Aysana

H E A L T H

Creating balance in your life

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

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Please email completed forms to: nutexcorporation@yahoo.com

"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 freelance 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 NO TO BE USED AS DIAGNOSTIC, PRESCRIPTION, OR MEDICAL TREATMENTS. 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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HEALTH
Creating balance in your life

SKIN

- ☐ Cuts heal Slowly
- ☐ Bruise Easily
- ☐ Rashes
- ☐ Pigmentation
- ☐ Changing Moles
- ☐ Calluses
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dryness/Cracking
- ☐ Oily Skin
- ☐ Itching
- ☐ Acne
- ☐ Boil or Skin Lesions
- ☐ Hives
- ☐ Nail Fungi
- ☐ Peeling Skin
- ☐ Shingles
- ☐ Nails Split
- ☐ White Spots on nail beds
- ☐ Crawling Sensations
- ☐ Burning on bottom of feet
- ☐ Athletes Foot
- ☐ Cellulite
- ☐ Bug Bites
- ☐ Bumps on Back of arms/Front of thighs
- ☐ Skin Cancer
- ☐ Body Order

Is your skin sensitive to:

- ☐ Sun
- ☐ Fabrics
- ☐ Detergents
- ☐ Lotions/Creams

HEAD

- ☐ Poor Concentration
- ☐ Confusion
- ☐ Headaches
- ☐ Concussions/Whiplash
- ☐ Mental Sluggishness
- ☐ Forgetfullness
- ☐ Indecisive
- ☐ Facial Twitching
- ☐ Poor Memory
- ☐ Hair Loss

EYES

- ☐ Gritty Sensation
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Poor Night Vision
- ☐ See bright flashes
- ☐ Halo around lights
- ☐ Eye Pains
- ☐ Dark Circle under eyes
- ☐ Light Sensitivity
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Visual Hallucinations
- ☐ Discharge
- ☐ Conjuctivitus

EARS

- ☐ Aches
- ☐ Ringing
- ☐ Deafness
- ☐ Itching
- ☐ Pressure

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- ☐ Frequent Infections
- ☐ Tubes in Ears
- ☐ Noise Sensitivity
- ☐ Auditory Hallucinations

NOSE/SINUS

- ☐ Congested
- ☐ Running/Discharge
- ☐ Post Nasal Drip
- ☐ Nasal Polyps
- ☐ Nose Bleeds
- ☐ Loss of sense of smell
- ☐ Seasonal Symptoms

MOUTH

- ☐ Teeth Problems
- ☐ Bleeding/Swollen gums
- ☐ Dry Mouth
- ☐ Bad Breath
- ☐ Coated Tongue
- ☐ Canker Sores
- ☐ TMJ
- ☐ Cracked/ Chapped Lips
- ☐ Root Canal
- ☐ Dentures

THROAT

- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Tonsillitis
- ☐ Mucus

Kidney/Urinary Tract

- ☐ Frequent Urination
- ☐ Burning Upon Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Bladder Infections (cystitis, etc.)
- ☐ Bedwetting

CIRCULATION/RESPIRATION

- ☐ Edema (swollen limbs)
- ☐ Numbness/Tingling Hands/feet
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Pain Between Shoulders
- ☐ Dizziness upon standing
- ☐ Fainting Spells
- ☐ Irregular Heartbeat
- ☐ Night Sweats
- ☐ Emphysema
- ☐ COPD
- ☐ Asthma
- ☐ Heart MurMur
- ☐ Frequent Respiratory Infections
- ☐ Prior Heart Attacks

GASTROINTESTINAL

- ☐ Peptic/Duodenal Ulcer
- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Gallstones
- ☐ Abdominal Pain
- ☐ indigestion/heartburn
- ☐ Hernia
- ☐ Nausea/Vomitting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Changes in bowel habit
- ☐ Rectal bleeding
- ☐ Rectal Itching
- ☐ Bloating
- ☐ Gas
- ☐ Bloody/Tarry stools
- ☐ Anal Fissure

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1. Please list your current medications:
2. Please list your current herbal and nutritional supplements (dosing not required)
3. Please list your chief complaints in order of importance to you (#1 = most important).
4. Please give a detailed narrative of your entire health history in chronological sequence from birth to the present. Include symptoms, accidents, illnesses, surgeries, injuries, exposure to toxins, family illnesses, and any other events or factors that may have contributed to your current state of health. Include relevant dates, years, or time spans right in the narrative. This answer alone should be a minimum of 2 complete pages of text, and even as long as 10 pages.
5. In timeline sequence, make a list of all diagnoses given to you. Include a brief personal opinion about each diagnosis.
6. What is your opinion on what you think has happened to your health? You don't have to be "right", just tell us what you think.
7. List in a timeline sequence all health care providers you have consulted, their opinions about your case, and their treatments.
8. Please list any treatments, medications, or supplements that have improved your health.
9. Please list any treatments, medications, or supplements that have caused reactions or decreased your health.
10. List in a timeline sequence any prescription medications that you have taken in the past.
11. List in a timeline sequence any medical procedures or surgeries you have had. Include this information here even if it is duplicated in other questions or on your compiled labs.

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12. List in a timeline sequence any significant laboratory or imaging results (include this information here even if it is duplicated in other questions or on your compiled labs.
13. List in a timeline sequence any exposure to environmental, industrial, or toxic compounds.
14. Please list any history of infections (excluding common colds). Include relevant dates if know.
15. Please give a concise summary of any emotional or personal factors that may have affected your health, such as emotional traumas, family issues, etc. Please include relevant Initial Intake Form dates or years. This question does not address medical health history; that is in Question 4 above.
16. Please submit a copy of any recent laboratory tests that have been done within the past year

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