COMPREHENSIVE HEALTH ASSOCIATION

Patient Information Questionnaire

(Please Fill Out Completely)

Name: _____ Age: _____ Birth Date: _____

Address: _____ Sex: M F

Marital Status: Single___ Widow___ Married___ Divorced___

Employer: _____

Occupation: _____

Home Phone: _____ Mobile: _____ Work: _____

Spouse: _____ Spouse Employer: _____

Referred By: _____

In your own words, what is the chief complaint? (Onset, Duration, Severity and current status?)

_____

_____

_____

_____

MEDICAL HISTORY

Surgery: _____

Major Illnesses: _____

Accidents/Injuries: _____

Other:

_____

FEMALES ONLY:

Age Menstrual Cycle Began: _____ Cycle (days): _____ Flow: _____

Pregnancies: _____ Children: _____ Living: _____ Date of last PAP: _____

Date of last menstrual period: _____

Do you have any Drug allergies? : _____

FAMILY HISTORY

Father Age: _____ Health: _____

Mother Age: _____ Health: _____

Brother(s) Age: _____ Health: _____

Sister(s) Age: _____ Health: _____

History of: (In whom)

Cancer: _____

Gout: _____

Allergy: _____

Tuberculosis: _____ Goutier: _____

Obesity: _____

Mental Disorder: _____

Epilepsy: _____ Nephritis: _____

Heart Disease: _____ Other: _____

_____

Anything else the doctor should know?

_____

_____

_____

IN CASE OF EMERGENCY PLEASE NOTIFY: _____

Home: _____ Mobile: _____ Work: _____

COMPREHENSIVE HEALTH ASSOCIATION

CHRONOLOGICAL HEALTH HISTORY

Patient Name: _____ Age: _____ Date: _____

Please complete the following with the approximate age of occurrence:

Serious Infections/Diseases Surgery — Age
(pneumonia, mono, TB, cancer, etc.)

Injuries/Accidents Without Stitches — Age

Injuries/Accidents with Stitches — Age

Dental Intervention — Age
(Root canals & extractions-please try to name & number tooth-refer to dental chart. Also, age of first silver amalgam filling, braces, retainer, etc.)

Now, please rewrite all of the above information in chronological order from your birth or childhood to the present. This way we have an easy to reference, exact chronology of all the stressors of your life.

COMPREHENSIVE HEALTH ASSOCIATION

CONTEXT OF CARE OVERVIEW

Patient Name: _____

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1.) Why did you choose to come to this clinic?

_____
_____
_____

What do you know about our approach?

_____
_____
_____

2.) What three expectations do you have from working with our clinic?

_____
_____
_____

What long term expectations do you have from working with our clinic?

_____
_____
_____

What expectations do you have of me personally as your physician?

_____
_____
_____

3.) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0-10, with 10 being 100%)

0% 1 2 3 4 5 6 7 8 9 10 100%

4.) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

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b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits? (Please list)

5.) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6.) Who do you know that will sincerely support your consistently with the beneficial lifestyle changes you will be making?

COMPREHENSIVE HEALTH ASSOCIATION

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y= a condition you **HAVE NOW** **N**= never had **P**= a condition you **HAVE HAD** before

HABITS

Main interests and hobbies: _____
Do you exercise? Y N P If yes what kind? _____ How often? _____
Average 6-8 hours of sleep? Y N P
Sleep well? Y N P
Awake rested? Y N P
Have a supportive relationship? Y N P
Have a history of abuse? Y N P
Any major traumas? Y N P
Use recreational drugs? Y N P
Been treated for drug dependence? Y N P
Do you eat three meals a day? Y N P
Do you eat out often? Y N P
Do you go on diets often? Y N P
Do you drink coffee? Y N P
Do you drink black or green tea? Y N P
Do you drink cola or other sodas? Y N P
Do you eat refined sugar? Y N P
Do you add salt? Y N P
Enjoy your work? Y N P
Take vacations? Y N P
Spend time outside? Y N P
Watch Television? Y N How many hours? _____
Read? Y N P How many hours? _____
Use alcoholic beverages? Y N P
Treated for alcoholism? Y N P
Do you use tobacco? Y N P
Smoked previously? Y N P
How many years? _____
How many packs per day _____
Do you have a religious or spiritual practice? Y N P
If yes, what? _____

GENERAL

Weight _____ lbs Weight 1 year ago _____ lbs
Maximum weight _____ When _____ Height _____
When during the day is your energy the best?_____ worst? _____

Comprehensive Health Association

PATIENT'S INFORMED CONSENT DOCUMENT

PATIENT IS TO READ AND SIGN AT THE BOTTOM OF EACH PAGE

Patient's Name: _____
Address: _____
Telephone: _____ Date of Birth: _____
Age: _____ Sex: Male/Female

Name and Address of Physician

Dr. Robert Battle
Comprehensive Health Association
9910 Long Point Road
Houston, TX 77055

I have specifically sought out the services and perspective of Dr. Robert Battle for the way in which he practices Complementary and Alternative Medicine. Dr. Battle has explained to me and I fully understand the following.

(a) Much of Dr. Battle's treatment being recommended is not recognized as traditional, but is an alternative method. Complementary and Alternative Medicine, like any other treatment or medication, may or may not alleviate or cure the condition(s) for which it is offered.

(b) Your physician believes that Complementary and Alternative Medicine may be valuable to your health. However, as with any type of treatment or testing, you should fully understand the potential risks and benefits of the testing, as well as other available testing options, including lab work, before deciding whether the work-up and following medical analysis and possible treatment provided by Dr. Battle is right for you. It is important you read and understand the information contained in this form so that you can make an informed choice about being treated at Comprehensive Health Association, by its agents, and Dr. Robert Battle, specifically. If after reading this form, you have any concerns or questions regarding this testing you should talk to your provider.

(c) The federal government, including Medicare and Medicaid, and most insurance companies, do not generally pay or reimburse for intravenous treatments and vitamin and mineral supplementations by Dr. Battle.

(d) Some of the testing being recommended at the Comprehensive Health Association are not recognized as traditional, but are alternative testing methods.

(e) The United States Food and Drug Association ("FDA") reviews the safety and effectiveness of particular uses of drugs but does not forbid physicians to use approved medications for off-label use.

(f) Some of the treatments being offered at Comprehensive Health Association are not FDA approved.
(g) Some of the treatments prescribed at Comprehensive Health Association are not FDA approved.
(h) Some of the formulations prescribed at Comprehensive Health Association have never been tested by the FDA for determination of the actual contents or the medical effectiveness of the formulas
(i) The medical/scientific proof of the effectiveness/therapeutic value of some of the treatments are disputed.
(j) While your treating doctor believes that the alternative and comprehensive treatments may be beneficial to your health and well-being, the traditional and medical scientific communities often dispute the medical/scientific proof of the effectiveness or therapeutic value of the treatments. You are free to contact any medical group, doctor, or association on their view of any testing or treatment before you begin. Dr. Battle believes the testing and treatment he oversees are valuable and might improve your health.
(k) I may discontinue treatment at Comprehensive Health Association at any time. It was my independent choice whether to see Dr. Battle and it is always my choice whether to continue with him. I also understand that Dr. Battle reserves the right, at any time and without cause, to discontinue any patient due to poor compliance with Dr. Battle's recommended program for any other reason.

THE TESTING AND TREATMENT BEING UTILIZED AND DESCRIBED BY RESPONDENT IN THIS DISCLOSURE STATEMENT IS NOT ENDORSED, APPROVED, ACCCEPTED, OR SUPPORTED BY THE TEXAS MEDICAL BOARD.

I, THE UNDERSIGNED, HAVE READ, AND FULLY UNDERSTAND THE ABOVE INFORMATION, THE ELEMNTS OF MY INFORMED CONSENT TO UNDERGO ALTERNATIVE AND COMPREHENSIVE TREATMENT AT COMPREHENSIVE TREATMENT AT COMPREHENSIVE TREATMENT AT COMPREHENSIVE HEALTH ASSOIATION. INFORMATION ABOUT MY RECORDS AND I WILL BE CONFIDENTIAL. DATA WILL BE STORED SECURELY AND WILL BE MADE AVAILABLE ONLY TO THE PERSONS PARTICIPATING IN MY EVALUATION AND SUBSEQUENT TREATMENT, IF ANY, UNLESS I SPECIFICALLY GIVE PERMISSION IN WRITING UNLESS OTHERWISE REQUIRED BY LAW.

Patient Date

Witnessed Date

COMPREHENSIVE HEALTH ASSOCIATION

PAYMENT POLICY

We accept cash, checks, and all major credit cards. It is the Policy of Comprehensive Health Association that all services are paid in full at the time services are rendered. (There will be a $35.00 charge for all returned checks)

We do not file with any Health Insurance companies. We do not accept assignment of benefits or supply letters of medical necessity; however, we WILL provide you with all the necessary paperwork to file your claim for reimbursements.

FINANCIAL QUESTIONS

We ask that you address all financial matters with the clinic manger ONLY, as other Clinic Staff are not authorized to make financial arrangements.

CANCELLATION POLICY

Last minute cancellations affect the ability of our office to function efficiently, and to properly serve our patients. If you are unable to honor your appointment for any reason, please contact our office to reschedule no later than 48 hours prior to your appointment to avoid a $100.00 cancellation fee.
This allows us sufficient time to book another patient into the vacated time slot. Your cooperation is greatly appreciated.

I have read the above financial policy and agree with the terms as stated.

Patient Name: _____ Date: _____

Signature: _____ Witness: _____