

# Kara Hayes, BS, NHD, Iridologist, Lifestyle Advisor

## INFORMED CONSENT STATEMENT

I, \_\_\_\_\_ hereby attest and agree to the following:

- 1) I fully understand the Kara Hayes is a lay natural health consultant who deals strictly in helping people to improve their general health and fitness through better nutrition, improved lifestyle, health habits, and positive mental attitudes.
- 2) I fully understand that Kara Hayes is not a licensed physician and cannot diagnose diseases, prescribe drugs or recommend treatments for specific disease conditions.
- 3) I understand that all evaluations/analysis performed by Kara Hayes or her 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.
- 4) I understand that Kara Hayes neither claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services or products she or her representatives provide, whether in person, by mail, by telephone or by internet, will cure, treat, prevent or mitigate any disease condition; but are provided solely for the purpose in increasing energy, supporting the natural function of body systems and otherwise improving general health and fitness.
- 5) I certify that Kara Hayes or her representatives have not suggested 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 Kara Hayes or her representatives responsible for the consequences of my decisions.
- 6) I certify that I am her on this and on any subsequent visit or contact, whether by mail, telephone, internet, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation.

## CANCELLATION POLICY

**Please be advised...In the event that you must cancel your scheduled appointment, please provide a minimum of 24 hours notice. Failure to contact Kara Hayes 24 hours prior to your scheduled appointment will require you to pay for your missed appointment in full.  
Thank you for your consideration and understanding of this policy.**

I have read and understand the foregoing and agree to the terms and conditions set therein.

Date \_\_\_\_\_ Signed by: \_\_\_\_\_

Client Signature: \_\_\_\_\_

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Rochester, NH 03867  
603-332-3232

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Holistic Lifestyle Advisor  
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### Medical & Health History

#### Identification

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Sex: M / F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_ Phone (C): \_\_\_\_\_  
Email: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How did you hear about me? \_\_\_\_\_  
Family Status: Single / Divorced / Married / Widow (er) / Significant Other (circle one)  
How many children do you have? \_\_\_\_\_ How old are your children? \_\_\_\_\_  
Eye Color: \_\_\_\_\_

#### Primary Concerns/Complaints

Please list your major problems/symptoms and the approximate date they began. Please rank in order of importance to you.

If you have no major complaints, please write the reason for seeking this consultation.

	When it began
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

What types of therapies have you tried?

Diet Modification \_\_\_ Fasting \_\_\_ Vitamin/Mineral \_\_\_ Herbs \_\_\_ Massage \_\_\_  
Homeopathy \_\_\_ Chiropractic \_\_\_ Acupuncture \_\_\_ Conventional Drugs \_\_\_ Exercise \_\_\_  
Other: \_\_\_\_\_  
\_\_\_\_\_

What are your expectations regarding what you would like our office to provide you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have seen (or are seeing) other professionals for your health concerns, please indicate the results of these sessions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

On a scale of 1-10, what level of stress are you experiencing? \_\_\_\_\_

Identify the major causes of your stress...

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications**

Please write name, dosage, and how often taken:

_____	_____
_____	_____
_____	_____
_____	_____

Please list any medications you may have an allergy to and the type of reaction:

\_\_\_\_\_

\_\_\_\_\_

**Vitamins & Supplements**

Please write name, dosage, and how often taken:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Over the Counter Medications**

Please list name, type and frequency.

_____	_____
_____	_____
_____	_____

**Lifestyle Habits**

**Tobacco**

Do you currently smoke or chew? \_\_\_\_\_

If yes,

How much per day? \_\_\_\_\_

For how long? \_\_\_\_\_

If no,

Did you ever smoke? \_\_\_\_\_

For how long? \_\_\_\_\_

When did you stop? \_\_\_\_\_

**Alcohol (Wine, Beer, Liquor)**

How often do you drink?

Never \_\_\_\_\_ Less than 1 per week \_\_\_\_\_ 2 to 5 times per week \_\_\_\_\_ At least 1 per day \_\_\_\_\_

What do you drink? \_\_\_\_\_ Was drinking ever a problem? \_\_\_\_\_

**Caffeine**

How many cups of the following do you consume daily?

Coffee \_\_\_\_\_

Black Tea \_\_\_\_\_

Green or White Tea \_\_\_\_\_

Cola \_\_\_\_\_

Diet Cola \_\_\_\_\_

Chocolate \_\_\_\_\_

**Recreational Drug Use (Type & Frequency)**

\_\_\_\_\_

\_\_\_\_\_



**H. Your Past Medical History / Symptoms Review**

Please use the following letters in the left hand columns. Leave blank if the symptom does not apply to you.

**“C” for a current problem**

**“I” for an intermittent problem**

**“P” for a past problem**

Acne _____	Allergies _____	Anemia _____
Arthritis _____	Asthma _____	Bloating _____
Cancer _____	Cataracts _____	Constant Hunger _____
Constipation _____	Crohn’s Disease/Colitis _____	Chronic Fatigue _____
Depression _____	Diabetes _____	Difficulty Swallowing _____
Diverticulitis _____	Dry Skin _____	Eczema _____
Eating Disorder _____	Fibromyalgia _____	Frequent Colds _____
Frequent Urination _____	Headaches _____	Heart Disease _____
Hepatitis _____	Herpes _____	High Blood Pressure _____
High Cholesterol _____	HIV _____	Hypoglycemia _____
Hyperthyroid (high) _____	Hypothyroid (low) _____	Infertility _____
Insomnia _____	Irritable Bowel _____	Joint Stiffness _____
Kidney/Bladder Infection _____	Leg Cramps _____	Liver Dysfunction _____
Loss of Appetite _____	Lupus _____	Lyme Disease _____
Mental Illness _____	Migraine Headaches _____	Multiple Sclerosis _____
Neck Lumps/Swelling _____	Nervousness/Anxiety _____	Osteoarthritis _____
Osteoporosis _____	Pneumonia _____	Psoriasis _____
Recurrent Ear Infections _____	Recurring Indigestion _____	Sinus/Nasal Congestion _____
Seizures _____	Stomach/Intestinal Ulcers _____	Stroke _____
Swollen Feet & Ankles _____	Swollen Glands _____	Thyroid Disease _____
Tuberculosis _____	Vertigo _____	Watering/Red Eyes _____
Other _____		

Please describe any other symptoms or complaints that may be helpful in reaching your health related goals:

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Thank-you for your time and honesty in completing this form!  
I look forward to meeting you and working with you to help you feel better!