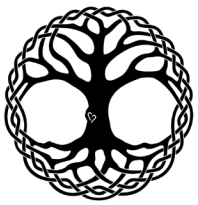


INTRINSIC INTEGRATIVE HEALTH

Confidential Patient Information

Intrinsic Integrative Health
2500 Youngfield St, Ste 6
Lakewood, CO 80215

P: (720) 924-6535
F: (720) 863-2003
www.youriihealth.com

Functional Medicine Intake

Date:_____/_____/_____

Patient's Full Name _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ E-Mail: _____

☐ Male ☐ Female Date of Birth:_____/____/_____ ☐ Married ☐ Single ☐ Other_____

Spouse's Name:_____ Number of Children/Ages_____

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed ☐ Other:_____

Occupation:_____ Employer:_____

Employer Address:_____ City:_____ State:____ Zip:_____ Phone #:_____-_____-_____

How did you find us?

☐ Existing Patient
Who?_____

☐ Physician
Who?_____

☐ Friend
Who?_____

☐ Other_____

☐ iiHealth Website

☐ Google

☐ Other Website:_____

Primary Care Physician (PCP):

PCP Group Name: _____ Physician's Name: _____

Address:_____ Phone #:_____-_____-_____

City:_____ State:_____ Zip:_____

Emergency Contact:

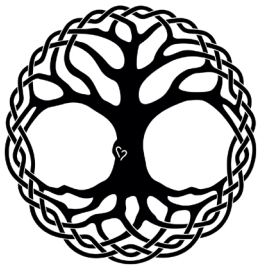
Contact Name: _____ Relationship:_____ Phone #:_____-_____-_____

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Intrinsic Integrative Health) are **paid in full**.

Patient or Guardians' Signature:_____ **Date:**_____/_____/_____



INTRINSIC
INTEGRATIVE
HEALTH

Dr. Julie Holland | Dr. Alan Yoder

Health Goals for Joy:
Setting the Bar

Please list your top 3 activities that bring you joy. Can you currently participate in and enjoy them; yes or no? If no, please explain why.

1. _____
   _____
   _____

2. _____
   _____
   _____

3. _____
   _____
   _____

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI (continued)				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Weight: _____ Date: _____

PATIENT DIAGNOSTIC QUESTIONNAIRE

Name_____ How old are you? _____ (001)

YOUR CHIEF COMPLAINTS

Please mark with an (X) the principle or major conditions which you are concerned about, would like eliminated, or desire treatment for:

002 ( ) Overweight
003 ( ) Underweight
004 ( ) Sexual Problems
005 ( ) Menopause Problems
006 ( ) Heart Condition
007 ( ) Blood Pressure Problems
008 ( ) Digestion Trouble
009 ( ) Gall Bladder Problems
010 ( ) Diabetes Mellitus
011 ( ) Skin Disorder
012 ( ) Ear or Hearing Disorder
013 ( ) Sinus Infections
014 ( ) Nervous/Emotional Trouble
015 ( ) Allergies to Food
016 ( ) Nutritional Evaluation
017 ( ) Arthritis/Rheumatism
018 ( ) Headaches
019 ( ) Female Problems
020 ( ) Extreme Fatigue
021 ( ) Cancer
022 ( ) Circulatory Problems
023 ( ) Lung and/or Breathing
024 ( ) Stomach and/or Gall Bladder
025 ( ) Intestine or Bowel Troubles
026 ( ) Neck and/or Spine Problems
027 ( ) Eye Condition
028 ( ) Nose/Throat/Mouth Problems
029 ( ) Dizziness/Balance Disorder
030 ( ) Kidney/Bladder/Urinary
031 ( ) Allergies in General
032 ( ) Thorough Diagnostic Checkup
033 ( ) Alcohol or Tobacco Addiction

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING THIS QUESTIONNAIRE:

Read each question carefully and mark with an (X) only those statements which are true for you (a yes answer). If a question does not apply to you, or you do not recognize the terminology or disease, or if you are not sure and have a doubt about a question, then do not check the box, simply leave it blank.

GENERAL

034 ( ) Are you overweight?
035 ( ) Are you underweight?
036 ( ) Are your fingernails ridged or have spots?
037 ( ) Do you sleep less than seven hours per night?
038 ( ) Do you rarely exercise?
039 ( ) Do you smoke over 9 cigarettes each day or inhale pipe/cigars?
040 ( ) Do you drink alcoholic beverages each day?
041 ( ) Do you usually drink less than 8 glasses of water each day ?
042 ( ) Are you sensitive to chemical, paint, exhaust fumes, cologne?
043 ( ) Are you unable to recall your dreams the next day?

EYES

044 ( ) Are you near sighted (can't see things at a distance)?
045 ( ) Are you far sighted (can't read small print without glasses)?
046 ( ) Do your eyes frequently itch?
047 ( ) Do you suffer from cross eyes?
048 ( ) Do you have or have you had cataracts?
049 ( ) Do you experience pain in your eyes?
050 ( ) Are your eyes bloodshot?
051 ( ) Do your eyes water?
052 ( ) Do your eyes feel gritty?
053 ( ) Is your vision blurred?
054 ( ) Are you hard of hearing?
055 ( ) Are you experiencing any discharge from your ears?
056 ( ) Do you have ringing or noises in your ears?
057 ( ) Do you suffer from recurrent ear infection?
058 ( ) Do you have a punctured ear drum?

PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

MOUTH and THROAT

059 ( ) Is your tongue badly coated?
060 ( ) Do you have bad breath?
061 ( ) Do you suffer from sores or cracks at corners of mouth?
062 ( ) Do you frequently experience canker sores (sore mouth)?
063 ( ) Are your gums sore?
064 ( ) Do you frequently suffer from fever blisters?
065 ( ) Do your gums bleed when you brush your teeth?
066 ( ) Do you have sore throats frequently?
067 ( ) Are your glands often swollen?
068 ( ) Do you suffer from toothaches?
069 ( ) Is your mouth often dry?
070 ( ) Do you have excessive saliva?
071 ( ) In the mornings do you have a bitter taste in your mouth?
072 ( ) Do you frequently have a sore tongue?

RESPIRATORY

073 ( ) Do you have frequent colds?
074 ( ) Do you suffer from nasal polyps?
075 ( ) Do you often have sinus infections?
076 ( ) Do you experience night sweats?
077 ( ) Do you have hay fever?
078 ( ) Do you wheeze?
079 ( ) Do you have Asthma?
080 ( ) Do you experience difficulty in breathing?
081 ( ) Do you have a chronic cough?
082 ( ) Do you spit up phlegm?
083 ( ) Do you spit up blood?
084 ( ) Do you have spells of sneezing?
085 ( ) Is your nose frequently stuffy?
086 ( ) Does your nose run constantly?
087 ( ) Do you have frequent nose bleeds?
088 ( ) Do you catch severe colds?
089 ( ) Do you have a chronic chest condition?
090 ( ) Do you have post nasal drip?

CARDIOVASCULAR

091 ( ) Do you have high blood pressure?
092 ( ) Do you have low blood pressure?
093 ( ) Do you have pains in the heart or chest?
094 ( ) Are you troubled with blood clots?
095 ( ) Do you have cold hands?
096 ( ) Are your feet frequently cold?
097 ( ) Do you have varicose veins?
098 ( ) Are your ankles frequently swollen?
099 ( ) Do you have an unusually slow pulse rate?
100 ( ) Do you experience spells of rapid heart beat?
101 ( ) Are you aware of your heart skipping beats?
102 ( ) Do you experience shortness of breath while sitting still?
103 ( ) Do you suffer from leg cramps after retiring to bed?
104 ( ) Do you suffer from leg cramps during the day?
105 ( ) Do you experience pain in your leg/hips when walking?

GASTROINTESTINAL

106 ( ) Is your appetite poor?
107 ( ) Do you have excessive hunger?
108 ( ) Do you experience fainting spells when hungry?
109 ( ) Does eating relieve fatigue?
110 ( ) Do you feel shaky when hungry?
111 ( ) Are you frequently drowsy after eating a meal?
112 ( ) Do you eat when nervous?
113 ( ) Do you frequently have diarrhea?
114 ( ) Do you have difficulty in swallowing?
115 ( ) Do you vomit frequently?
116 ( ) Are you frequently nauseated?
117 ( ) Are you bloated after eating?
118 ( ) Do you have abdominal gas?
119 ( ) Does eating greasy foods cause you to have indigestion?
120 ( ) Do you belch or burp after eating?
121 ( ) Do you have: indigestion immediately upon eating?
122 ( ) Indigestion within 1 hour after meals?
123 ( ) Indigestion 2 hours or more after meals?
124 ( ) Do you have loose bowel movements?
125 ( ) Have you ever had intestinal worms?
126 ( ) Do you have pale or yellow colored stools?
127 ( ) Do you suffer from constipation?
128 ( ) Do you have one or less bowel movements daily?
129 ( ) Are your stools bloody?

PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

130 ( ) Do you have black tarry stools?
131 ( ) Do you use laxatives?
132 ( ) Do you suffer from severe abdominal pains?
133 ( ) Do you have hemorrhoids (piles)?
134 ( ) Do you have stomach ulcers?
135 ( ) Do you have gall bladder disease?
136 ( ) Do you have liver disease?

NEUROMUSCULAR

137 ( ) Do you have neck pain?
138 ( ) Do you have pain between the shoulders?
139 ( ) Do you suffer from low back pain?
140 ( ) Do you have swollen joints?
141 ( ) Do you have a spinal curvature?
142 ( ) Do you suffer from muscle spasms?
143 ( ) Are your muscles frequently sore?
144 ( ) Do you have muscle weakness?
145 ( ) Are your joints stiff in the morning?
146 ( ) Do you have shoulder/arm pain?
147 ( ) Do you suffer from leg pain at rest?
148 ( ) Do you have rheumatism?
149 ( ) Does any part of your body experience numbness/tingling?
150 ( ) Do you have frequent headaches?

FEET

151 ( ) Are you often dizzy?
152 ( ) Do you frequently feel faint?
153 ( ) Do you have epilepsy?
154 ( ) Do you bite your nails badly?
155 ( ) Do you stutter or stammer?
156 ( ) Are you a sleep walker?
157 ( ) Do you have rheumatoid arthritis?
158 ( ) Do you have osteoarthritis?
159 ( ) Do you suffer from motion sickness?
160 ( ) Do you suffer from painful feet?
161 ( ) Do you have frequent foot cramps?
162 ( ) Do you have plantar warts?
163 ( ) Do you have heel spurs?
164 ( ) Are you troubled with corns?

SKIN

165 ( ) Is your skin tender?
166 ( ) Does your skin itch?
167 ( ) Do you have skin eruptions?
168 ( ) Is your skin rough, especially on the back of your arms?
169 ( ) Do you have Psoriasis?
170 ( ) Do you bruise easily?
171 ( ) Do you have Acne?
172 ( ) Are you troubled with boils?
173 ( ) Do you have Eczema?
174 ( ) Are you aware of moles which are changing in size or color?
175 ( ) Do you frequently experience goose bumps?
176 ( ) Do you have hives (allergy reaction of the skin)?
177 ( ) Do you have excessive perspiration?
178 ( ) Do you get sores that are slow to heal?

URINARY

179 ( ) Do you have frequent urination?
180 ( ) Do you awaken at night to urinate?
181 ( ) Are you a bed wetter?
182 ( ) Do you dribble when sneezing or laughing?
183 ( ) Have you ever lost control of your bladder?
184 ( ) Do you have painful urination?
185 ( ) Do you have blood in your urine?
186 ( ) Are you troubled by urgent urination?
187 ( ) Do you have difficulty in starting the stream?
188 ( ) Do you have frequent bladder infections?
189 ( ) Do you have frequent kidney infections?
190 ( ) Do you have kidney stones?

ENDOCRINE

191 ( ) Do you have excessive thirst?
192 ( ) Do you frequently feel cold?
193 ( ) Do you frequently feel hot?
194 ( ) Are you unusually tired most of the time?
195 ( ) Are you unusually jumpy or nervous?
196 ( ) Is your hair coarse?
197 ( ) Is your skin coarse?
198 ( ) Are you diabetic?
199 ( ) Do you get lightheaded when standing quickly?

PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

FOR WOMEN ONLY

200 ( ) Do you have painful periods?
201 ( ) Do you have an excessive flow?
202 ( ) Do you have irregular cycles?
203 ( ) Do you suffer from menstrual cramps?
204 ( ) Do you have hot flashes?
205 ( ) Do you have vaginal discharge?
206 ( ) Do you have a bloody spotting discharge?
207 ( ) Have you had a hysterectomy?
208 ( ) Do you retain fluid during your periods?
209 ( ) Have you ever miscarried?
210 ( ) Do you have Acne worse at menstruation?
211 ( ) Do you have tender breasts?
212 ( ) Do you have frequent yeast infections?
213 ( ) Do you have lumps in your breasts?
214 ( ) Do you have heavy hair growth on face or body?
215 ( ) Do you take birth control pills?
216 ( ) Do you have pre-menstrual depression?
217 ( ) Is intercourse painful for you?
218 ( ) Do you have a diminished sex desire?
219 ( ) Do you have poor or infrequent orgasm?

FOR MEN ONLY

220 ( ) Do you have painful genitals?
221 ( ) Do you have prostate troubles?
222 ( ) Do you have lumps in your testicles?
223 ( ) Do you have a discharge from the urethra?
224 ( ) Do you have sores on external genitalia?
225 ( ) Do you have difficulty getting or keeping an erection?
226 ( ) Do you have difficulty completing intercourse?
227 ( ) Have you had difficulty fathering children?

BEHAVORIAL

228 ( ) Do you have difficulty falling asleep?
229 ( ) Do you have difficulty staying asleep?
230 ( ) Do you have recurrent bad dreams?
231 ( ) Do you have difficulty in concentrating?
232 ( ) Is your memory poor?
233 ( ) Do strange people or places make you afraid?
234 ( ) Are you scared to be alone?
235 ( ) Do you always need someone to advise you?
236 ( ) Are you afraid to eat anywhere except at home?
237 ( ) Are you unhappy when others are happy?
238 ( ) Are you usually unhappy and depressed?
239 ( ) Do you often cry?
240 ( ) Are you frequently miserable or blue?
241 ( ) Do you sometimes wish you were dead and away from it all?
242 ( ) Are your feelings easily hurt?
243 ( ) Does criticism always upset you?
244 ( ) Do people usually misunderstand you?
245 ( ) Do you have to be on guard even with your friends?
246 ( ) Do people often annoy you?
247 ( ) Are you easily angered?
248 ( ) Do you frequently become scared for no reason?
249 ( ) Do you feel you are under considerable emotional stress?

Thank you for completing this questionnaire.

INTRINSIC
INTEGRATIVE
HEALTH

Dr. Julie Holland
2500 Youngfield St., Suite 6
Lakewood, CO 80215
P: 720.924.6535
F: 720.863.2003
www.youriihealth.com

CONSENT AGREEMENT AND WAIVER OF LIABILITY FOR LABORATORY ASSESSMENT, FUNCTIONAL MEDICINE AND NUTRITIONAL THERAPY

PLEASE READ THOROUGHLY, SIGN, AND RETURN EACH PAGE

It is important for you to understand fully that Dr. Holland uses laboratory analysis and other exam findings to uncover deficiencies and their causes, and not for the diagnosis of a medical condition or illness. Dr. Holland and the Intrinsic Integrative Health Clinic (iiHealth/ iiH) offer laboratory testing for the purpose of assessing the complete metabolic and biochemical terrain of the patient. She also offers nutritional support as part of her individualized treatment plans.

This office does not treat symptoms or diagnose diseases, but rather focuses to uncover the underlying causes of imbalance. A nutritional deficiency may be associated with a specific symptom, or it may be the cause of the symptom, or it may occur as a result of that symptom. Dr. Holland prescribes vitamins, minerals, herbal agents, hormone supporting catalysts and therapeutic agents for the sole purpose to aid and support the body to restore proper function and optimal wellness. Instead of focusing on disease and illness, Dr. Holland uses many modalities to support the body nutritionally, energetically and spiritually, in addition to educating the patient on how to be responsible caregivers to their own bodies. A fully functioning body will by nature, be less likely to manifest disease or illness. This office also uses laboratory assessment and nutritional therapy for the **prevention** of symptoms. Functional laboratory evaluations and scientific nutritional therapy are powerful tools for healing imbalances, as well as for prevention of illness. One must be pro-active in their health in order to preserve that health and avoid illness.

The laboratory tests and subsequent nutrient recommendations are not intended to diagnose, treat or cure any specific disease. The nutritional recommendations we make based on laboratory tests, physical and clinical findings, history and symptoms, do not constitute treatment for any specific disease.

In the nutritional management of a case, we routinely prescribe numerous vitamins, minerals, enzymes, homeopathics, nutraceuticals, hormone catalyst support and other nutritional substances. We do not want you to have any misconceptions about their use in this clinic. In the event that any vitamin, mineral, food or other nutritional substance mentioned above is prescribed or administered in your case, we want you to understand explicitly that its purpose will be for:

1) Improvement of your overall nutritional status;
2) Improvement of your metabolism, including absorption, proper utilization and detoxification;
3) Improvement of the sense of well-being; and/or
4) Possible remission or reduction of pain where present.

You may or may not receive any/all of these benefits, because they do not occur predictably with every patient. Also, it is up to you to follow the dietary and/or lifestyle instructions given to you, as this allows the prescribed nutraceuticals to be utilized properly and be supportive for your healing. Nutritional supplements are an important part of the healing process in that they provide missing or lacking nutrients and can affect metabolic changes in the body which need support. However, it is vital to understand that nutritional supplements do not "fix" problems or treat symptoms. They are part of a holistic treatment plan which is offered here and may include dietary and lifestyle modifications.

I read, understand, and consent to the information on this page: _____
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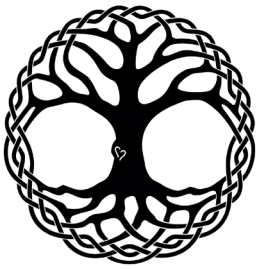

INTRINSIC
INTEGRATIVE
HEALTH

Dr. Julie Holland
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Lakewood, CO 80215
P: 720.924.6535
F: 720.863.2003
www.youriihealth.com

Dr. Holland uses only the highest quality nutritional products available. Most of what she prescribes is only available through licensed qualified healthcare practitioners. They are of higher quality, and in many cases, of greater potency than what is available in supermarkets or health food stores. She has researched every nutritional supplement that is offered so that the patients under her care will receive only the highest quality, scientifically formulated, and clinically proven products. Supplements bought elsewhere are often not put through strict manufacturing processes and may not even contain labeled ingredients. All supplements offered through Dr. Holland are meticulously manufactured by state of the art facilities with advanced raw material testing, production processes, and are verified by third parties as to the purity and potency of each product. Buying a cheaper & less qualified supplement may only delay the healing process and in some instances may be toxic to your body and exacerbate a condition.

Dr. Holland has also received advanced training in the administration of nutraceuticals and continues to stay current on the latest research and clinical effectiveness using natural therapeutics. It is important that you follow her instructions to the best of your ability. This office is not be held responsible for any adverse reactions or absence of effectiveness. In order to improve your health outcome, please implement all suggestions given (including dietary and lifestyle changes). The individualized treatment plan given to you is dependent on all facets working synergistically together. To give a simple analogy, how well does a car move with only two or three wheels? **Healing is a partnership and you must be willing to do your part**.

There are always **risks and benefits** associated with any therapy. Supplements are prescribed in your case because there has been a clinical need or indication established. They may also be prescribed as purely preventive or supportive in nature. However, everybody reacts differently to something new, and often when the body is undergoing a shift, it may feel uncomfortable for a period of time. Please advise Dr. Holland if any reactions appear, as they may be part of the healing process or signify that a change in dosage or product is needed. Possible unintended reactions include stomach pain/cramps, change in bowel function, rashes, headaches, fatigue, allergy, joint pain, vomiting, sweating, increase in body odor, etc. If any severe allergic reaction is noted, please discontinue use and go to the nearest urgent care facility, and later inform Dr. Holland of the occurrence.

It is also important that you return to our office for scheduled appointments to review the results and interpretation of your test(s), and to discuss your experiences under the treatment plan designed for you. With good intent, our office policy (not state law) requires that you see or discuss your results with Dr. Holland **before** we can release the results of the test to you or to anyone else, with your best in mind. These tests allow you and Dr. Holland to better understand your unique physiology and design an effective and thorough health care plan. Follow up tests are often required as well, in order to ensure that the underlying imbalances are improving with treatment. It is also highly encouraged to acquire annual preventive laboratory exams so that the baseline tests can be compared and trends observed over time. Knowing your own individual, biochemical uniqueness is of great advantage when interpreting laboratory tests. Allowing the same doctor to run your annual labs and physical exam can cut down on unnecessary tests and procedures, or at very least choosing a healthcare team that can co-treat and work together well as a team for you.

Payment, Insurance, Refunds: Payment is due at time of service. Payment for laboratory tests differs slightly: some may require upfront pay at the time of specimen collection. Payment for service is not conditional on response to care. iiHealth does not bill insurance, nor contracted with any insurance company. You may choose to bill your insurance yourself if you choose to. All reimbursements are between you and your insurance company. No refunds are given for any reason for services rendered.

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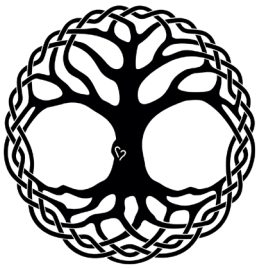

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Return Policy: Once a supplement is purchased, it cannot be returned for any reason, even if the bottle/package is unopened. Once the supplement leaves this office, we can no longer guarantee the potency, purity or condition of the product, how it was handled, stored, etc. (Please keep all supplements in a cool, dry place or refrigerated if indicated).

By signing below I am attesting that I HAVE READ AND UNDERSTAND THE ENTIRETY OF THIS CONSENT DOCUMENT, and have had all my questions answered satisfactorily. I hereby, voluntarily place myself under Dr. Holland's care for such advice, recommendation, treatment and administration as may appear to be indicated in her professional judgment. I understand there is no guarantee of results of care. I agree to hold Dr. Holland, Intrinsic Integrative Health Clinic and all of it's staff and affiliates free of any and all liability for any adverse reactions that may result from testing procedures and/or administration of nutraceuticals or other treatments.

DO NOT SIGN unless you have read and fully understand each page of this document.

Patient Name (print): _____ Date: _____

Patient Signature: _____

Doctor's Signature: _____ Date: _____