Community Wellness on Adams Ave
3239 Adams Avenue
San Diego, CA 92116
Phone - 619-546-4806
Fax - 619-546-5326
Email - adamsave@communitywellness.org
www.communitywellness.org

This is a CONFIDENTIAL questionnaire to determine the most appropriate treatment plan for you.

Name: _____ Date_____ Date of Birth: _____

Home Address: _____ City:_____ State: _____

Zip: _____ Email Address: _____

Phone: _____ In Case of Emergency Name: _____

Pregnant? ☐Y ☐N # of Weeks?_____ Height: _____ Weight: ____ Emergency Phone:_____

Do you have Insurance? ☐Y ☐N Medicare? ☐Y ☐N Medi-Cal: ☐Y ☐N TriCare? ☐Y ☐N Flex Spending ? ☐Y ☐N

Preferred Pronoun: ☐He / ☐She / ☐They

☐Other: _____

Gender Identity: (Check as many as appropriate)

- ☐ **Female**
- ☐ **Male**
- ☐ **Trans Female (MTF)**
- ☐ **Trans Male (FTM)**
- ☐ **Non-Binary**
- ☐ **Other** _____

How did you hear about our clinic?

- ☐ **Google**
- ☐ **Yelp**
- ☐ **Social Media**
- ☐ **Outreach (Event / Free Clinic / Company**
- ☐ **Wellness Program)**
- ☐ **Referral (insurance / doctor)**
- ☐ **Other**
  (please list):_____

Have you previously had Acupuncture?
☐ **Yes** ☐ **No**

Have you previously had Chiropractic care?
☐ **Yes** ☐ **No**

Have you had previous Massage Therapy?
☐ **Yes** ☐ **No**

Have you previously seen a Naturopathic Doctor?
☐ **Yes** ☐ **No**

We offer a SLIDING SCALE if you'd like to share:

Annual Household Income: _____

Family Size: _____

Take a further 10% discount for the following with proof:

- ☐ **Disabled**
- ☐ **Student**
- ☐ **Military**
- ☐ **Senior (62 years or older)**
- ☐ **Adams Avenue Business Associate**
- ☐ **Employee Friends and Family**
  (please specify _____)

Please check your reason(s) for coming in today. (check all that apply):

- ☐ **Pain Management (headache, injury, etc)**
- ☐ **Mental Health (depression, anxiety, ADD, etc)**
- ☐ **Hormonal Imbalances (infertility, acne, etc)**
- ☐ **Digestive Problems (IBS, gluten/dairy/sugar**
- ☐ **sensitivities, heartburn, etc)**
- ☐ **Virus or Infection**
- ☐ **Allergies**
- ☐ **Insomnia**
- ☐ **Weight Loss**
- ☐ **Wellness Care/Prevention/Relaxation**
- ☐ **Addiction (alcohol, cigarettes, drugs, etc)**
- ☐ **Injury (sports, automobile, fall, etc)**
- ☐ **Other:**_____

I understand that work done at Alternative Healing Network, dba Community Wellness on Adams Ave, dba Community Wellness Collaborative may not be covered under some insurance policies. Alternative Healing Network accepts insurance payments ONLY when eligibility has been confirmed prior to the beginning of your treatment. You may request a "Superbill" during your visit to submit to your insurance company for possible reimbursement. There is a 3-5 day processing period for all Superbills, or up to 7 days if requesting them AFTER initial date of service. Alternative Healing Network does not guarantee you will receive reimbursement for any payments made for services, products, or packages

All payments for services rendered are due at the time of service, unless prior arrangements have been made.

Patient Signature (Guarantor): _____ Date:_____

ALL PATIENTS

Chief Complaints Why are you seeking care?	When did this first become an issue?	What do you think caused this?	How severe is it on a scale of 1 -10? (1 = mild; 10=very severe)	What makes it better? What makes it worse?	What have you tried so far for relief?

1. Past Medical History including accidents, surgeries (including cosmetic), and hospitalizations:

_____ Date: _ _____

_____ Date: _ _____

_____ Date: _ _____

_____ Date: _ _____

_____ Date: _____

Please include all additional accidents, surgeries and hospitalizations o n another page

2. **Please list all medications, herbs, supplements and over-the-counter drugs:**

What are you taking?	Dosage	Reason	How long?	Prescribed by	Advised to take (but not)

ALL ACUPUNCTURE, CHIROPRACTIC & NATUROPATHIC MEDICAL PATIENTS

3. **Please list all Allergies:** _____

Food Cravings: _____ **Food Sensitivities:** _____

Special Diets (Vegan, Vegetarian, Gluten Free, etc): _____

4. **Please indicate any illnesses you or a blood relative (parent, grandparent, or sibling) have had:**

	You	Relative	Who?		You	Relative	Who?
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐		_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Mental Illness	☐	☐	_____	Tuberculosis	☐	☐	_____
Depression/Anxiety	☐	☐	_____	Arthritis	☐	☐	_____
Alcoholism	☐	☐	_____	High Cholesterol	☐	☐	_____
Stroke	☐	☐	_____	Auto-immune disease	☐	☐	_____
Osteoporosis	☐	☐	_____	Allergies	☐	☐	_____
Thyroid Dysfunction	☐	☐	_____	Asthma	☐	☐	_____

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes

5. **How would you rate these significant stressors?**

	Extremely Stressful	Moderately Stressful	Not Stressful at All
Work/School	☐	☐	☐
Family Matters	☐	☐	☐
Moving	☐	☐	☐
Relationship/Marriage	☐	☐	☐
Finances	☐	☐	☐
Health Status	☐	☐	☐
Other (please list): _____	☐	☐	☐

6. What do you do to manage your stress or health condition now?

Check all that apply.

Exercise	☐	**Herbs**	☐
Yoga/Meditate	☐	**Supplements**	☐
Massage	☐	**Friends**	☐
Family time	☐	**TV/Media**	☐
Personal Time/Rest	☐	**Alcohol/Drugs**	☐
Medication	☐	**Other (please list)**	☐ _____

7. What is your current level of physical activity?

Not physically active	☐	**Less than 1 hour/week**	☐
Less than 30 minutes/day	☐	**30 minutes-1 hour/day**	☐
More than 1 hour/day	☐		

8. What type of physical activity do you do? _____

_____

9. What time do you generally go to bed? _____; Wake up? _____

10. Do you wake up during the night? ☐ **Yes** ☐ **No** **How many times?** _____

How long does it take to get back to sleep? _____ **Do you wake rested?** _____

11. What is your energy level?

	Morning	**Midday**	**Evening**	**after Meals**
Very Low	☐	☐	☐	☐
Low	☐	☐	☐	☐
Medium	☐	☐	☐	☐
High	☐	☐	☐	☐
Very High	☐	☐	☐	☐

13. Please indicate the use and frequency of the following:

Coffee/Black Tea: _____ **Tobacco:** _____ **Vaping:** _____ **Daily Water:** _____
Recreational Drugs: _____ **Alcohol:** _____ **Soft Drinks:** _____

14. Do you drink alcohol ? ☐ Yes ☐ No

How much? _____ ☐ Daily ☐ Weekly ☐ Monthly

15. Do you smoke cigarettes or vape ?

Never ☐

Used to ☐ **when did you quit?** _____ **how much did you used to smoke?** _____

Yes ☐ **How much do you smoke now?** _____

For Men/ Assigned Male at Birth

Date of last prostate checkup: _____ **PSA Results:** _____
Lab Results: _____ **Frequency of urination: daytime** _____ **nighttime** _____
Color of urine: ☐ **Clear** ☐ **Murky** **Urine Odor:** _____
Symptoms related to prostate:

☐ **Prostate problems**	☐ **Delayed stream**	☐ **Dribbling**	☐ **Incontinence**	☐ **Retention of urine**
☐ **Rectal dysfunction**	☐ **Increased libido**	☐ **Decreased libido**	☐ **Premature ejaculation**	☐ **Impotence**
☐ **Back pain**	☐ **Groin pain**	☐ **Testicular pain**	☐ **Other:** _____	

For Women / Assigned Female at Birth

Age of 1st period: _____ Are you pregnant? ☐ Y ☐ N # of pregnancies/abortions: _____
Age of last period: _____ # of live births: _____ # of miscarriages: _____
Number of days between periods: _____ Have you ever had an abnormal pap smear? _____
Number of days of flow: _____ Color of flow: _____ Blood Clots? ☐ Y ☐ N
How many tampons/pads do you use per day?
Day 1:_____ Day 2:_____ Day 3: _____ Day 4: _____ Day 5: _____ Day 6: _____ Day 7: _____
Ever been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID
☐ Other: _____
Location of any menstrual pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other: _____

Nature of Pain (Please indicate before, during or after menses)
Cramping:_____ Stabbing: _____
Burning: _____ Aching: _____
Dull: _____ Bloating: _____
Bearing down sensation: _____

Other symptoms related to menses:
☐ Discharge ☐ Vaginal dryness ☐ Headache
☐ Nausea ☐ Constipation ☐ Diarrhea
☐ Mood Swings ☐ Hot Flashes ☐ Insomnia
☐ Night Sweats ☐ Swollen Breasts

☐ Decreased libido ☐ Increased libido Appetite during menses: ☐ Consistent ☐ Intermittent ☐ Poor ☐ Ravenous

Symptom Survey (for EVERYONE)

The following is a list of common symptoms.
Please indicate how often you experience the following :

NO MARK = never experience
1 = sometimes experience
2 = frequently experience

_____ Lack of appetite
_____ Excessive appetite
_____ Loose stool or diarrhea
_____ Indigestion
_____ Vomiting
_____ Belching, burping
_____ Heartburn/acid reflux
_____ Feeling the retention of food in the stomach
_____ Tendency to become obsessive in work, relationships…

_____ Difficulty sleeping
_____ Heart palpitations
_____ Cold hands and feet
_____ Nightmares
_____ Mentally restless
_____ Laughing for no apparent reason
_____ Angina pains
_____ Abdominal pain
_____ Chest pain
_____ Sciatic pain
_____ Headaches

_____ Pain or coldness in the genital area
_____ Cough
_____ Shortness of breath
_____ Decreased sense of smell or taste
_____ Nasal problems
_____ Skin problems
_____ Feeling of claustrophobia
_____ Bronchitis
_____ Colitis or diverticulitis
_____ Constipation
_____ Hemorrhoids
_____ Recent antibiotic use

_____ Eye problems
_____ Jaundice (yellowish eyes or skin)
_____ Difficulty digesting oily foods
_____ Gall stones
_____ Light colored stool
_____ Soft or brittle nails
_____ Easily angered or agitated
_____ Difficulty in making plans or decisions easily

_____ Spasms or twitching of muscles

_____ Low back pain
_____ Knee problems
_____ Ear ringing
_____ Kidney stones or infection
_____ Decreased sex drive
_____ Hair loss
_____ Urinary problems
_____ Fatigue
_____ Edema
_____ Blood in stool
_____ Black tarry stool
_____ Easily bruised
_____ Difficult to stop bleeding
_____ Asthma
_____ Tendency to catch colds easily
_____ Intolerance to weather changes
_____ Allergies
_____ Hay fever
_____ Dizziness
_____ Tendency to faint easily
_____ High cholesterol levels
_____ Sudden weight loss

Policies and Responsibilities

Cancellation Policy

- Community Wellness Collaborative requires 24 hours' cancellation for all appointments; patients **cancelling within this period will be charged the price of all appointments, up to $45/appointment, to the credit card on file. Members may opt to use a "member credit" to cover the full cost of this fee.**
- **Because we understand unexpected situations may arise, we will extend forgiveness for ONE cancellation within 24 hours.**
- **You will not be charged the $45 late cancellation fee if we are able to fill your spot or you are able to reschedule on the same day, with the same clinician.**
- **For services that cost less than $45, the cancellation fee will be equal to that of the booked appointment. Please note that your co-pay does not represent the complete cost of your service. All Insurance visits will incur a $45 cancellation fee if a fee is to be charged.**
- **If there are 3 or more cancellations/last minute reschedules within 6 months, the patient may lose the ability to schedule appointments earlier than 48 hours in advance.**

_____ I have read and agree to Community Wellness Collaborative's cancellation policies
(Initial)

Privacy

- **Your confidentiality is important to us. None of your personal information is shared or disclosed outside of our clinical team without your express written permission. If you happen to overhear** someone else's private information, do not share this information with others. We ask that you show **the same respect for others as you would expect for yourself.**

_____ I have read and agree to Community Wellness Collabortive's privacy policy
(Initial)

Payments

- **Fees for all services, nutritional and herbal products, and other items are due and payable at the time items are received or special ordered. All special orders may require shipping and handling charges (if applicable) and all retail and shipping costs are due and payable prior to ordering.**
- **All services, nutritional and herbal products, orthotics and all other items are non-refundable.**
- **Fees will be assessed on checks returned for any reason at the maximum amount allowed by the state.**
- **By signing this agreement you agree to accept full financial responsible for any and all charges incurred at** Community Wellness Collaborative **.**
- **All services are considered fee-for-service and payment is due at the time of service.**
- **If you have a copay for your treatment, coverage must be verified prior to the delivery of your treatment.**

_____ I have read and agree to Community Wellness Collaborative's payment policies.
(Initial)

I have read, or have had read to me, the above terms of Policies and Responsibilities Agreement. I have had the opportunity to have any questions answered to my satisfaction. I agree to and accept fully these terms of agreement.

Patient (Guarantor) Signature _____Date: _____

Community Wellness Collaborative
3239 Adams Avenue
San Diego CA 92116
619-546-4806

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

ALTERNATIVE HEALING NETWORK, INC. dba COMMUNITY WELLNESS COLLABORATIVE
NOTICE OF PRIVACY PRACTICES

My signature below indicates that a written copy of the Alternative Healing Network Notice of Privacy Practices was provided to me. It can also be downloaded directly here: https://communitywellness.org/hipaa-questions/
I have also been informed that if I require additional information about this notice I may call the Privacy Office.

PATIENT NAME:	
PATIENT SIGNATURE:	DATE:

Alternative Healing Network dba
Comminity Wellness Collaborative
3239 Adams Ave
San Diego, CA 92116

Privacy Office
(619) 546 - 4806