Hello and welcome!

In a few short generations, we've gone from having organic, whole food as the norm to chemically laden, genetically modified, semi edible food-like substances as the norm. Following conventional nutritional wisdom doesn't actually make us healthier: it makes us sicker. It's time for you to feel empowered and in charge of your own wellness. Investing in your health is crucial, because without it, you can't get very far.

I'm excited you've chosen this path! As people learn to slow down, look within, and care lovingly for their bodies, life's twists and turns often appear a little gentler. As a health consultant, we partner to help you make positive changes. Change is a nonlinear process, so allow yourself grace as we move you toward a healthier, more balanced version of yourself. I look forward to collaborating with you to help establish goals and create manageable action steps.

Health consulting is not just about your physical well-being, it's also about you as a whole person: your values, goals, work, balance, fulfillment, and life purpose. Through the coaching process, we work together to improve your ability to make positive changes and enhance your quality of life. My goal is for you to feel confident in your health choices and feel great in your body.

I know this paperwork seems long. Can you believe it's half the length of what I used in my old clinic? The point is, the more I know, the better I can guide you. When you complete this paperwork, either scan and email it back to me: DoctorWittman@gmail.com or email me at that same email address and request my mailing address.

Once I receive your paperwork and your case is accepted, you'll be emailed a link to schedule your appointment and pay for the first 2 hours. Additional hours are billed afterward. Health consulting is $600/hour.

Our initial appointment will be alive with insight, as I learn who you are, what makes you tick, and how I can help you reach your health goals. You will learn skills, information, and behaviors to facilitate improved health.

As someone who believes it's imperative for each of us to take charge of our health in order to give future generations a shot at true wellness, I thank you for doing just that.

Namaste!

Melissa Wittman, DC, CFMP

DrWittman.com

Personalized Health Plan

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Biological Sex: M / F

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

1. What is your optimal health vision?

How would you like to feel and look? What activities would you like to be able to do? Paint a vivid word picture of what optimal health would be like for you. You may want to review the areas on the following "Current and Desired States" form to stimulate your thinking about an 'overall' optimal health vision.

2. What is most important to you as you think about your optimal health vision?
List and/or describe at least 3 values that your vision represents.

You may list more areas and prioritize them.

3. For each area, please take a moment to consider where you are and where you would like to be. In each "current" box, briefly note the reasons you chose your number.

Mindful Awareness Awareness of the present moment; paying attention to what you are doing while you are doing it.	
CURRENT – WHAT'S SO? On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	DESIRED STATES Improvements, changes or enhancements. What would make this area a "10" for you?
Movement, Exercise & Rest Activities of daily living like cleaning and gardening as well as stretching, dancing, yoga, walking, running, cycling etc. balanced with adequate rest and relaxation.	
CURRENT – WHAT'S SO? On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	DESIRED STATES Improvements, changes or enhancements. What would make this area a "10" for you?
Nutrition Eating a balanced, healthy diet.	
CURRENT – WHAT'S SO? On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	DESIRED STATES Improvements, changes or enhancements. What would make this area a "10" for you?

Physical Environment

Spaces where you live/ work (light, noise, toxins, color), as well as landscapes surrounding those spaces.

CURRENT – WHAT'S SO?	DESIRED STATES
On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	Improvements, changes or enhancements. What would make this area a "10" for you?

Relationships and Communication

Spending time with family, friends and/or coworkers who are supportive and with whom you communicate effectively.

CURRENT – WHAT'S SO?	DESIRED STATES
On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	Improvements, changes or enhancements. What would make this area a "10" for you?

Spirituality

Seeing purpose and meaning in something larger than one's self; may include religious affiliation or other areas such as nature or the arts.

CURRENT – WHAT'S SO?	DESIRED STATES
On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	Improvements, changes or enhancements. What would make this area a "10" for you?

Personal and Professional Development

Growing and developing one's own abilities, talents and interests, both in 'being' and 'doing', and living with both in balance.

CURRENT – WHAT'S SO?	DESIRED STATES
On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	Improvements, changes or enhancements. What would make this area a "10" for you?

Mind-Body Connection

Paying attention to the interconnectedness of the mind and body and the effects they have on each other. Using techniques such as breathing practices, meditation, progressive muscle relaxation or guided imagery to activate the body's relaxation and healing response.

CURRENT – WHAT'S SO?	DESIRED STATES
On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	Improvements, changes or enhancements. What would make this area a "10" for you?

Professional Care: Prevention and Intervention; Conventional and Complementary Approaches

Routine screenings such as mammograms, prostate screenings, colonoscopies, pap tests, dental exams, along with prescribed use of vitamins and supplements; Following treatments recommended by your conventional medical care providers as well as recommended complementary approaches such as acupuncture, massage, hypnosis, osteopathy.

CURRENT – WHAT'S SO?	DESIRED STATES
On a scale of 1 (low) - 10 (high), how would you rate this area of your life? 1 2 3 4 5 6 7 8 9 10	Improvements, changes or enhancements. What would make this area a "10" for you?

Definitions (To help clarify your understanding of the terms for current and desired states)

Mindful Awareness: How much to you run on 'automatic pilot' and tend to 'tune out' of what's going on around you? Practicing mindfulness means to pay more careful attention in a particular way. When we are mindful, we are aware of what's going on outside and inside our own skin. All of our senses are alive and active and we know what is happening in this, the present moment. We allow ourselves to become more deeply and completely aware of what it is we are sensing.

Movement, Exercise and Rest: Most adults should do 30 minutes of exercise, 5 days per week. To break this down further it's suggested a minimum of 2 ½ hours a week of moderate-intensity aerobic activity (i.e. brisk walking, dancing, gardening, etc.) or 1 ¼ hours of vigorous aerobic activity (i.e. jogging, aerobic dancing, jumping rope, etc.) in episodes of at least 10 minutes, and preferably spread throughout the week. There should also be some muscle strengthening activities (pushups, weight bearing exercises, yoga, etc.).

Nutrition: Developing a healthy and balanced nutritional program is a cornerstone for attaining optimal health. Traditional American diets contain excessive amounts of processed foods which contribute to the development of disease and impede the healing process. Do you take the time to find nutritious foods and cook at home?

Physical Environment: The spaces we inhabit have a major impact on how we feel, physically and emotionally. Consider: The climate, urban/country, your view, your home (clean, uncluttered, comfortable, temperature good, plants, music, lighting, décor, use of healthier alternatives for cleaning products).

Relationships and Communication: There is a positive correlation between positive social relationships and good health. Do you get along well with your 'inner circle' of family and friends without them adding additional stress to your life?

Spirituality: Spirituality is at the core of your being; it is a central component of how you experience life and see the world. Spirituality frequently comes from our own experience of deep connection, meaning and purpose. This can provide a source of healing strength in the face of adversity, illness suffering or death.

Personal and Professional Development: Some people have careers or daily activities (motherhood, volunteer work, creative endeavors, reading, etc.) that resonate with their purpose and values in life, while others work in jobs that have high demands with little personal or professional rewards. Sometimes there is a lack of balance across personal and professional aspects of their lives. Activities that connect us with energy, interest, satisfaction, and sheer pleasure enhance our sense of contentment and joy and ultimately to our health. These can be 'doing' activities or 'being' activities (watching the stars, watching the tide roll in, etc.).

Mind-Body Connection: A growing body of evidence indicates that virtually every illness we experience is influenced, for good or bad, by our thought patterns and emotions. The more we can encourage different modes of 'communicating' between the mind, the brain and the body, the more we can gradually form healthier pathways for thought, behavior and health. How positively do I think about things and myself throughout the day?

Professional Care – Prevention and Intervention: Do you integrate the healthcare you receive from your physicians with complementary approaches to support your health such as acupuncture, massage, nutrition counseling or weight loss programs, nutritional supplements, energy medicine, etc. Do you generally lead a healthy lifestyle – avoid tobacco, excessive alcohol and drugs, take medications as prescribed?

Medical History

Please check "yes" for the health conditions that your doctor has diagnosed, and then record the approximate date of onset.

CONDITION	Yes	Date of Onset	CONDITION	Yes	Date of Onset
GASTROINTESTINAL			**INFLAMMATORY / AUTOIMMUNE**		
Irritable Bowel Syndrome	☐		Chronic Fatigue Syndrome	☐	
Inflammatory Bowel Disease	☐		Rheumatoid Arthritis	☐	
Crohn's Disease	☐		Lupus SLE	☐	
Ulcerative Colitis	☐		Frequent Infections	☐	
Celiac Disease	☐		Severe Infectious Disease	☐	
Gastric or Peptic Ulcer Disease	☐		Herpes	☐	
GERD, reflux / heartburn	☐		Gout	☐	
Hepatitis C or Liver Disease	☐		Other:	☐	
Food Intolerance	☐				
Other:	☐				
RESPIRATORY			**MUSCULOSKELETAL / PAIN**		
Asthma	☐		Osteoarthritis	☐	
Chronic Sinusitis	☐		Chronic pain	☐	
Sleep Apnea	☐		Fibromyalgia	☐	
Bronchitis or Emphysema	☐		Migraines	☐	
Tuberculosis	☐		Other:	☐	
Other:	☐				
CARDIOVASCULAR			**URINARY / REPRODUCTIVE**		
Heart Disease / Heart Attack	☐		Kidney Stones	☐	
Stroke	☐		Urinary Tract Infections	☐	
Elevated Cholesterol	☐		Yeast Infection	☐	
Irregular Heart Rate	☐		Prostate Problem	☐	
High Blood Pressure	☐		Other:	☐	
Other:	☐				
NEUROLOGICAL / BRAIN			**METABOLIC / ENDOCRINE**		
Depression	☐		Type 1 Diabetes	☐	
Anxiety	☐		Type 2 Diabetes	☐	
Bipolar disorder	☐		Metabolic syndrome	☐	
ADD/ADHD	☐		Hypoglycemia	☐	
Multiple Sclerosis	☐		Hypothyroidism	☐	
Seizures	☐		Hyperthyroidism	☐	
Anorexia Nervosa	☐		Polycystic Ovarian Syndrome	☐	
Bulimia	☐		Infertility	☐	
Unspecified Eating Disorder	☐		Other:	☐	
Parkinson's Disease	☐				
Other:	☐				
DERMATOLOGICAL			**CANCER: Please list type(s) and treatments.**		
Eczema	☐				
Psoriasis	☐				
Acne	☐				
Other:	☐				

Additional health conditions your doctor has diagnosed:

Please list any previous injuries, surgeries, and hospitalizations. Provide your age and date if known.

Allergies		Allergic Symptoms Experienced
Food		
Medication		
Supplement		
Environmental		

Medications and Supplements: Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.

Medication Name	Year Started	Dose	Frequency	Reason

Herb/Supplement	Year Started	Dose	Frequency	Reason

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc.)? ☐ Yes ☐ No

Have you taken antibiotics > 3 times per year? ☐ Yes ☐ No

Have you been on antibiotics long term (> 1 month continuously)? ☐ Yes ☐ No

Your Birth History: ☐ Vaginal ☐ C-section

Were you breastfed as an infant? ☐ Yes ☐ No

Lifestyle Information

Do you engage in physical activity on a regular basis? ☐ Yes ☐ No If yes, complete the table below

Activity	Number of Days per Week	Duration (minutes) per Session

How many hours do you sleep on weeknights? ☐ < 6 ☐ 6-8 ☐ 8-10 ☐ 10 +

How many hours do you sleep on weekends? ☐ < 6 ☐ 6-8 ☐ 8-10 ☐ 10 +

Check which apply to you: ☐ Trouble falling asleep ☐ Wake up during the night ☐ Don't feel rested

How do you handle stress? What helps you relax?

Environmental Exposures

What is your occupation?

Are you regularly exposed to any of the following?

☐ Cigarette smoke ☐ Paint fumes ☐ Perfumes ☐ Nail Polish

☐ Auto exhaust / fumes ☐ Chemicals ☐ Dry-cleaned clothes ☐ Hair dyes

Do you feel dizzy or get a headache when exposed to strong chemical odors or fumes? ☐ Yes ☐ No

If yes, please explain.

Please describe any significant past or present exposure to substances such as recreational drugs, alcohol, or chemicals.

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? ☐ Yes ☐ No

Have you changed your eating habits for a health reason? ☐ Yes ☐ No Please describe.

Are you currently following a particular diet or nutrition plan? ☐ Yes ☐ No Please describe.

Do you avoid any particular foods? ☐ Yes ☐ No

Please explain.

Nutrition History (continued)

Do you have any adverse food reactions (intolerances or allergies)? ☐ Yes ☐ No Please explain.

Height:	Current Weight:	Usual Weight Range:	Desired Weight:

Have you recently lost or gained weight? ☐ Yes ☐ No If yes, please describe.

Do you have or have you had an eating disorder? ☐ Yes ☐ No If yes, please describe.

How many meals do you eat each day?	How many snacks do you eat each day?

How many meals do you buy from a restaurant or fast food **per week?** ☐ 0-1 ☐ 2-3 ☐ 4-6 ☐ > 6

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks **per week?**

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how many cups **per day?**

Do you use any natural or artificial sweeteners? ☐ Yes ☐ No If yes, which ones?

What is your favorite meal?

Check all of the factors that apply to your eating habits and current lifestyle:

☐ Love to eat
☐ Love to cook
☐ Emotional eater
☐ Late night eater
☐ Struggle with eating issues
☐ Family members have different tastes
☐ Dislike cooking
☐ Fast eater
☐ Erratic eating patterns
☐ Eat too much
☐ Rely on convenience foods
☐ Eat fast food frequently
☐ Make poor snack choices
☐ Confused about food/nutrition
☐ Live alone or eat alone often
☐ Do not plan meals or menus
☐ Time constraints
☐ Travel frequently
☐ Eat only because I have to
☐ Negative relationship with food
☐ Dislike healthy food
☐ Don't know how to cook

Food Diary: Please record what you eat and drink during one typical day (24 hour period).
Please be sure to include all beverages, cream and sweetener added to beverages, and condiments added to foods.

Time woke up:		Bedtime:	
Time	Food / Beverage Items	Amount (e.g. cups, oz., tsp)	Location (Home/Away)

Food Frequency Questionnaire – How often do you eat the following?

Food	Never or <4x/year	Rarely or <4x/month	Once/wk	2x/wk	3x/wk	Daily
Cheese	☐	☐	☐	☐	☐	☐
Yogurt, Kefir	☐	☐	☐	☐	☐	☐
Cow's Milk	☐	☐	☐	☐	☐	☐
Milk Substitute (soy, coconut, almond, rice, or hemp seed milk)	☐	☐	☐	☐	☐	☐
Red Meat	☐	☐	☐	☐	☐	☐
Pork (pork loin, pork roast, pork chops, barbecue)	☐	☐	☐	☐	☐	☐
Processed Meat (sausage, bacon, lunch meat)	☐	☐	☐	☐	☐	☐
Chicken	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Cold Water Fish (*striped bass, wild Alaskan salmon, herring, sardines, anchovies, mackerel, Alaskan halibut, Alaskan cod)*	☐	☐	☐	☐	☐	☐
Other fish or shellfish- Indicate type:	☐	☐	☐	☐	☐	☐
Beans, Legumes (black beans, kidney beans, white beans, lentils)	☐	☐	☐	☐	☐	☐
Whole Soy Foods (edamame, soy nuts)	☐	☐	☐	☐	☐	☐
Tofu, Tempeh	☐	☐	☐	☐	☐	☐
Soy "meat alternative" (ex. Tofurkey, soy "sausage", soy "bacon")	☐	☐	☐	☐	☐	☐
Berries	☐	☐	☐	☐	☐	☐
Other Fruits- Indicate type:	☐	☐	☐	☐	☐	☐
Cruciferous Vegetables (cabbage, broccoli, Brussels sprouts)	☐	☐	☐	☐	☐	☐
Green Leafy Vegetables (e.g. spinach, kale, collards, greens)	☐	☐	☐	☐	☐	☐
Yellow Fruits and Vegetables (e.g. yellow peppers, corn)	☐	☐	☐	☐	☐	☐
Other Green Fruits and Vegetables (e.g. peas, broccoli, avocado, cucumbers)	☐	☐	☐	☐	☐	☐
Blue/Purple Fruits and Vegetables (e.g. blueberries, prunes, beets, purple cabbage)	☐	☐	☐	☐	☐	☐
Red Fruits and Vegetables (e.g. cherries, apples, tomatoes, kidney beans)	☐	☐	☐	☐	☐	☐
Orange Fruits and Vegetables (e.g. orange, cantaloupe, carrots, sweet potato)	☐	☐	☐	☐	☐	☐
White/Tan Fruits and Vegetables (e.g. onions, garlic, ginger, nuts)	☐	☐	☐	☐	☐	☐
Turmeric, Cumin, Ginger, Rosemary, Oregano, Parsley	☐	☐	☐	☐	☐	☐
Nuts, Nut Butters- Indicate type:	☐	☐	☐	☐	☐	☐
Avocado, Extra Virgin Olive Oil , Canola Oil	☐	☐	☐	☐	☐	☐
Vegetable oil (corn, sunflower, safflower, etc. – NOT olive oil)	☐	☐	☐	☐	☐	☐
Butter, ghee	☐	☐	☐	☐	☐	☐
White Rice	☐	☐	☐	☐	☐	☐
White Pasta	☐	☐	☐	☐	☐	☐
White Bread	☐	☐	☐	☐	☐	☐
Bagels	☐	☐	☐	☐	☐	☐
English Muffins	☐	☐	☐	☐	☐	☐
Pancakes or Waffles	☐	☐	☐	☐	☐	☐

Food	Never or <4x/year	Rarely or <4x/month	Once/wk	2x/wk	3x/wk	Daily
Buttermilk Biscuits	☐	☐	☐	☐	☐	☐
Chips	☐	☐	☐	☐	☐	☐
Pretzels	☐	☐	☐	☐	☐	☐
Popcorn	☐	☐	☐	☐	☐	☐
Other Snack Food (crackers, Goldfish)	☐	☐	☐	☐	☐	☐
100% Whole Wheat, Rye, Barley (whole wheat bread and pasta)	☐	☐	☐	☐	☐	☐
Other Whole Grains (millet, quinoa, amaranth, flax, oats, brown rice)	☐	☐	☐	☐	☐	☐
Ice Cream	☐	☐	☐	☐	☐	☐
Pastries, cookies, cakes	☐	☐	☐	☐	☐	☐
Juice- Indicate type:	☐	☐	☐	☐	☐	☐
Punch, Lemonade, or Sweet Tea	☐	☐	☐	☐	☐	☐
Diet Soda	☐	☐	☐	☐	☐	☐
Soda (not diet)	☐	☐	☐	☐	☐	☐
Red Wine	☐	☐	☐	☐	☐	☐
Tea (white, green, black)	☐	☐	☐	☐	☐	☐

Daily Intake Summary

What type(s) of protein do you consume most days of the week? (Check all that apply.)

☐Animal meat ☐Beans ☐Eggs ☐Soy-based ☐Dairy ☐Nuts and seeds

How many servings of fruit do you have in a day?	
How many servings of vegetables do you have in a day?	

Provide an estimate of the amount of each beverage that you consume on an average day.
Circle the label that is most appropriate based on how you consume the beverage.

Water: _____ ounces, cup(s) Diet soda:_____ cup(s), can(s), liter(s) Tea: _____cup(s)

Coffee: _____ ounces, cup(s) Non-diet soda: ____ cup(s), can(s), liter(s) Other:

SYMPTOM SURVEY

Completing this form is particularly helpful if you have experienced persistent and bothersome symptoms from more than one category below. Score every symptom based on your experience over the last 30 days. Start with the first symptom and ask yourself, "Lately, have I experienced this symptom?" If you answer no or almost not at all, then write a "0" in the corresponding field. If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). After you have decided on the frequency, then ask yourself if the symptom is "Severe" or "Not Severe". Using the SCALE OF SYMPTOM POINTS listed below, write the appropriate score in the corresponding field for EVERY symptom listed. Total the points for each category, and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS: 0 = Do Not Suffer From This Ever or Almost Ever 1 = Suffer OCCASSIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASSIONALLY and is severe 4 = Suffer FREQUENTLY and is severe	Grand Total:

CONSTITUTIONAL

_____ Fatigue (sluggish, tired)
_____ Hyperactive (nervous energy)
_____ Restless (can't relax/sit still)
_____ Sleepiness During Day
_____ Insomnia at Night
_____ Malaise
_____ TOTAL (0-20)

EMOTIONAL/MENTAL

_____ Depression (feelings of hopelessness)
_____ Anxiety (vague fears, uneasiness)
_____ Mood Swings (rapid distinct changes)
_____ Irritability
_____ Forgetfulness
_____ Lack of concentration/focus
_____ TOTAL (0-24)

HEAD/EARS

_____ Headache (any kind)
_____ Migraine (diagnosed)
_____ Earache
_____ Ear Infection
_____ Ringing in Ear
_____ Itchy Ears
_____TOTAL (0-24)

SKIN

_____ Blemishes, Acne
_____ Rashes, Hives
_____ Eczema
_____ "Rosy" Cheeks
_____ TOTAL (0-16)

NASAL/SINUS

_____ Post Nasal Drip
_____ Sinus Pain
_____ Runny Nose
_____ Stuffy Nose
_____ Sneezing
_____ TOTAL (0-20)

MOUTH/THROAT

_____ Sore Throat
_____ Swollen Throat
_____ Swelling of Lips/Tongue
_____ Gagging/Throat Clearing
_____ Lesions ("Canker Sores")
_____ TOTAL (0-20)

LUNGS

_____ Wheezing" (Asthma or Asthma-like Symptoms)
_____ Chest Congestion
_____ Non-Productive Coughing
_____ Productive Coughing
_____ TOTAL (0-20)

EYES

_____ Red or Swollen Eyes
_____ Watery Eyes
_____ Itchy Eyes
_____ Dark Circles" or "Baggy"
_____ TOTAL (0-16)

GENITOURINARY

_____ Increased Urinary Frequency
_____ Painful Urination
_____ TOTAL (0-8)

MUSCULOSKELETAL

_____ Joint Pains/Aching
_____ Stiff Joints
_____ Muscle Aches
_____ Stiff Muscles
_____ TOTAL (0-20)

CARDIOVASCULAR

_____ Irregular Heartbeat
_____ High Blood Pressure
_____TOTAL (0-8)

DIGESTIVE

_____ Heartburn/Esoph.Reflux
_____ Stomach Pains/Cramps
_____ Intestinal Pains/Cramps
_____ Constipation
_____ Diarrhea
_____ Bloating Sensation
_____ Gas (of Any Kind)
_____ Nausea, Vomiting
_____ Painful Elimination
_____ TOTAL (0-36)

WEIGHT MANAGEMENT

_____ Fluctuating Weight
_____ Food Cravings
_____ Water Retention
_____ Binge Eating or Drinking
_____ Purging (all methods)
_____ TOTAL (0-20)

Comments:

Melissa Wittman
DC, CFMP
Visionary Health Consultant

Policies

I understand that:

• All consultations are for educational purposes only.
• A legally binding doctor/patient relationship is not established by this consult.
• With this consultation, Dr. Wittman is not diagnosing me, ordering labs, or treating me.
• Assessments and recommendations are intended to assist my primary health care provider and I in using natural means to support my health.
• Medical insurance will not cover these consultations.
• It may take 3 business days before Dr. Wittman has prepared and delivered, via my provided email address, any written summary of my consult.
• If I have additional questions, I can email Dr. Wittman, but Dr. Wittman has the discretion to charge an additional cost if the question is complicated.
• Cancellation Policy: A minimum of 48 hours notice is required for cancellations.
• There is no refund for consultations.
• I am ultimately responsible for my health and what I put in my body.

Signature _____

Printed Name _____

Date _____