ | Meat _____ |
| Bread _____ | Salt _____ | Fried Foods _____ |
| Coffee _____ | Drugs _____ | Sleep Hours _____ |

Weekly Hours Worked _____ Exercise _____

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Women Only

Have you been on the pill? _____

If yes, how long? _____

Ovarian Problems _____

Uterine Problems _____

Any Other Issues/Complaints _____

Men Only

Average Urinary Frequency per day _____

Any Dribbling? _____

Do you have any leg pains? _____

Insomnia? _____

Prostate Gland Trouble? _____

If yes, explain

Other problems

Genealogy Traits

How was your relationship with your parents? _____

Please explain briefly why:

Finally, what is your main physical or emotional complaint?

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Cranio Sacral Therapy (CST) is a gentle, hands-on approach that releases tensions deep in the body to relieve pain and dysfunction and improve whole-body health and performance. Using a soft touch restriction in the soft tissues that surround the central nervous system and spine are released.

CST is increasingly used as a preventative health measure for its ability to bolster resistance to disease. It is also effective for a wide range of medical problems associated with pain and dysfunction. Floyd Johnson has received a diploma as a Cranio Sacral Therapist from the Upledger Institute. (CST1)

Note: This is not chiropractic or a massage. This therapy will not be used in insurance and accident cases of any type and documentation of this sort will not be kept. By signing the document below, I am attesting that I understand and agree to all the above and that I am free to accept or reject this therapy(s), which by signing below, I choose to take at my own risk and the end results be it to my favor or not. I, again, confirm to understand that this is not medical treatment nor that it is pretending to be so. Overall, I understand Aysana Health and or Floyd Johnson do not take responsibility for any of my decisions or actions or the results of taking or receiving suggestions or therapy(s) and I release any and all claims to a negative or unfavorable outcome whatever it may be.

Date: _____

Signature: _____

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