Welcome to Living Well Clinical Nutrition Center

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The Vision and Goal of Living Well Clinical Nutrition Center

The vision and goal we offer is to guide and mentor each individual client to their optimal wellness. We believe all life starts and stops at the cellular level, and nutrition is the fundamental backbone to optimize cellular repair. We are committed to creating incremental, safe, and effective change to your health. Every client that comes in will be exposed to ideas that challenge the status quo in every area of standardized health taught by many medical professionals today. Because food is the primary component of our health and well-being, it is what makes our work so special, so unique, and so important. All food, no matter how basic, plays a part in the expressive nature of your genes. We set out to find the underlying cause of every disease process that people may be experiencing. Getting sick people well is our top priority. We believe that nothing will help you more than persisting with our program recommendations to the best of your ability.

Dr. Aaron Chapa, D.C., A.C.N is an Applied Clinical Nutritionist and Clinical Kinesiologist (a wellness doctor), specializing in Applied Clinical Nutrition, Applied Kinesiology, Neuro-Emotional Technique, diet, weight loss, detoxification therapy, cold laser therapy, family pediatric wellness, and Quantum Neurology. It is his belief that nutrition, energy, and a properly functioning nervous system are the building blocks of life. When these foundational aspects are balanced, it allows the body the greatest opportunity to use its own naturally occurring restorative capabilities. The vision and goal of Living Well Clinical Nutrition Center is to guide and mentor each individual to his or her optimal wellness. Dr. Chapa strives to master the top tier cutting edge techniques in the field of alternative wellness. He is in constant pursuit of how to rapidly bring the body back to its natural state of health. Nutrition, applied incrementally, sequentially, and safely over time, is the cornerstone of this work.

Dr. Amber Sorcic D.C. is a board-certified chiropractor with a passion for preventative family care. She is trained in a variety of adjustive techniques, which allows her to treat family members of all ages. She has postgraduate training on prenatal and postpartum care and is continuing her education in women's health. Dr. Amber believes that when we provide the proper framework (through structural, emotional, and nutritional care), the body is able to live up to its fullest potential of health. Most importantly, she is raising her family of 6 in a holistic manner, right alongside you. She is pleased to be serving our community by helping families reach their wellness goals.

Lynn Pappas CM,IM,NANC is a functional wellness practitioner, specializing in nutrition, allergy elimination and holistic healing. Lynn began her wellness journey to provide a safe place for healing, focusing on the mental, spiritual, and emotional aspects of life through Neuro-emotional Technique (NET) along with clinical nutrition, and homeopathy. She also uncovers root problems that can be resolved using healing properties of dilutions of botanical, plant-based and flower essence homeopathics. With over 20 years of experience in functional medicine and natural remedies, Lynn welcomes the opportunity to partner with you on your wellness journey.

Jeanne Harner CNC is a Licensed Psychiatric Technician and certified in Health Coaching through Precision Nutrition. Jeanne brings a wealth of experience and certifications that will contribute to our mission of providing holistic and comprehensive care. Jeanne is well-equipped to guide individuals towards their health and wellness goals. Her expertise in client relationship management, data analysis, program development, and positive health outcome facilitation will undoubtedly enhance the quality of care we provide to our valued clients. Her passion for helping individuals improve their well-being through non-pharmaceutical and non-surgical methods will be invaluable in our efforts to promote holistic health and empower our clients on their wellness journeys.

Aimee Luna LMT is a licensed massage therapist who graduated from the Fingers Lakes School of Massage specializing in therapeutic massage and hydrotherapy. In 2012, she certified with the National Certification Board of Therapeutic Massage and BodyWork. Her skill set is diverse and comprehensive, encompassing various massage techniques such as Swedish, Deep Tissue, Thai, Connective Tissue, Sports Massage, and Neuromuscular Therapy. Aimee previously owned a practice that focused on rehabilitation and deep tissue work, catering primarily to athletes, hikers, and runners. Additionally, Aimee has volunteered as a firefighter for mountain search and rescue, showcasing her commitment to helping others.

Today's Date:_____ Referred By: _____

Name: _____ Gender: M or F Birthday: ____/____/_____ Age: _____

Mailing Address: _____E-mail Address: _____

City: _____ State:_____ Zip:_____ Occupation:_____

Height: _____Blood Type: A AB B O - + Marital Status: M D S W # of Children:_____Weight: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Emergency Contact (Name): _____Phone Number: _____

Living Well Clinical Nutrition Center Initial Evaluation

Appointment(s) requested: Nutrition _____ Chiropractic_____ Massage_____ Other_____

1. PURPOSE OF THIS APPOINTMENT: Please tell us the main reason for coming to see our office.

_____

_____

2. HEALTH CONDITIONS & COMPLAINTS: Please list in order of severity.

_____

_____

3. MEDICATIONS (List meds by name, mg's, what for, how long. Don't forget birth control, aspirin, pain meds.)

_____

_____

4. SURGERIES (List surgeries, operations, plastic surgery, and trauma. Please date when they occurred.)

_____

_____

5. ALLERGIES (Please list food, environmental, chemical, and drug allergies.)

_____

_____

6. SUPPLEMENTS & HERBS: (List name and why you are taking them.)

_____

_____

7. OTHER INFORMATION: (Please list anything else about your health that may be important.)

_____

_____

My signature Below confirms that this information is true.

Signature _____ Date:_____

Living Well CLINICAL NUTRITION CENTER

Health Overview

SMOKING: Do you smoke? Y N If yes, how much? _____ How long have you smoked? ____

DRUG USE: (CONFIDENTIAL) Do you use any recreational drugs?_____(If yes, *CIRCLE*: marijuana cocaine heroin uppers downers Others:_____
How Often? _____
STRESS: Please rate your current stress level on a scale 1 to 10; 10 being the highest.
What are the main reasons for your stress?_____
How do you reduce stress? _____
SLEEP: How is your sleep? (*CIRCLE*: restful restless hard to fall asleep wake-up often bad dreams.)_____
What time do you go to sleep? _____ Number of hours of sleep per night? _____

DIGESTION: (*CIRCLE*: good adequate poor acid reflux burping bloating burning pain cramping.)
Other complaints: _____

URINATION: (*CIRCLE:* every 2-3 hours too frequent sense of urgency burning dribbling urinate at night)
Other Complaints: _____

BOWELS: How many bowel movements per day? _____ per week? _____
Consistency: (*CIRCLE*: normal hard soft diarrhea) Color: (*CIRCLE*: tan brown black green)
Other: (*CIRCLE* : gas mucous smell) Amount: (normal, too big, too small)
Other complaints: _____

EXERCISE: Do you exercise? _____ What kind of exercise? _____
How often? _____ For how long a time? _____

SUNLIGHT: How many hours of sunlight do you get daily? _____ weekly? _____
How many hours daily do you spend under fluorescent lights? _____

ELECTROMAGNETIC POLLUTION: **How many hours do you spend daily?** Watching TV?_____ Working on a computer?_____ Talking on a phone or cell phone?_____ Wearing a watch?_____
Wearing a hearing aid?_____ Riding in a car?_____ Do you live next to power lines? _____
DIET: How many times a day do you eat?_____How often do you eat out?_____

DRINKING: What kind of water do you drink?_____
(*CIRCLE*: Tap Filtered Spring Reverse Osmosis Distilled Well water)
(*CIRCLE*: beverages you drink and how many times per day **(D)** or per week **(W)** you drink them:
Milk_____ Coffee_____ Tea_____ Herbal Tea_____ Regular Tea_____

Soda_____ Beer_____ Wine_____ Liquor_____)

(*CIRCLE*: foods you eat and how many times per day **(D)** or per week **(W)** you eat them:

Corn_____	Bread_____	Rice_____	Cereal_____	Pasta_____
Cheese_____	Potatoes_____	Cookies_____	Candies_____	Cakes_____
Ice cream_____	Pork_____	Red Meat_____	Chicken_____	

Chocolate_____

***WOMEN ONLY:** Are you pregnant?_____ Are you breastfeeding?_____Do you have monthly periods?_____
Last period date_____ Are you going through menopause? Y N Have your periods stopped?_____

MENSTRUAL CYCLE: Number of days of flow:_____ (*CIRCLE*: heavy light spotting normal)
(*CIRCLE*: cramping bloating weakness mood swings cravings pain bright blood dark blood blood clots)
Other menstrual complaints:_____

My signature Below confirms that this information is true.

Signature _____ Date:_____

Living Well CLINICAL NUTRITION CENTER

Toxicity Questionnaire

Please rate each of the following based on your health profile based on the last 90 days:

*(**0** = Rarely or never experience the symptom **1**= Occasionally experience but effective is not severe **2** = Occasionally experience but effect is severe **3** = Frequently experience and effect is not severe **4** = Frequently experience and effect is severe)*

Digestive:

Nausea	0 1 2 3 4
Diarrhea or Vomiting	0 1 2 3 4
Heartburn, Reflux	0 1 2 3 4
Straining on bowel mvmt	0 1 2 3 4
Day without bowel mvmt	0 1 2 3 4
Gas, Belch, Bloating	0 1 2 3 4
Hemorrhoids	0 1 2 3 4
Total for section:	_____

Heart:

Shortness of Breath	0 1 2 3 4
Skipped, Rapid Heartbeat	0 1 2 3 4
High/Low Blood Pressure	0 1 2 3 4
Chest Pain	0 1 2 3 4
Tightness in chest	0 1 2 3 4
Total for section:	_____

Emotions:

Mood Swings	0 1 2 3 4
Anxiety / Fear / Nervous	0 1 2 3 4
Anger / Irritability	0 1 2 3 4
Panic Attacks	0 1 2 3 4
Depression	0 1 2 3 4
Sense of Despair	0 1 2 3 4
Total for section:	_____

Energy:

Fatigue / Tired	0 1 2 3 4
Sluggishness	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Restlessness	0 1 2 3 4
Brain Fog	0 1 2 3 4
Irritable if miss meals	0 1 2 3 4
Swelling hands and feet	0 1 2 3 4
Total for section:	_____

Skin, Hair, Nails:

Flushing	0 1 2 3 4
Cold hands & feet	0 1 2 3 4
Acne	0 1 2 3 4
Dry skin /Oily skin	0 1 2 3 4
Hives, rashes	0 1 2 3 4
Eczema, Psoriasis	0 1 2 3 4
Hair loss	0 1 2 3 4
Cracked heels on feet	0 1 2 3 4
Bruising	0 1 2 3 4
Brittle nails	0 1 2 3 4
Total for section:	_____

Hormones:

Oily Skin, Acne	0 1 2 3 4
Pain during period	0 1 2 3 4
Breast tenderness	0 1 2 3 4
Irregular cycle	0 1 2 3 4
Weight gain	0 1 2 3 4
Cry easily	0 1 2 3 4
Vaginal dryness	0 1 2 3 4
Hot flashes	0 1 2 3 4
Loss of sex drive	0 1 2 3 4
Erectile dysfunction	0 1 2 3 4
Balding	0 1 2 3 4
Anger easily	0 1 2 3 4
Total for section:	_____

Head, Eyes:

Blurred Vision	0 1 2 3 4
Pressure	0 1 2 3 4
Faintness	0 1 2 3 4
Dizziness	0 1 2 3 4
Headaches	0 1 2 3 4
Total for section:	_____

Allergies:

Watery, Itchy Eyes	0 1 2 3 4
Runny Nose	0 1 2 3 4
Sneezing	0 1 2 3 4
Itchy throat	0 1 2 3 4
Itchy skin	0 1 2 3 4
Post nasal drip	0 1 2 3 4
Total for section:	_____

Immune:

Frequent illness	0 1 2 3 4
Sore throat	0 1 2 3 4
Fever	0 1 2 3 4
Genital itch, Discharge	0 1 2 3 4
Yellow nail fungus	0 1 2 3 4
Total for section:	_____

Urinary Tract:

Frequent urination	0 1 2 3 4
Burning on urination	0 1 2 3 4
Dribbling urine	0 1 2 3 4
Leaky bladder	0 1 2 3 4
Blood in urine	0 1 2 3 4
Kidney stones	0 1 2 3 4
Total for section:	_____

Ears, Sinus, Nose:

Popping ears	0 1 2 3 4
Fluid in ears	0 1 2 3 4
Ringing ear	0 1 2 3 4
Hearing loss	0 1 2 3 4
Ear Infections	0 1 2 3 4
Excessive mucous	0 1 2 3 4
Stuffy nose	0 1 2 3 4
Sinus headache	0 1 2 3 4
Nose bleeds	0 1 2 3 4
Total for section:	_____

Mouth, Throat, Teeth:

Dry Mouth	0 1 2 3 4
Canker sores	0 1 2 3 4
Cold sores	0 1 2 3 4
Tooth pain	0 1 2 3 4
Bleeding gums	0 1 2 3 4
Gagging, clearing throat	0 1 2 3 4
Total for section:	_____

Lungs:

Difficulty breathing	0 1 2 3 4
Chest congestion	0 1 2 3 4
Coughing	0 1 2 3 4
Asthma	0 1 2 3 4
Total for section:	_____

Joints, Muscles, Bones:

Twitching	0 1 2 3 4
Cramping	0 1 2 3 4
Stiff & achy joints	0 1 2 3 4
Pain in joints	0 1 2 3 4
Swelling in Joints	0 1 2 3 4
Muscle aches	0 1 2 3 4
Muscle pains	0 1 2 3 4
Osteoporosis	0 1 2 3 4
Numbness, Burning	0 1 2 3 4
Flat feet, Fallen arch	0 1 2 3 4
Total for section:	_____

Sleep:

Can't fall asleep	0 1 2 3 4
Wake up often	0 1 2 3 4
Nighttime Urination	0 1 2 3 4
Wake up tired	0 1 2 3 4
Bad dreams/Nightmare	0 1 2 3 4
Night sweats	0 1 2 3 4
Total for section:	_____

Signature:_____ Date:_____

Total For All Sections:_____

EMOTIONAL HEALTH QUESTIONNAIRE

(ACES Assessment)

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Living Well CLINICAL NUTRITION CENTER

Additional Information

Fill out if you are participating in any exercise or athletic routine:

Are you a professional athlete? Yes/No Your sport is:_____ Your Team name is:_____

Are you an amateur athlete? Yes/No Your sport is:_____ Your Team name is:_____

Your purpose for your routine is (examples: career, lose/gain weight, be faster/stronger, de-stress)?

_____

Fill out as a massage therapy client:

Are you interested in our massage therapy sessions? Yes / No
Have you ever received a professional massage before? Yes / No
When was your last massage? _____
What types of massage work do you prefer? _____
What kind of pressure do you prefer? Light / Medium / Firm
What are your goals for receiving a massage? _____

_____

Please indicate conditions that you have had in the past. Circle all that apply.

Muscle/Joint pain
Muscle/Joint stiffness
Numbness/Tingling
Swelling
Bruise easily
Sensitive to touch
High/Low Blood Pressure
Stroke/Heart Attack
Dizziness/Ringing in ears

Varicose Veins
Shortness Breath/Asthma
Cancer
Neurological issues
Epilepsy/Seizures
Headaches
Diabetes
Endocrine/Thyroid
Memory Loss

Broken Bones
Gas/Bloating/Constipation
Kidney Disease
Arthritis
Osteoporosis
Scoliosis
Allergies
Digestive conditions
Depression/Anxiety

If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical aliment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so (I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment) Understanding all of this, I give my consent to receive care.

My signature below confirms that this information is true, and I consent for massage.

Signature:_____ Date:_____

Living Well CLINICAL NUTRITION CENTER

Pediatric Form

(only fill out if 5 years old or under)

Name of minor: _____ Date: _____

Your Name: _____

Prenatal History:

Were you taking prenatal vitamins while pregnant? _____When did you begin taking them? _____

Did you take any medications while pregnant? _____ Why? _____

How stressful would you rate your pregnancy on a scale of 1-10 (10 being the most stressful?) _____

Birthing History:

How long were you pregnant? _____weeks.

Who delivered your baby? Circle: Obstetrician, Midwife, Other:_____

How was your baby delivered? ***Circle:*** vaginal, C-section, forceps, vacuum, other:_____

Did you receive any medications during labor? ***Circle***: induction (Pitocin), pain meds (epidural), other: _____

What was your baby's APGAR score? 1 2 3 4 5 6 7 8 9 10

Infant or Toddler:

What is the number one complaint today?_____

How long has it been going on? _____

What makes the situation worse? _____

What makes the situation better? _____

******Please circle all that your infant or toddler is having trouble with:***

eyes ears nose throat heart lungs breathing gassy

diarrhea constipation vomiting seizures skin learning disorders

emotional disorders behavioral disorders genetic disorders

What does your baby's diet consist of? _____

Is there anything else that may be important? _____

Mothers Information:

How many past pregnancies? _____How many were delivered? _____

Do you take vitamins? _____ What kind? _____

Do you smoke? _____ How many packs per day? _____ How long have you smoked? _____

******If you are breastfeeding continue:***

Do you drink alcohol? _____ How much? _____ How often? _____

Do you drink soft drinks? _____ How many per day? _____

Do you drink coffee? _____ How many cups per day? _____

Do you consume dairy products? _____ How much per day? _____

What food do you eat regularly? _____

Legal Guardian Signature: _____ Date: _____

Practitioner/Client INFORMED CONSENT

HEALTH AND WELLNESS

We want you to be informed about our goals, philosophies, and expectations at Living Well Clinical Nutrition Center in regards to how we work to achieve health and wellness for you and your family. It is our premise that nutrition, energy, and a properly functioning nervous system are the building blocks of life. When these foundational aspects are balanced, it allows the body the opportunity to optimize its own naturally occurring recuperative abilities. With this in mind, we seek to restore health through natural means without the use of drugs or surgery. (If medication or surgery is warranted, we advise the individual with the building blocks of life, we give their body the maximum opportunity to utilize its inherent recuperative powers.) We do not claim to treat or cure any specific disease or condition. The staff at Living Well Clinical Nutrition Center provide a specialized, unique, non-duplicating health service and are certified in their special areas of practice.

ANALYSIS AND APPROACH

At your appointment, we will conduct an analysis for the express purpose of determining the nutritional, neurologic, and/or energetic deficiencies or any interference that hinders you from achieving optimal wellness. Specialties of our practitioners include Applied Clinical Nutrition, Applied Kinesiology, Quantum Neurology, joint mobilization, Neuro-Emotional Technique, diet and weight loss support, detoxification, cold-laser therapy, family and pediatric wellness. They will utilize the aforementioned, safe and non-invasive techniques to achieve your optimal wellness.

RESULTS

The purpose of office visits is to promote natural health through the stabilization of the nutritional, neurological, and energetic systems of your body. Due to the individuality of every person, it is difficult to predict the healing time. Most often the response is incredible as to how the body begins to heal quickly, however, in some cases, there is a more gradual healing process. Two or more similar conditions may respond differently to the same type of care and actual response time is unpredictable. Many conditions, for which the medical field has not found much improvement, have found significant benefit through the approach we use at Living Well Clinical Nutrition Center. Our practitioners work with you to help you make an informed decision prior to being accepted as a new client.

DIAGNOSIS

Although the staff at Living Well Clinical Nutrition Center are experts in the analysis of the nutritional, neurological, and energetic aspects of the human body, they will not make a diagnosis outside of their scope of practice. Individuals that require additional testing (MRI, X-Ray, Blood, etc...) will be informed of and have access to those reports at any time.

INFORMED CONSENT

By signing this page, you give Living Well Clinical Nutrition Center permission and authority to use any or all of the aforementioned analyses and techniques. You are giving permission to utilize the gathered data, according to HIPAA guidelines (no use of names/complete anonymity, etc...), for research, research presentations, and other office applications should the practitioners deem the case appropriate. It is the responsibility of the client to make any diagnosed or observed deformities, injuries, illnesses, or other pathological conditions known in order to receive the most optimal care. If you have any further questions concerning our office, please feel free to ask.

Signature: _____ **Date:** _____

Fees and Policies

Living Well Clinical Nutrition Center

(As of 07.07.2023)

At your appointment: We appreciate the fact that people have schedules to follow and for that **we do our very best to run on time**. This ensures that you know when your appointment begins and ends and can make plans accordingly. This also ensures that you get the full allotted time for your visit. We do ask that arrive 15 minutes early for your appointed time.

Payment: Payment is due at the time of services rendered. We accept cash, check, and credit cards. We do not accept insurance. Payment for an "Initial Evaluation" is required at the time of scheduling.

Cancellation Policy: If for some reason you must reschedule or cancel your existing patient appointment, we do ask that you give us **24 hours notice**. If we do not answer the phone, please leave a message because the machine will identify the date and time that you called. By giving us 24 hours notice, it allows us to fill the spot with another patient on our waiting list. If we do not receive 24 hours notice, we will charge you in the amount of the appointment that you missed, and that must be collected before rescheduling your next appointment.
Note: Our "Initial Evaluation" reschedule/cancellation policy is at least 7 days notice prior to the scheduled appointment date for a full refund. If we do not receive 7 days notice there will be a $60 cancellation fee applied and the remainder of your "Initial Evaluation" payment will be refunded.

Office Fees: Our fees are based on the time that you spend in the office. If the patient does not complete a nutrition or a chiropractic appointment with Living Well within 1 year, the patient will be required to complete a re-evaluation appointment.

Initial Nutrition Evaluation	**$165.00 - $220.00**
Initial Chiropractic Evaluation	**$120.00**
Initial Nutrition Evaluation with Chiropractic	**$300.00**
Initial Nutrition Evaluation for infants under 12 months (includes Chiropractic) *	**$60.00**
***Parent must be an active patient**	
60 or 90 Minute Massage	**$90.00 - $120.00**

NOTE: An active patient is a patient that has completed a nutrition or chiropractic appointment with Living Well Clinical Nutrition Center within the past 12 months.

Supplements and laboratory work are NOT included in the price of the visit. This amount will vary based on your evaluation. Blood work is discounted over 75% as a client of Living Well Clinical Nutrition Center.

Supplement Return Policy: Supplements must be returned within 30 days of purchase, in original packaging/ unopened/ unexpired, and have the original receipt as proof of purchase.

Fees and policies are subject to change without notice.

I have read and understand the information above. My signature below is my consent that I accept the policies of Living Well Clinical Nutrition Center.

Signature: _____ Date: _____