BRIGHT HEALTH AND WELLNESS 120 W. Germantown Pike Suite 210 Plymouth Meeting, PA 19462

Client Privacy

Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved directly and indirectly in that treatment.
- Obtain payment from third-party payers (if applicable)
- Conduct normal healthcare operations, such as quality assessments and practitioner certifications (if applicable).

I understand that I may request in writing that you may restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that any information you send me via a Google email account, may not be completely safe and is subject to a third party retrieving my confidential information without consent of Rachel Bright, ND or myself, because it is being sent through the Internet.

I understand that I may revoke this consent in writing at any time, except to the extent that Rachel Bright, ND, BS, HHP has taken action relying on this content.

Client/Guardian Printed Name:

____

Signature:

____

Date

____

AGREEMENT FOR CONSULTATION AND EDUCATION SERVICES

This agreement is between Bright Health and Wellness ("Practitioner") and the individual whose name and signature appears below ("I" or "the Client") or the legal guardian thereof (the "Agreement"). In consideration of the wellness services provided to the Client by Practitioner at the present and at all times in the future, I agree as follows (agreement is indicated by placing Client initials on the lines following each section and by signing in the space provided at the bottom of the page):

1. **Consent for Services:** I, ______________________________, the undersigned, do hereby authorize and give consent to Practitioner to provide wellness consultation and education services ("Services") to the Client, which may include but is not limited to the following:

(a) General Assessment: Including, but not limited to wellness assessments.

(b) Lifestyle & Naturopathic Dietary Counseling: Including, but not limited to approaches to support health issues; allergies, bone health, cleansing and detoxification, homeopathy, digestive health, natural diet approaches (including gluten free diets), immune enhancement, women's and men's health, longevity and anti-aging, exercise plans, nutritional and herbal supplements, and counseling concerning sleep hygiene, stress reduction, and balance of life activities.

(c) Wellness Techniques: Including, but not limited to, ionic foot detox, neuromuscular technique, yoga techniques, energy therapies, imagery, and relaxation techniques.

I understand that neither Practitioner nor its employees, independent contractors or agents, including Rachel L. Bright, N.D., are licensed medical or osteopathic doctors. She does not diagnose, treat or cure any diseases. Her qualifications are only to evaluate in a holistic healthcare manner. I understand that Rachel Bright, ND is a Board-Certified Traditional Naturopath by the American Naturopathic Medical Certification Board, Doctor of Traditional Naturopathy, Certified Nutritional Practitioner and Holistic Health Care Practitioner. This form of an evaluation is not considered a medical diagnosis. For a medical diagnosis,

please see your physician. The Services being provided to me involve naturopathic wellness consultation and education and counseling and not the practice of medicine. I understand that any changes to my diet or lifestyle should be reviewed with my personal physician. (Initial)___________

Although general information may be provided regarding the relation of homeopathy, herbal remedies and naturopathy to general immune health and viruses, I understand that neither Practitioner, nor its employees, independent contractors, or agents, including Rachel Bright, N.D.(Traditional), will provide information regarding COVID or COVID vaccinations. For information regarding COVID and COVID vaccinations, I understand that I should consult my personal physician. (Initial)_____ ________

I acknowledge that neither Practitioner, its employees, independent contractors or agents has made any guarantees or promises as to the outcome, the safety or the efficacy of the Services and that nobody has guaranteed, warranted, assured or otherwise promised me that the wellness and educational consultation services provided will cure, heal, remedy, resolve, or improve any disease, sickness, ailment, malady, disability, disorder, injury or bodily condition. (Initial)__________

2. **Information I Have Provided to Practitioner.** I hereby verify that I have provided Practitioner with a complete list of all prescription and non-prescription medications and substances I am currently or have recently been taking; and I agree to update such list whenever a change is made. I have also provided a list of all known allergies including medications, dietary/nutritional substances, and plant and animal substances. I have also provided a list of all medical, surgical and/or psychological conditions I currently have, and any such major conditions I have had in the past. The information I have provided, including but not limited to the information required by this Section 2, is true, accurate, complete and up-to-date to the best of my knowledge. (Initial)__________

3. **Right to Decline Services** . I acknowledge and understand that IT IS MY RIGHT TO DETERMINE THE EXTENT OF THE SERVICES TO BE PROVIDED HEREUNDER AND THAT I MAY DECLINE SERVICES AT ANY TIME BEFORE OR DURING CONSULTATION. (Initial)__________

4. **Miscellaneous.** I acknowledge that this Agreement constitutes the entire agreement between Practitioner and the Client regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by the Client. This Agreement shall be binding on the Client, his/ her successors, heirs, legal representatives and assigns. This Agreement shall be governed by the laws of the Commonwealth of

Pennsylvania without regard to any choice of law principal. (Initial)__________

5. **Financial Responsibility**. I acknowledge that all programs and consultations are my responsibility. In the event that my insurance plan, flexible spending account, health savings account, medical savings account or similar plan or account does not cover a program, consultation or other service, I am responsible for payment of these charges. (Initial)

6. **NO GUARANTEE OF RESULTS.** I recognize that this agreement is not a guarantee of results and deals solely with these services to be rendered and fees to be paid for the care as provided. My payment obligation is not contingent upon the outcome of care.

7. **Extended Health Coverage.** Rachel Bright's services are not billable. They may be covered under some HSA accounts, although not guaranteed. I have read and understand the information and policies presented. I intend for this consent form to cover the entire course of my recommendations as suggested by Rachel Bright, ND. I understand that I am free to withdraw this consent and discontinue participation at any time.

8. **Rachel Bright, ND is not necessarily expected to be able to anticipate and explain all the risks and complications from recommendations.** The client chooses to rely on Rachel Bright, ND to exercise professional judgment when deciding which recommendations will be in the client's best interest based on the facts known at the time. Natural Healthcare and
Conventional Medicine are not mutually exclusive and therefore, the client is free to and encouraged to seek or continue medical care from a qualified physician.

9. **Client records will be kept confidential** and will not be released to others without consent from both Rachel Bright and the client, unless required by law. Rachel Bright may share pertinent information with other Natural Healthcare Practitioners, MD's, Nutritionist, Herbalists, Chiropractors within her wellness field with the purpose of discussing the best course of treatment and to deliver safe and efficient care. Your personal information may be used to establish and maintain contact, communicate with other treating health-care providers, and to allow for efficient follow-up with treatment, billing and processing of payments.

10. **I understand that I could experience the following when using homeopathic remedies:**

1. Old and chronic symptoms may be stirred up temporarily. They can be uncomfortable to experience, but hence the word temporary. 2. Healing speeds differ at times (sometimes it is faster sometimes it is slower - but the body is always in a state towards healing) 3. Homeopathy has been shown to not interfere with any medications, supplements or herbs.

BY SIGNING THIS AGREEMENT, I INDICATE THAT I HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, THAT I AM THE CLIENT, GUARANTOR, THE CLIENT'S LEGAL REPRESENTATIVE OR GUARDIAN, OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

I agree to inform my practitioner immediately if:
* I am pregnant
* If I have any changes to my prescriptive medications
* If I experience any negative side effects

Client or Legal Guardian
Interpreter (If necessary)

Signature:

Print Name & Title of Witness / Print Name if not the Client Name / Title of Interpreter ____

Date Relations, if signed by other than Client:
____

Bright health & wellness

CLIENT INTAKE FORM

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.

Client Information

Name ____________________

Address ____________________

City ____________________

State ____________________ Zip Code ____________________

Phone (day) ____________________

Phone (cell) ____________________

Phone (night) ____________________

Email ____________________

Referred by ____________________

Statistics

Age ____________________

Birth Date ____________________

Gender ____________________

Height ____________________

Blood Type ____________________

Current Weight ____________________

Ideal Weight ____________________

Weight One Year Ago ____________________

Birth Weight (if known) ______________________________

Birth Order (please list ages of biological siblings): ______________________________

Family/Living Situation: ______________________________

____

Children: ______________________________

____

Occupation: ______________________________

____

Exercise/Recreation: ______________________________

____

History

1. Have you lived or traveled outside of the United States? If so, when and where?:

2. Have you or your family recently experienced any major life changes? If so, please comment:

3. Have you served for the military? And what is your vaccination history?

4. How much time have you had to take off from work or school in the last year?

   - ☐ 0 to 2 days
   - ☐ 3 to 14 days
   - ☐ more than 15 days

Health Concerns

5. What are your main health concerns? (Describe in detail, including the severity of the symptoms):

6. When did you first experience these concerns?

7. How have you dealt with these concerns in the past?

    - ☐ doctors
    - ☐ self-care

8. Have you experienced any success with these approaches?

9. What other health practitioners are you currently seeing? List name, specialty and phone # below.

10. Please list the date and description of any surgical procedures you have had (including breast reduction or augmentation).

11. How often did you take antibiotics in infancy/childhood?

12. How often have you taken antibiotics as a teen?

13. How often have you taken antibiotics as an adult?

14. List any medicine you are currently taking:

15. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

16. Have any other family members had similar problems (describe)?

Nutritional Status

17. Are there any foods that you avoid because of the way they make you feel?
    If yes, please name the food and the symptom:

18. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives?
    If so, please explain:

19. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

20. Are there foods that you crave? If so, please explain:

21. Describe your diet at the onset of your health concerns:

22. Do you have any known food allergies or sensitivities?

23. Which of the following foods do you consume regularly?

- ☐ soda
- ☐ diet soda
- ☐ refined sugar
- ☐ alcohol
- ☐ fast food
- ☐ gluten (wheat, rye, barley)
- ☐ dairy (milk, cheese, yogurt)
- ☐ coffee

24. Are you currently on a special diet?

- ☐ autoimmune paleo (AIP)
- ☐ SCD/GAPS
- ☐ dairy restricted or dairy-free
- ☐ vegetarian
- ☐ vegan
- ☐ Other (please describe)
- ☐ paleo
- ☐ blood type
- ☐ raw
- ☐ refined sugar-free
- ☐ gluten-free

25. What percentage of your meals are home-cooked?

- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60
- ☐ 70
- ☐ 80
- ☐ 90
- ☐ 100

26. Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

27. Bowel Movement Frequency

- ☐ 1–3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every day

28. Bowel Movement Consistency

- ☐ soft & well formed
- ☐ often float
- ☐ difficult to pass
- ☐ diarrhea
- ☐ thin, long or narrow
- ☐ small and hard
- ☐ loose but not watery
- ☐ alternating between hard and loose

29. Bowel Movement Color

- ☐ medium brown
- ☐ very dark or black
- ☐ greenish
- ☐ blood is visible
- ☐ variable
- ☐ yellow, light brown
- ☐ chalky colored
- ☐ greasy, shiny

30. Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

31. Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

Medical Status

32. Please identify any current or past conditions and add a date for when the condition appeared. In the space below each list, please briefly describe your symptoms, chosen treatment(s), and dates.

Gastrointestinal

PAST	NOW	DATE	
☐	☐	________	Irritable Bowel Syndrome
☐	☐	________	Crohn's
☐	☐	________	Ulcertative Colitis
☐	☐	________	Gastritis or Peptic Ulcer Disease
☐	☐	________	GERD (reflux or heartburn)
☐	☐	________	Celiac Disease
☐	☐	________	SIBO

PAST	NOW	DATE	
☐	☐	________	Gut infections
☐	☐	________	Dysbiosis
☐	☐	________	Leaky gut
☐	☐	________	Food allergies, intolerances or reactions
☐	☐	________	Gallstones
☐	☐	________	Known absorption or assimilation issues
☐	☐	________	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Cardiovascular

PAST	NOW	DATE	
☐	☐	________	Heart attack
☐	☐	________	Heart Disease
☐	☐	________	Stroke
☐	☐	________	Elevated cholesterol
☐	☐	________	Arrhythmia (irregular heartbeat)

PAST	NOW	DATE	
☐	☐	________	Hypertension (high blood pressure)
☐	☐	________	Rheumatic Fever
☐	☐	________	Mitral Valve Prolapse
☐	☐	________	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Hormones/Metabolic

PAST	NOW	DATE	
☐	☐	________	Type 1 Diabetes
☐	☐	________	Type 2 Diabetes
☐	☐	________	Hypoglycemia
☐	☐	________	Metabolic Syndrome
☐	☐	________	Insulin Resistance or Pre-Diabetes
☐	☐	________	Hypothyroidism (low thyroid)
☐	☐	________	Hyperthyroidism (overactive thyroid)
☐	☐	________	Hashimoto's (autoimmune hypothyroid)
☐	☐	________	Grave's Disease (autoimmune hyperthyroid)

PAST	NOW	DATE	
☐	☐	________	Endocrine problems
☐	☐	________	Polycystic Ovarian Syndrome (PCOS)
☐	☐	________	Infertility
☐	☐	________	Weight gain
☐	☐	________	Weight loss
☐	☐	________	Frequent weight fluctuations
☐	☐	________	Eating disorder
☐	☐	________	Menopause difficulties
☐	☐	________	Hair loss
☐	☐	________	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Cancer

PAST	NOW	DATE	
☐	☐	________	Lung Cancer
☐	☐	________	Breast Cancer
☐	☐	________	Colon Cancer
☐	☐	________	Ovarian Cancer

PAST	NOW	DATE	
☐	☐	________	Prostate Cancer
☐	☐	________	Skin Cancer (Melanoma)
☐	☐	________	Skin Cancer (Squamous, Basal)
☐	☐	________	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Genital & Urinary Systems

PAST	NOW	DATE	
☐	☐	________	Kidney Stones
☐	☐	________	Gout

PAST	NOW	DATE	
☐	☐	________	Interstitial Cystitis
☐	☐	________	Frequent urinary tract infections

☐ ☐ ________ Erectile Dysfunction or Sexual Dysfunction

☐ ☐ ________ Frequent Yeast Infections

☐ ☐ ________ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Musculoskeletal/Pain

PAST NOW DATE

☐ ☐ ________ Osteoarthritis

☐ ☐ ________ Fibromyalgia

☐ ☐ ________ Chronic Pain

☐ ☐ ________ Sore muscles or joints, undiagnosed

☐ ☐ ________ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Immune/Inflammatory

PAST NOW DATE

☐ ☐ ________ Chronic Fatigue Syndrome

☐ ☐ ________ Rheumatoid Arthritis

☐ ☐ ________ Lupus SLE

☐ ☐ ________ Raynaud's

☐ ☐ ________ Psoriasis

☐ ☐ ________ Mixed Connetive Tissue Disease (MCTD)

☐ ☐ ________ Poor immune function (frequent infections)

☐ ☐ ________ Food allergies

☐ ☐ ________ Environmental allergies

☐ ☐ ________ Multiple chemical sensitivities

☐ ☐ ________ Latex allergy

☐ ☐ ________ Hepatitis

☐ ☐ ________ Lyme (and co-infections)

☐ ☐ ________ Chronic Infections (Epstein-Barr, Cytomegalo-virus, Herpes, etc.)

☐ ☐ ________ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Respiratory Conditions

PAST	NOW	DATE	
☐	☐	________	Asthma
☐	☐	________	Chronic Sinusitis
☐	☐	________	Bronchitis
☐	☐	________	Emphysema

PAST	NOW	DATE	
☐	☐	________	Pneumonia
☐	☐	________	Sleep Apnea
☐	☐	________	Frequent or recurrent Colds/Flus
☐	☐	________	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Skin Conditions

PAST	NOW	DATE	
☐	☐	________	Eczema
☐	☐	________	Psoriasis
☐	☐	________	Dermatitis
☐	☐	________	Hives
☐	☐	________	Rash, undiagnosed

PAST	NOW	DATE	
☐	☐	________	Acne
☐	☐	________	Skin Cancer (Melanoma)
☐	☐	________	Skin Cancer (Squamous, Basal)
☐	☐	________	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Neurologic/Mood

PAST	NOW	DATE	
☐	☐	________	Depression
☐	☐	________	Anxiety
☐	☐	________	Bipolar Disorder
☐	☐	________	Schizophrenia
☐	☐	________	Headaches
☐	☐	________	Migraines
☐	☐	________	ADD/ADHD
☐	☐	________	Autism

PAST	NOW	DATE	
☐	☐	________	Mild Cognitive Impairment
☐	☐	________	Memory problems
☐	☐	________	Parkinson’s Disease
☐	☐	________	Multiple Sclerosis
☐	☐	________	ALS
☐	☐	________	Seizures
☐	☐	________	Alzheimer’s
☐	☐	________	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Miscellaneous

PAST	NOW	DATE	
☐	☐	________	Anemia
☐	☐	________	Chicken Pox
☐	☐	________	German Measles
☐	☐	________	Measles
☐	☐	________	Mononucleosis
☐	☐	________	Mumps
☐	☐	________	Sleep Apnea
☐	☐	________	Whooping Cough
☐	☐	________	Tuberculosis
☐	☐	________	Known genetic variants (SNPs, polymorphisms, etc)
☐	☐	________	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

33. Please check frequency of the following:

Short term memory impairment	☐ yes	☐ no	☐ sometimes
Shortened focus of attention and ability to concentrate	☐ yes	☐ no	☐ sometimes
Coordination and balance problems	☐ yes	☐ no	☐ sometimes
Problems with lack of inhibition	☐ yes	☐ no	☐ sometimes
Poor organization abilities	☐ yes	☐ no	☐ sometimes
Problems with time management (late or forget appts)	☐ yes	☐ no	☐ sometimes
Mood instability	☐ yes	☐ no	☐ sometimes
Difficulty understanding speech and word finding	☐ yes	☐ no	☐ sometimes
Brain fog, brain fatigue	☐ yes	☐ no	☐ sometimes
Lower effectiveness at work, home or school	☐ yes	☐ no	☐ sometimes
Judgment problems like leaving the stove on, etc	☐ yes	☐ no	☐ sometimes

Health Hazards

34. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

35. Do odors affect you?

36. Are you or have you been exposed to second-hand smoke?

Oral Health History

37. How long since you last visited the dentist? What was the reason for that visit?

38. In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

39. What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

40. Do you have any mercury amalgams? (If no, were they removed? If so, how?)

41. Do you have any concerns about your oral or dental health?

42. Is there anything else about your current oral or dental health or health history that you'd like us to know?

Lifestyle History

43. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

44. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

45. How do you handle stress?

Sleep History

46. Are you satisfied with your sleep?

47. Do you stay awake all day without dozing?

48. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

49. Do you fall asleep in less than 30 minutes?

50. Do you sleep between 6 and 8 hours per night?

For Women Only

51. How old were you when you first got your period?

52. How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

53. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

54. Have you experienced any yeast infections or urinary tract infections? Are they regular?

55. Have you/do you still take birth control pills: If so, please list length of time and type.

56. Have you had any problems with conception or pregnancy?

57. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Sexual History

58. Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?

59. In the past year, have your sexual partners been men, women, or both? And how many partners have you had in the past year?

Mental Health Status

60. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

61. On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

62. At what point in your life did you feel best? Why?

Other

63. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

64. Who in you family or on your health care team will be most supportive of you making dietary change?

65. Please describe any other information you think would be useful in helping to address your health concern(s):

66. What are your health goals and aspirations?

67. Though it may seem odd, please consider why you might want to achieve that for yourself: