BAIN MED

DR. ALAN BAIN, DO

S1 HOMEOPATHY STUDY GROUP

I _____ hereby acknowledge and confirm that I have agreed to participate in this experimental study using a Homeopathic, non-allopathic treatment approach.

_____ I am fully aware that this protocol has not been evaluated by the FDA.

_____ The plan for this study has been fully explained to me and I do not hold the investigators or Dr. Alan Bain, DO responsible or accountable for my decision to participate in this experimental study.

_____ I am here on my own behalf and not as an agent for federal or local regulatory agencies or associations and I am not seeking information under cover for false identity or misrepresentation of my situation or on a mission of entrapment. Further, I have agreed to proceed with the treatment plan of my own accord without promise or assurance of the efficacy of the study treatment.

_____ I understand I may remove myself from this study at any time.

_____ I understand the suggested donation fee for this study is $111. (This is a non-medical, non-allopathic approach and includes consultation with homeopathic ultra dilute nonmaterial therapy)

_____ I agree to prescheduled regular provider follow up visits regarding the state of my health every two weeks.

_____ I understand the follow up visit fee of $72 will be due at the time of my appointment if I do not have insurance coverage.

PLEASE LIST ALL COVID-19 VACCINATIONS RECEIVED AND DATE ADMINISTERED:

_____

_____

_____

Patient or Guardian Name Printed

Date

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312-236-7010
F: 877-325-2058

patientservices@docintheloop.com

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PATIENT FIRST NAME | PATIENT LAST NAME | PATIENT D.O.B.

HOME ADDRESS | CITY | STATE | ZIP CODE

PATIENT EMAIL | PATIENT PHONE #1 | PATIENT PHONE #2

OCCUPATION | EMPLOYER | EDUCATION LEVEL

I AM: ☐ MARRIED ☐ DIVORCED ☐ WIDOW ☐ SINGLE

DO YOU HAVE CHILDREN? IF YES, PLEASE LIST AGES: ☐ YES ☐ NO

AGES: _____

HOW DID YOU HEAR ABOUT US? _____

ARE YOU FAMILIAR WITH HOMEOPATHY? ☐ YES ☐ NO

HAVE YOU EVER TRIED ALTERNATIVE THERAPIES? ☐ YES ☐ NO

WHAT IS YOUR LEVEL OF HEALTH? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

PLEASE LIST YOUR MOST CONCERNING HEALTH PROBLEMS AT THIS TIME:

_____

_____

PLEASE LIST ANY SUPPLEMENTS AND MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

WHEN DID YOUR CHIEF PROBLEM OR ILLNESS BEGIN? _____

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WHAT DO YOU THINK MAY HAVE CAUSED YOUR CHIEF COMPLAINT?

_____

_____

PAST SURGICAL HISTORY:

PLEASE LIST ANY SURGICAL PROCEDURES YOU HAVE HAD AND THE APPROXIMATE DATE:

	PROBLEM	DATES
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PAST MEDICAL HISTORY:

PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED OR HOSPITALIZED IN THE PAST.

	PROBLEM	DATES
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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PLEASE CHECK NEXT TO ANY OF THE FOLLOWING THAT YOU HAD IN THE LAST 5 YEARS:

- ☐ HEART DISEASE
- ☐ DEPRESSION
- ☐ STROKE
- ☐ STD
- ☐ DIABETES
- ☐ HIV / AIDS
- ☐ HYPERTENSION
- ☐ TUBERCULOSIS
- ☐ ASTHMA
- ☐ ALLERGIES
- ☐ ECZEMA
- ☐ POLIO
- ☐ CANCER
- ☐ MAJOR TRAUMA

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING HEALTH ISSUES, WHETHER NOW OR PAST:

NOW	PAST		NOW	PAST	
☐	☐	HEART ATTACK	☐	☐	CHEST TIGHTNESS
☐	☐	ANGINA	☐	☐	PALPITATIONS
☐	☐	HEART VALVE PROBLEM	☐	☐	IRREGULAR HEARTBEAT
☐	☐	CHEST PAIN	☐	☐	ANKLE OR LEG SWELLING
☐	☐	STOMOMACH ULCER	☐	☐	BLOATING
☐	☐	GASTRITIS	☐	☐	DIARRHEA TENDENCY
☐	☐	REFLUX	☐	☐	CONSTIPATION TENDENCY
☐	☐	HEARTBURN	☐	☐	BLOOD IN STOOL
☐	☐	FREQUENT NAUSEA	☐	☐	HEMORRHOIDS
☐	☐	FREQUENT VOMITING	☐	☐	FISSURES
☐	☐	INDIGESTION	☐	☐	RECTAL ITCHING

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NOW	PAST		NOW	PAST	
☐	☐	BELCHING	☐	☐	PARASITES
☐	☐	GAS	☐	☐	LIVER PROBLEMS
☐	☐	FREQUENT URINATION	☐	☐	WAKING TO URINATE
☐	☐	PAINFUL URINATION	☐	☐	INCONTINENCE
☐	☐	DIFFICULTY URINATING	☐	☐	BLOOD IN URINE
☐	☐	PROSTATE PROBLEMS	☐	☐	TESTICLE PAIN OR SWELLING
☐	☐	ERECTION PROBLEMS	☐	☐	INFERTILITY
☐	☐	DISCHARGE FROM PENIS	☐	☐	VARICOCELE
☐	☐	VAGINAL DISCHARGE	☐	☐	LONG LASTING PERIODS
☐	☐	FEW OR NO ORGASMS	☐	☐	BLEEDING BETWEEN PERIODS
☐	☐	PAINFUL INTERCOURSE	☐	☐	FIBROIDS
☐	☐	VAGINAL ITCHING	☐	☐	OVARIAN CYSTS
☐	☐	PMS	☐	☐	ENDOMETRIOSIS
☐	☐	HEAVY PERIODS	☐	☐	MENOPAUSAL PROBLEMS
☐	☐	IRREGULAR PERIODS	☐	☐	MUSCLE PAIN
☐	☐	JOINT PAIN	☐	☐	BONE PAIN
☐	☐	BROKEN BONES	☐	☐	NUMBNESS OR TINGLING

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NOW	PAST		NOW	PAST	
☐	☐	WEAKNESS IN ARMS/LEGS	☐	☐	ROUGH/DRY SKIN
☐	☐	RASHES	☐	☐	ITCHING
☐	☐	WARTS	☐	☐	HIVES
☐	☐	BOILS/ABCESSES	☐	☐	ACNE
☐	☐	NAIL PROBLEMS	☐	☐	DIFFICULTY FALLING ASLEEP
☐	☐	NIGHTMARES	☐	☐	WAKING FREQUENTLY
☐	☐	WAKING TOO EARLY	☐	☐	SLEEP APNEA
☐	☐	MEMORY PROBLEMS	☐	☐	CONFUSION
☐	☐	DIFFICULTY CONCENTRATING	☐	☐	IMPULSIVE
☐	☐	RESTLESSNESS	☐	☐	NERVOUSNESS / ANXIETY
☐	☐	STRONG FEARS	☐	☐	IRRITABILITY
☐	☐	ANGER PROBLEMS	☐	☐	MOOD SWINGS
☐	☐	DEPRESSION / SADNESS	☐	☐	HALLUCINATIONS
☐	☐	FEELINGS OF EUPHORIA			

PLEASE LIST ANY SPECIFIC FEARS THAT YOU HAVE:

_____

_____

WOMEN: AGE MENSTRUATION BEGAN: _____

HOW FREQUENT ARE YOUR PERIODS? _____ HOW LONG DO THEY LAST? _____ DAYS

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_____ I hereby acknowledge and confirm that I have agreed to participate in this private; non-medical, non-clinical study using a Homeopathic, non-allopathic treatment approach.

_____ The information I have provided is accurate to the best of my knowledge.

_____ I understand this is a privately funded homeopathic study which is non-clinical and non-medical and has not been approved nor evaluated by the FDA.

_____ The plan for this study has been fully explained to me and I do not hold the investigators or Dr. Alan Bain, DO responsible or accountable for my decision to participate in this study.

_____ I understand that my results may be shared with other investigators and doctors taking part in this study with Dr. Alan Bain, DO.

_____ I am here on my own behalf and not as an agent for federal or local regulatory agencies or associations and I am not seeking information under cover for false identity or misrepresentation of my situation or on a mission of entrapment. Further, I have agreed to proceed with the treatment plan of my own accord without promise or assurance of the efficacy of the study treatment.

_____ I understand I may remove myself from this private study at any time by sending a written request to the office via mail: 444 N Northwest Hwy, ste 200, Park Ridge, IL 60068 or by email: Patientservices@docintheloop.com

_____ HOMEOPATHIC STUDY ENROLLMENT: I understand this study group is PRIVATE and consists of multiple investigators and doctors along with Dr. Bain. I understand the suggested fee for this private study is $200. Includes 8 weeks of homeopathic protocol. SHIPPING NOT INCLUDED. SHIPPING IS CALCULATED BASED ON YOUR LOCATION. This is a non-medical , non-allopathic approach and includes consultation with homeopathic ultra dilute non-material therapy. Additional treatment available for additional cost. Visits will take place bi-weekly or weekly if necessary. This is not a clinical or medical trial.

_____ GENERAL STUDY ENROLLMENT: I understand this study group is PRIVATE and consists of multiple investigators and doctors along with Dr. Bain. I wish to enroll in a general study and will purchase possible treatments at a later date. This is not a clinical or medical trial.

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Patient or Guardian Name Printed

Date of Birth

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