Informed Consent Statement

I _____, hereby attest and agree to the following:

I fully understand that Thomas Maurice Easley is a lay natural health ADVISOR and TEACHER who deals strictly in helping people to improve their general health and fitness through better nutrition, improved lifestyle, health habits, and positive mental attitudes.

I fully understand that Thomas Maurice Easley is NOT a licensed physician, and cannot diagnose diseases, prescribe drugs, or recommend treatments for specific disease conditions.

I understand that all evaluations performed by Thomas Maurice Easley or his representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits, and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have, and do not replace the diagnostic services offered by licensed physicians.

I understand that Thomas Maurice Easley neither claims, nor implies, that any instruction, advice, counsel, suggestions, recommendations, services, or products he or his representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent, or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems, and otherwise improving general health and fitness.

I understand that Thomas Maurice Easley or his representatives will not suggest that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Thomas Maurice Easley or his representatives responsible for the consequences of my decisions.

I understand that Thomas Maurice Easley believes that genuine healing comes only from God, and that God has provided simple and natural methods such as rest, nutrition, herbs, exercise, attitude changes, and touch to help people recover and maintain their health. I further understand that Thomas Maurice Easley shares these methods with others as part of his God-given and constitutional rights of freedom of speech and freedom of religion.

I have read and understand the foregoing and agree to the terms and conditions set therein.
I have received a copy of this agreement.

Dated this _____ Day of _____, 20___

_____
Client Signature

Disclosure Statement

PERSONAL INFORMATION

Name_____
Date of birth_____Age_____
Address:_____
City_____State_____Zip code_____
Phone(day)_____(evening)_____
Occupation_____

NOTE: this is a confidential record of your medical history and will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so. Your medical history, without your name or personal information might be used in teachings by Thomas. Please complete the questionnaire as thoroughly as possible. Thank you.

I. Family Medical History

Has anyone in your immediate, biological family (parents, grandparents, siblings or children) ever been diagnosed with any of these conditions?

□ Cancer/Type _____ □ Diabetes □ Heart disease □ High Blood Pressure

□ Thyroid Disease □ Mental Health Issues □ Seizures □ Alcoholism □ Hepatitis

□ Other (please list) _____

II. Diet, Nutrition and General Health Practices

48 hour food recall

Breakfast	Lunch	Dinner

Breakfast	Lunch	Dinner
Snack	Snack	Snack

 Do you crave sugar? What kind of sweets do you enjoy?

 Do you crave salt? What kind of salty foods do you enjoy?

 Cigarettes: Do you currently smoke? How many cigarettes per day? If you smoked in the past, how many years did you smoke? When did you quit?

 Alcohol: How much alcohol do you drink each day? _____Each week? _____ Each month? ____

What kind of alcoholic beverages do you enjoy? _____

 Has your drinking ever caused problems in your life such as family issues, job loss, legal problems?

 Coffee: How many cups per day? _____

 Tea: What kind? _____ How much per day? _____

 Soda: What kind?_____ How many sodas per day? _____

 How much water do you drink each day? _____ cups.
What kind of water do you drink?

 Television: How much TV do you watch each day?_____

Each week? _____

 Computer: What amount of time do you spend on a computer each day? _____

Each week? _____

 Video games: What amount of time do you spend playing video games each day? _____

Each week? _____

 How often do you exercise? _____ hours per _____.
What do you do for exercise?

Sleep Habits

	Hours of sleep per night		Insomnia
	Usual bedtime		Trouble falling asleep
	Usual time you wake up		Trouble staying asleep
	Different sleep schedule on weekends/days off		Dreams:
	Work at night		Use sleep medications. How often?
	Disturbed sleep for any reason		Sleep apnea

Health History

Have you ever been diagnosed with any of the conditions listed here? If so, who made the diagnosis? When? Describe any treatments.

□ Cancer □ Diabetes □ High Blood Pressure □ Hepatitis □ Thyroid disease

□ Seizures □ Other?

What are the major concerns that have brought you to this office today? When did this begin?

Has anything recently changed or become worse?

Have you had a diagnosis? If so, what was it, how was it arrived at, and by whom?

Are you currently receiving care from any other health professional?(Name)

For what condition(s)?

Are you currently taking **any** medications, prescription or otherwise? List of all medications you have used in the past 6 months. Be sure to include prescription drugs and over-the-counter medications.

Were any of these medications helpful? If so, please note which ones were helpful.

List all supplements and herbs you are currently taking:

Do you have any infectious diseases that you know of? YES_____ NO_____
If yes, please list them:

Do you have any known allergies or sensitivities (drugs/chemicals/foods)? If so, please list them:

How were your allergies/sensitivities diagnosed and/or treated?

Is there any reason why you could not take remedies made in alcohol?

Have you ever been hospitalized or had any surgeries? If so, please note date and reason:
Surgeries (including cosmetic & dental)? Provide date for each.

Hospitalizations? Provide date and reason for each.

Major trauma (concussion, accidents, physical or emotional trauma)? Provide date for each.

Please check any health issue that you have had in the past or are currently experiencing, along with a description of any treatments used for each symptom checked.

Skin

	Ulcerations/ poor healing sores		Excessively oily skin
	Hives/itching		Excessively dry skin
	Eczema/Psoriasis		Hair loss
	Moles		Dandruff
	Acne		Other:

Treatments:

Head, Eye, Ear, Nose, Throat

	Glasses or contacts		Frequent ear infections		Nose bleeds		Grinding Teeth/Clicking jaw
	Blurred vision		Earaches		Sinus problems (chronic congestion/infections)		TMJ
	Spots in front of eyes		Dizziness		Frequent colds		Excessive/insufficient saliva
	Glaucoma		Hearing aids		Hay fever		Chronic dental problems (cavity/root canal/etc)
	Eye pain		Hearing loss		Mucous in throat		Mouth ulcers/Cold Sores
	Cataracts		Ringing in ears		Sore throat		Gum disease
			Facial pain		Swollen gland		Migraine or other chronic headaches

Treatments:

Cardiovascular

	Arrhythmia (irregular heart rate)		Chest pain
	Elevated cholesterol or triglyceride levels		Heart disease
	Swelling in hands or feet		Numbness (where?)
	Heart palpitations		Pacemaker
	Fainting		Other:

Treatments:

Respiratory

	Chronic cough		Difficulty breathing
	Coughing Blood		Difficulty breathing when lying down
	Bronchitis (frequency/treatment):		Shortness of breath without exertion
	Pneumonia (frequency/treatment):		Breathless with exertion
	Asthma (onset/treatment):		Number of colds per year:
	Frequent colds/respiratory infections:		Number of sinus infections per year:
	Lung disease (describe):		Emphysema:
	Production of phlegm □ YES □ NO If yes, what color?_____		Other:

Treatments:

Urinary Tract

	Bladder infections (current or in the past)		Frequent urination
	Wake up in the night to urinate		Painful urination
	Cystitis		Urinary urgency
	Blood in urine		Irregular flow
	Kidney infections		Decreased flow
	Kidney stones		Difficulty starting/stopping flow
	Incontinence/Inability to hold urine		Other:
	Family history of kidney disease		

Treatments:

Gastrointestinal

	Poor appetite		Irritable Bowel Syndrome
	Nausea		Abdominal Pain
	Gastric reflux/ Heartburn		Indigestion
	Vomiting		Diverticulitis
	Difficulty swallowing		Bad breath (halitosis)
	Gas		Crone's disease
	Belching		Bloating after meals
	Gastric bypass or similar procedures		Black Stools/ Blood in stool
	Chronic or frequent constipation or diarrhea		Undigested food in stool
	Hemorrhoids		Mucous in stool
	Pain or discomfort with bowel movements		Number of bowel movements per day:
	Other:		□ Loose □ Normal □ Hard?

Treatments:

Men: Reproductive Health

	Prostate inflammation or swelling		Infertility issues
	Pain or difficulty urinating		Frequent marijuana user
	Prostate cancer		Benign prostate hypertrophy
	Venereal disease		Impotence or erectile problems
	If you are over 50 years of age: Do you have annual PSA screening?		Last screening:

Treatments:

Women: General Reproductive Health

Age of first menses:	Length of period:
Breakthrough bleeding: Y/N	Ovarian cysts/PCOD: Y/N
Cycle of menstrual period/days:	Fibroids/type?:
Uterine cancer:	Ovarian cancer:
Breast augmentation:	Breast cancer:
Pain with intercourse:	Discharges:

PMS symptoms (please check all that apply)

	Pelvic inflammatory disease		Vaginal warts
	Edema (swelling of hands or feet)		Headaches
	Sexually transmitted disease/type?		Cramping
	Food cravings		Bloating
	Herpes		Breast tenderness
	Mood swings		Breast lumps/cysts

	Insomnia		Breast pain
	Cervical dysplasia		Irregular PAP test/when?
	Irregular menstrual cycle		Skipped periods
	Pain at ovulation (mid cycle pain)		Heavy menstrual flow/Blood clots
	Other:		

Treatments:

Pregnancy

Have you ever been pregnant?	Number of live births:
Are you or could you be pregnant now?	Health issues during pregnancy?:
Currently using birth control: Y/N	Number of miscarriages:
Type of birth control used:	Number of abortions:
Infertility issues:	
Date of last PAP/ results:	Date of last mammogram:
Other:	

Treatments:

Peri-menopausal/Menopausal symptoms (please check all that apply)

	Are you currently having regular menstrual periods?(Y/N)		Heavy menstrual bleeding/flooding
	Headaches		Night sweats
	Hot flashes		Memory problems/Poor concentration
	Incontinence/frequent urination		Weight gain
	Insomnia/sleep problems		Mood swings
	Lack of libido		Depression
	Vaginal dryness		Fatigue
	Currently using hormone replacement therapy		Currently using bio-identical hormones
	Date of last menstrual period:		Other symptoms:

Treatments:

Musculoskeletal

	Chronic neck or back pain		Low back pain
	Back surgery		Rheumatoid arthritis
	Neck or shoulder tightness		Osteoporosis
	Osteoarthritis		Frequent sprains/torn ligaments
	Osteopenia		Other:
	Sports injuries/Surgeries/Broken Bones:		

Do you see a chiropractor or massage therapist? (name)

_____

Treatments:

Neuropsychological

	Depression		Poor memory
	Frequently feel overwhelmed		Difficulty concentrating
	Anxiety attacks		Lose your temper easily
	Experiencing high stress levels		Poor sleep
	Ever considered or attempted suicide		Seizures
	Irritability		Headaches/Migrains
	“Spacey”/foggy feeling		Lack of coordination
	Treated for alcohol or drug addiction		Loss of balance
	Treated for depression or other psychological issues		Numbness

 Do you take prescription medications for depression, anxiety or other psychological symptoms?

 Recreational drugs: Are you currently using any kind of recreational drug? _____
What kind and how often? _____ Have you used them in the past? _____

 Have you ever been treated for drug or alcohol addiction? _____
Are you currently in any type of recovery program? _____

Reactivity: ☐Light / White ☐Light Gray ☐Dark Gray ☐Balanced
Resiliency: ☐Mild ☐Moderate ☐Strong ☐Very Strong

Color Type: ☐Blue/Lymphatic ☐Mixed/Biliary ☐Brown/Hematogenic
Colorations: ☐Yellow ☐Orange ☐Dark Orange ☐Light Brown ☐Brown
☐Central Heterochromia ☐Discolored Absorption Zone ☐Sectional Heterochromia

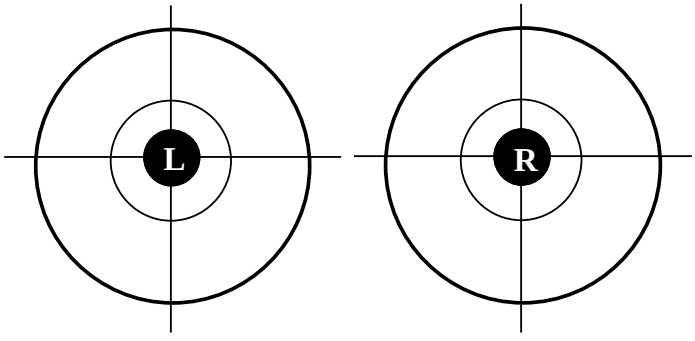
Personality Type: ☐Active/Kinesthetic (Stream) ☐Emotional/Spontaneous (Flower)
☐Analytical/Thinking (Jewel) ☐Extremist/Innovative (Shaker)
Mixed Types: ☐Emotional/Kinesthetic (Flower/Stream) ☐Analytical/Kinesthetic (Jewel/Stream)
☐Emotional/Extremist (Flower/Shaker) ☐Analytical/Extremist (Jewel/Shaker)

Pupil Tonus: ☐Small (Miosis) ☐Enlarged (Mydriasis) ☐Pulsing (Hippus)
☐Flattening (show areas on chart below) ☐Ellipses (draw below)

Collarette: ☐Constricted and Tight ☐Atonic and Floppy ☐Jagged / Star Shaped ☐Double
☐Intermittent ☐Thick / Ropy ☐Thin / Whispy ☐Absent ☐Pocketed ☐Collapsed

Major Signs/Subtypes:
☐Stomach Zone _____ ☐Radial Furrows (Radii Solaris)
☐Ferrum Chromatose Subtype
☐Over-Acid Subtype ☐Febrile Subtype ☐Uric Acid Diathesis Subtype
☐Contraction Furrows (Nerve Rings) / Anxiety Tetanic Subtype
☐Lymphatic Tophi (Lymphatic Rosary) / Hydrogenoid Subtype
☐Corneal Arcus (Lipid Ring) / Lipemic Diathesis ☐Scurf Rim
☐Neurogenic Subtype ☐Connective Tissue Subtype ☐Polyglandular Subtype

Sclerology: ☐Blue Wash ☐Red Wash ☐ Pterygium ☐ Pinguecula (Fatty Deposits)



Pulse Analysis

Pulse: Rate: _____ ☐Rapid ☐Normal ☐Slow

Width: ☐Thin ☐Full / Normal ☐Wide / Atonic ☐Wiry ☐Weakly Tense

Strength ☐Weak ☐Strong / Normal ☐Hard ☐Bounding

Height: ☐Floating ☐ Normal ☐Deep ☐Other:

Other: ☐Rolling / Slippery ☐Resistant ☐Non-resistant Other:

Positions: Left: Heart Stomach Kidney/Intestinal

Right: Lungs Liver Kidney/Intestinal

VIII. Tongue Analysis

Body: Color: ☐Bright Red ☐Dark Red ☐Pink ☐Pale ☐Other:

Moisture: ☐Damp ☐Normal ☐Dry ☐Other:

Characteristics: ☐Swollen ☐Quivering ☐Smooth

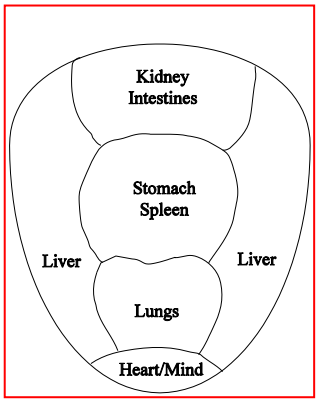
☐Scalloped ☐Withered ☐Furry

☐Cracked ☐Geographic ☐Red Tip

Other:

Moss: ☐Absent ☐Light ☐Heavy ☐Rooted ☐Unrooted

Color: ☐White ☐Yellow ☐Brown ☐Other:



Interview Notes

Additional Client Complaints:
Additional Observations:
Recommendations: