ABUNDANT HEALTH
and Wellness Center

Name: _____ Home # _____
Work # _____ Cell # _____

Street Address: _____ City _____
State: _____ Zip code: _____
E-mail address: _____ Date of birth: _____

Please list your major physical complaints in the order that you think is most important: _____
_____
_____
_____

Please list any major surgeries and the dates:: _____
_____
_____
_____

Please list any medications you are taking at the present time and the reason they were prescribed for you: _____
_____
_____

ASYRA/EAV INFORMED CONSENT FORM

_____

Please read the following and sign below:

The Asyra computerized health test provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the procedure is to disclose patterns of stress in the body and to provide feedback to help put together a program to restore each system of the body back into balance.

I understand that the Asyra testing does not provide a medical diagnosis, and that the testing technician may recommend further medical testing. If YOU suspect that you need further medical intervention, you should contact YOUR medical physician.

I give permission for the testing technician to do an evaluation with the Asyra system. I understand that by doing so THE TESTING TECHNICIAN IS NOT BECOMING MY PRIMARY CARE PHYSICIAN. I understand that the testing technician will make recommendations to improve my health based on what is found. Any decision to follow through with the program will be my own decision, and I will not hold the testing technician responsible. The testing fees and products which are purchased are non-refundable.

Date: _____ Patient Signature: _____