Welcome to Concepts For Health and thank you for choosing us for your health care needs. We are committed to ensuring that the confidence you have placed in us results in improvement of your health and wellbeing.

At Concepts For Health, you will be proactively involved in your own care and treatment at every step. Please begin by reading and completing the following form to the best of your ability. The more detailed and accurate you are the better care we can provide for you. No symptom is insignificant. Our form is designed to help us get to the cause of your current health problem as quickly as possible.

Please bring your completed paperwork to your initial consultation.

HOW OUR PROCESS WORKS:

STEP 1:
During your initial consultation, Dr. Art Capperauld will review your health history, current diet, symptoms you are experiencing and your health concerns. He will also perform many tests and exams, many of which you have never experienced before. These will help him to understand and determine your specific needs.

STEP 2:
From the information gathered in STEP 1, Dr. Art Capperauld will create a personalized health improvement program which you will receive at your Report of Findings.

STEP 3:
At your Report of Findings, you will be presented with the findings from your consultation and examination and what is needed for you to reach your health goals.

STEP 4:
Subsequent office visits are scheduled to monitor your progress.

Should you have any questions, or need assistance during the course of your treatment, you may contact us via email or phone. We may be reached at (559)475-8611 and via email support@conceptsforhealth.com. We look forward to working with you to achieve your health goals.

With Health and Happiness,
Concepts For Health
# Personal History Form

<table>
<thead>
<tr>
<th>Date: / /</th>
<th>Name:</th>
<th>Birth Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Zip:</td>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Home Phone: ( )</td>
<td>Cell Phone: ( )</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td>Sex:</td>
<td>Height: ft. in.</td>
</tr>
<tr>
<td>Employer:</td>
<td>Type of Work:</td>
<td></td>
</tr>
<tr>
<td>Check One:</td>
<td>Married</td>
<td>Single</td>
</tr>
<tr>
<td>Spouse’s Name:</td>
<td>No. of Children:</td>
<td></td>
</tr>
<tr>
<td>Referred to this office by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are/have you been disabled from work?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Current Medications:</td>
<td>Tranquilizers</td>
<td>Pain Killers/Muscle Relaxants</td>
</tr>
<tr>
<td></td>
<td>Insulin</td>
<td>Aspirin/Similar</td>
</tr>
<tr>
<td>List of Medications:</td>
<td></td>
<td></td>
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<tr>
<td>Natural Remedies:</td>
<td>Vitamins/Minerals:</td>
<td></td>
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<td></td>
<td>Herbs:</td>
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<td></td>
<td>Homeopathics:</td>
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<tr>
<td></td>
<td>None</td>
<td></td>
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<tr>
<td>Do you presently, or have you ever had any of these conditions? (Check each one that applies to you?)</td>
<td>Anemia</td>
<td>Diabetes</td>
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<tr>
<td></td>
<td>Arthritis</td>
<td>Frequent Headaches</td>
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<tr>
<td></td>
<td>Asthma</td>
<td>Heartburn</td>
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<tr>
<td></td>
<td>Chest Pains</td>
<td>High Blood Pressure</td>
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<tr>
<td></td>
<td>Chronic Cold/Flu Symptoms</td>
<td>High Cholesterol</td>
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<td></td>
<td>Chronic Fatigue</td>
<td>Hypoglycemia</td>
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<tr>
<td></td>
<td>Depression</td>
<td>Kidney Problems</td>
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<tr>
<td>Are you trying to lose/gain weight?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>What Methods have you tried to lose/gain weight?</td>
<td></td>
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<tr>
<td>How long has it been since you really felt good?</td>
<td></td>
<td></td>
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<tr>
<td>Are you happy in your life right now?</td>
<td></td>
<td></td>
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<tr>
<td>Where are your main sources of stress?</td>
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<tr>
<td>How do you deal with your stress?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Concepts For Health, Inc • Ph: (559) 475-8611 • Fax: (559) 641-5302 • support@conceptsforhealth.com
SLEEP HABITS
Average hours per night: ____________ Is it quality sleep? ☐ Yes ☐ No
Do you awake refreshed? ☐ Yes ☐ No Do you awake tired and exhausted? ☐ Yes ☐ No

BOWEL MOVEMENTS
Times per week: ________ Color: __________ Consistency: __________

DIET
Do you have any food allergies, sensitivities, restrictions? ☐ Yes ☐ No

Please describe your diet by indicating how many times per day/week/month you consume the following:

<table>
<thead>
<tr>
<th>Food Type</th>
<th>Day</th>
<th>Week</th>
<th>Month</th>
<th>Day</th>
<th>Week</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eggs</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Wheat Products</td>
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<tr>
<td>Bread</td>
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<tr>
<td>Red Meat</td>
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<tr>
<td>Fish</td>
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<tr>
<td>Fresh Vegetables</td>
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<tr>
<td>Canned Vegetables</td>
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<tr>
<td>Frozen Fruit</td>
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<tr>
<td>Salad</td>
<td></td>
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<tr>
<td>Tea (Caffeinated)</td>
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<tr>
<td>Chocolate</td>
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<tr>
<td>Soft Drinks</td>
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<tr>
<td>Water</td>
<td></td>
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<tr>
<td>Cigarettes</td>
<td></td>
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<tr>
<td>Foods Craved</td>
<td></td>
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</tr>
</tbody>
</table>

Office Use Only - Dr’s Notes:

EXERCISE
Type: __________
Type: __________
Type: __________

Do you have fun when you exercise? ☐ Yes ☐ No

FAMILY HEALTH HISTORY
Please list any and all medical conditions and/or diseases by individual relatives of yours:

Your Children: ____________________________

Brother(s): ____________________________ Sister(s): ____________________________

Mother: ____________________________ Father: ____________________________

Grandmother (Mother’s): ____________________________ Grandmother (Father’s): ____________________________

Grandfather (Mother’s): ____________________________ Grandfather (Father’s): ____________________________

Office Use Only - Dr’s Notes:

HEALTH GOALS
Please list your five main health goals in order of their importance:

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Office Use Only - Dr’s Notes:
SPIT TEST
INSTRUCTIONS:
1. Spit in the AM before putting anything in mouth into a glass of water.
2. Check the water every 15 minutes for up to one hour.
3. Type what you see in the glass in box below. If no strings are present and the saliva is floating after one hour, then write “none”.

Date: / / Results:
New Patients
During your initial consultation Dr. Art Capperauld will review your health history, current diet, symptoms you are experiencing and your health concerns. He will also perform many tests and exams, many of which you have never experienced before. These will help him to understand and determine your specific needs. It is critical that you have all paperwork completed prior to your initial consultation. You will be asked to reschedule your appointment if your paperwork is not completed prior to your initial consultation.

I understand/agree to Concept For Health’s paperwork policy.

Signature: ____________________________ Date: __/__/____

Appointments
Report of Findings and Routine Office Visits are scheduled for 30 minutes.
We encourage you to book your appointments 2 weeks in advance when possible.
As a courtesy to you, our office will confirm your appointment via email or text one day in advance.

Cancellations & Late Arrival
All patients must contact Concepts For Health, via phone, text or email at least 24 hours in advance if they need to cancel or reschedule their appointment. Failure to provide sufficient notice prior to the scheduled appointment date will result in the cost of the scheduled visit.
Patients arriving after the first 15 minutes for their appointment may be required to reschedule their appointment in order to avoid disrupting the appointments of other patients.

I understand/agree to Concepts For Health’s Cancellation and Late Arrival policy.

Signature: ____________________________ Date: __/__/____

Product Orders
Orders are shipped within 24 hours of payment unless otherwise stated. Saturdays, Sundays and holidays not included.
Orders are shipped by regular Ground UPS.
We cannot ship orders to P.O. Boxes.

Refund Policy
Products:
If products purchased from Concepts For Health need to be returned - our policy is any unopened products can be returned within 14 days. Once the product is received, refunds will be processed within 7 business days. Shipment costs of all returns are the purchaser’s responsibility. Herbal products that are manually mixed and packaged are non-refundable.

Prepayment Packages of 10 Visits:
Prepayment packages are non-refundable and do not expire. If a patient purchases one of these packages and chooses not to continue their care, no refund will be given. The remaining balance can be used at a later date, towards products or other services offered at Concepts For Health.

I understand/agree to Concepts For Health’s Refund policy.

Signature: ____________________________ Date: __/__/____

Dr. Capperauld is not a medical doctor; he does not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911! Please contact our office if you have any questions.
I specifically authorize the natural health practitioners at Concepts For Health, Inc. to perform a nutritional health analysis and to develop a natural, complimentary health improvement program for me. My program may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or “cure” of any disease.

I understand that the analysis’ used are a safe and non-invasive natural method of analyzing the body’s physical and nutritional needs, and that deficiencies or imbalances in these areas could cause or contribute to various health problems.

I understand that the analysis used is not a method for “diagnosing” or “treating” any disease, including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of any analysis performed or any natural health, nutritional or dietary programs recommended. I understand that the analysis performed is a means by which to determine possible nutritional imbalances, so that safe, natural programs can be developed for the purpose of bringing about a more optimum state of health.

This permission and authorization form applies to all visits and consultations.

I____________________________________________have read and understood the foregoing.

(Please Print Name)

I____________________________________________have read and understood Concepts For Health, Inc’s Policies and Procedures.

(Please Print Name)

I____________________________________________understand and agree that my health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, outstanding charges for professional services rendered me will be immediately due and payable.

Patient’s Signature:________________________________________ Date: / / 

Guardian or Spouses
Signature Authorizing Care:________________________________ Date: / / 

Concepts For Health, Inc • Ph: (559) 475-8611 • Fax: (559) 641-5302 • support@conceptsforhealth.com
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE:
This notice describes Concepts For Health, Inc.'s practices and that of:
- Any health care professional authorized to enter information into your patient chart.
- All employees, staff and other clinic personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor’s use and disclosure of your medical information created in the doctor’s office or clinic. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:
The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nutritionists, technicians, or other clinic personnel who are involved in taking care of you at the clinic.

For Health Care Operations: We may use and disclose medical information about you for clinic operations. These uses and disclosures are necessary to run the clinic and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many clinic patients to decide what additional services the clinic should offer, what services are not needed, and whether certain new treatments are effective. We may also combine the medical information we have with medical information from other clinics to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment at the clinic.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law.

SPECIAL SITUATIONS

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the clinic. To request an amendment, your request must be made in writing and submitted to the address below. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the clinic; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the clinic. The notice will contain on the first page, in the top left-hand corner, the effective date.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with the clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with the clinic, call 559-248-9527. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION:
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.
Concepts For Health, Inc. protects the privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, or telephone number. Concepts For Health, Inc. will not disclose this information without your authorization, except as permitted by law.

Our Notice of Privacy Practices provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about you is used or disclosed. Please review the Notice of Privacy Practices before signing this consent.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal information is not shared with third parties such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: ___________________________________________(Please Print Name)

Patient Signature: ___________________________________________ Date: __/__/____