Complementary* Consultation

Date ______/______/______ _____ Male ____ Female Date of Birth ______/______/______

Your Name (Last, First, MI) ________________________, ________________________, ________

Address ____

City ____________________ State ______________ Zip ____________________

Cell Phone ( ) _________-______________ Home Phone ( ) _________-______________

E-mail address ____

My Private E-mail address for the Doctors to contact me ______________________________________

Primary complaint ____

Length of time with this condition? ____________ Past history of same problem? □ Yes □ No

How did you hear about Free Talk/Seminar/Consultation? ______________________________

Use the 0-10 chart to estimate your overall symptoms score or burden **Please Circle a number**

I have or think I have the following: (check all that apply)

□ Anxiety | Depression
□ Diabetes | Pre Diabetes
□ Male or Female Issues
□ Chronic Fatigue
□ Toxic Issues
□ Parkinson's
□ IBS/IBD/GERD/Acid Reflux/
□ Thyroid Problems
□ Auto Immune Diseases
□ Hormone Issues
□ Edema | Heart or Vascular
□ Multiple Sclerosis
□ Fibromyalgia
□ Weight Issues
□ Sleep Issues
□ Skin Issues
□ Headaches
□ Brain Issues
□ Gut Issues
□ Tic Borne Diseases
□ Arthritis
□ Allergies
□ Chronic Illness
□ Other

I describe my symptoms as: ____

I have been to other functional or holistic medicine doctors. Circle One: □ Yes □ No
I am currently under the care of a Pain Management doctor: Circle One: □ Yes □ No

You are attending as out guest, a Free* Talk/ Lecture/ Seminar. We will offer everyone that attends a Free* Consultation to meet with one of our Doctors and talk about your particular problem and our possible solutions. I understand that this Free Consultation is Free and all other services are at regular fees. This is not a new patient examination and only a Free consultation. I give my informed consent to have the free consultation, history, basic workup and whatever test may be ordered. Free* All other services at regular fees. Results Vary Patient to Patient.

Greg Millar, DC PhD CFMD • Bonnie Sims, ND M.Div • Helen Stoddart, MD

Do Not Write On This Side: For Office Use Only

Doctor: ____________________ Date: ____________________ Accept them as a patient: □ Yes □ No

Notes from Free Consultation:

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What is ______________ problem preventing them from doing?

____

Working Problem list:

1) ____ 2) ____

3) ____ 4) ____

Test Needed:

1) ____ 2) ____

3) ____ 4) ____

Proposed Treatment:

CP:____

TP:____

Referrals:

____

Insurance or Financial Considerations:

____

Comments:

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□ Seminar □ Talk □ Webinar □ Internet □ FB Group | □ Physical Practice □ Virtual Practice

□ FreeC1 □ FreeC2 □ FreeTC1 □ FreeTC2