PATIENT INFORMATION

Please print clearly

Last Name ________________________________ First Name _________________________ Date ______________

Address ____ Apt.# ______________

City ___________________________________ State _____________ Zip Code ___________

Mailing Address (if different from above) ____

____

Home Phone (____) ____-_________ Cell/Work Phone (____) ____-_________

E-mail address (for internal use only): ____

Referred by: ____

Date of Birth: ____________ Age: ____ Height: ______ Weight: _____

Please circle the options that apply to you. If you answer Yes to any questions, please answer the question(s) that follows.

Gender: Male / Female

Marital Status: Single / Married / Divorced / Widowed

Overall Health: Excellent / Good / Fair / Poor / Other: ________________________

Do you smoke, consume coffee, or alcohol? Yes / No

If yes, please indicate the activity or activities that you do________________________

If yes, please indicate the amount per week ________________________

Do you exercise periodically? Yes / No

If yes, please indicate the type of exercise ________________________

Do you sleep an average of 6-8 hours of sleep? Yes / No

Do you enjoy your work? Yes / No

How stressful is your average day? Very / Somewhat / Not at all

Please answer the following questions. Please write clearly

Describe your diet on a typical day: ____

____

Chief Complaint (Reason You are Here): ____

____

____

Brief Medical History (Past and current illnesses): ____

____

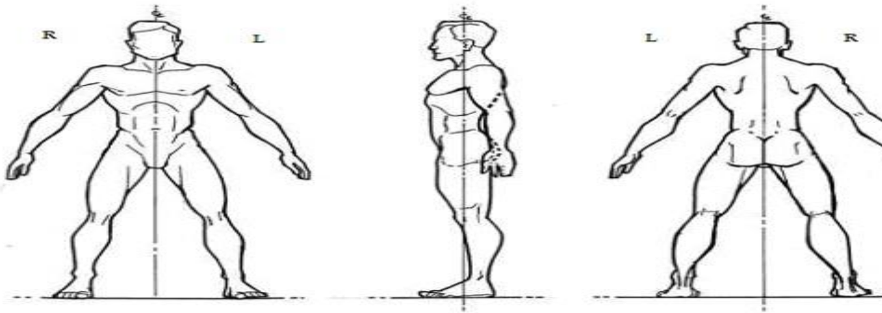
____

Past Surgeries (Please include dates): ____

____

____

Pain/ discomforts/Where are they in your body? (Please circle from the following areas):



Please indicate dosage and frequency of current Medications/Supplements/Treatments/Therapies

____

____

What are your top three expectations that you would like to achieve at our office?

____

____

____

____

PLEASE READ BEFORE SIGNING:

I specifically authorize the consultant or nutritional health practitioner ("NHP") to use a muscle testing health analysis and to develop a natural, complementary health improvement program for me, which may include acupuncture, therapeutic massages (including traditional Chinese techniques), dietary guidelines, herbal teas, or nutritional supplements in order to assist me in improving my health, and **not** for the treatment, or "cure" of any disease including, but not limited to, conditions of cancer, autoimmune deficiency syndrome (AIDS), systematic lupus erythematosus (SLE), bacterial infections, gastroesophageal reflux disease (GERD), or any other medical conditions.

I understand that the muscle testing system is a non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

No promise or guarantee has been made regarding the results of the Nutritional Program, but rather I understand that muscle testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances. I understand that the Nutritional Program has been developed to complement, aid, or supplement the guidelines of my primary care physician. Neither muscle testing, nor nutritional consultation is licensed by the state of California I promise that I will consult with my primary care physician on an ongoing basis regarding the Nutritional Program. I agree that the doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I understand that I am to adhere to the guidelines of the Nutritional Program and that it has been fully laid out before me and discussed in detail. Although no promises or guarantees have been made, I understand that if I do not fully comply, that my failure to comply will greatly impact my results and success. **I agree to take full responsibility for asking questions, making follow-up visits, and informing the doctor of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during my care.**

I explicitly confirm that I have consulted and will continue to consult with my primary care physician regarding the Nutritional Program. In case of an emergency I promise to contact my primary care physician, or call 911 or the emergency telephone number in my area.

I authorize the doctor to discuss the details of my health and recommendations with the following person or people:

______ (Your Initials) Please list:____

______ (Your Initials) Medical Practitioner: ____

I agree to cooperate and take an active role in my treatment under the Nutritional Program by maintaining a positive attitude regarding treatment, adding or maintaining an exercise program and a nutritious meal plan, continuing contact with and treatment from medical practitioners, communicating progress and side effects to the NHP handling my case**. I understand that I am to continue all medication and other treatment modalities as they have been prescribed to me unless otherwise directed by the medical doctor or primary care physician who prescribed them to me.**

I understand that I am financially responsible for all services rendered. Any disputes arising out of or relating to this agreement will be handled in arbitration and both parties will agree on an arbitrator from the American Arbitration Association. In the event of any dispute arising out of or relating to his agreement, I agree to pay all costs of collection, and reasonable attorney's fees. I agree that this agreement, all services, including, but not limited to, in-person consultations, phone consultations, testing, and analysis were rendered in California and all products were distributed in California. Venue will be in Los Angeles County, and California law, including California arbitration law, will apply. If any term of this agreement is unlawful, then that term will be severed, and the remainder of the agreement will be deemed valid and enforceable. I hereby authorize the doctor to release all information necessary to secure the payment of insurance benefits.
I have read, understand and agree to the terms and conditions above. I further agree that a photocopy of this agreement will be as valid as the original. This agreement applies to subsequent visits and consultations. I understand that there are no refunds for any services rendered.

Signature: ____ Date: ____________

Print Name:____

Additional Information Regarding the Responsibility of Consulting Your Primary Care Physician Before Beginning the Kwang Nutritional Program:

In order to diagnose, treat, cure, or prevent any disease you must consult with your primary care physician, medical doctor, or healthcare professional (individually or collectively, "physician") without delay. I have created the Kwang Nutritional Program, which may include acupuncture, therapeutic massages, dietary guidelines, herbal teas, or nutritional supplements. I cannot diagnose, treat, cure, or prevent any disease. The Kwang Nutritional Program is a complementary and alternative medicine program and the Kwang Nutritional Program should not be substituted for the advice of your physician. It is your responsibility to discuss with your physician before you try the Kwang Nutritional Program. To delay or ignore medical treatment prescribed by your physician could be fatal. Do not try any complementary or alternative medicine program without first consulting your physician – because it is possible that the program could cause more harm instead of benefiting you.

The recommendations contained in the muscle testing analysis, and reports that I will create for you are based on unorthodox ideas and opinions that are not normally accepted by the consensus of medical opinions. Before following these medically non-approved recommendations under the Kwang Nutritional Program, please check with your physician. If you feel you must, precede contrary to your physician's recommendation, then conduct research, be informed, and proceed with extreme caution. Remember that any herb, food, or alternative medicine can produce dangerous allergic reactions or side effects in *some* people. If you decide to participate in the Kwang Nutritional Program, it is your responsibility to inform your physician about each stage of the Kwang Nutritional Program, and, if applicable, about what cleansing teas in the Kwang Nutritional Program that you are consuming. It is also important for you to inform your physician of all ingredients of the cleansing teas, especially before and after surgery.

The approaches described in the Kwang Nutritional Program are expressions of my opinion and have not been approved by the United States Food and Drug Administration ("FDA") or any other government agency. *Do not endanger yourself*, it is essential that you consult a physician. Also, when misapplied, complementary and alternative medicine programs can cause as much harm as any other method. We strongly recommend that you seek your physician's guidance before doing any complementary and alternative medicine program.
I attest that I fully understand the above information and I will take full responsibility to coordinate with my physician before following the Kwang Nutritional Program.

________________________ ________________________ ________________________
Patients Name (print please) Patients Signature Date

________________________ ________________________ ________________________
Witness Name (print please) Witness Signature Date

Charles Kwang, D.C.
Kwang Wellness Center
3755 Beverly Blvd, Suite 300
Los Angeles, CA 90004 323-953-4881
www.kwangwellness.com

Disclosure

I, Charles Kwang, am NOT a licensed chiropractor. I am a certified Ulan Nutritional Response Testing ("NRT") clinician, and certified in Ulan Advanced Clinical training ("ACT"). I have a bachelor's of science ("B.S.") degree from University of California, San Diego in animal physiology and neuroscience. I have a doctorate of chiropractic ("D.C.") degree from Southern California University of Health Science. I have hundreds of hours of chiropractic, NRT, and ACT training, and thousands of hours of experience working with clients. I have thousands of hours of training and experience in traditional Chinese herbal teas.

The types of work that I do as a nutritional consultant and muscle testing are NOT licensed by the state of California. The traditional Chinese medicine that I practice is NOT licensed by the state of California. The muscle testing (also known as chi, qi, applied kinesiology or energy) analysis, nutritional consultation, and use of traditional Chinese herbal teas are considered alternative or complementary to healing arts services NOT licensed by the state. I am not a licensed physician. The muscle testing that I use is a biofeedback tool that works with your body's natural ability to provide information about your body's nutritional needs. I provide consulting, teaching, and coaching designed to help people learn about their nutritional needs. I provide traditional Chinese herbal teas that are designed to help people achieve their nutritional goals.

Payment Policy

Fees are due at the time the service is provided. Payment in advance may also be made for multiple sessions. Payment plans are available, please ask in advance.

Client Acknowledgment

I have read the above disclosure, and payment policy. I understand that Charles Kwang's consultations are intended to be alternative or complementary treatments, and are not intended as substitutes for medical services by a licensed physician. My services, nor my herbal teas will not diagnose, treat, cure, or prevent disease, pain, or injury.

Signature ____ Date _____________

Print your name____

Keep this page for your records.

Notice

Kwang Wellness Center (KWC) policy is that any patient that misses an appointment will be charged for it unless the patient called 24 hours in advance and rescheduled.

Note: If you arrive late for a massage you will be charged for the full hour and it will not run over your original scheduled time. For example, if your appointment is at 1:00 p.m. and you arrive at 1:15 p.m., you will be charged the full hour and your message session will end at 2:00 p.m.

The following fees will be applied if you:

Missed appointment with Dr. Kwang: **$35.00** to be applied in addition to your next fees.
Missed massage appointment: **$60.00** to be paid in addition to your next appointment fees.

By signing, I agree to the terms discussed above.

Signature ____ Date _____________

Print your name____

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