Welcome To:
Complete Wellness Associates

11613 Spring Cypress A Houston, Tx 77377
Phone: 281-655-WELL (9355) Fax: 281-655-9356

About Dr. Mark Hopkins BS, DC, ACN and Dr. Brooke Fowler BS, DC:

Dr. Hopkins and Dr. Fowler are Clinical Kinesiologists (wellness doctors). They specialize in Applied Clinical Nutrition, Applied Kinesiology, Neuro-Emotional Technique, diet and weight loss, detoxification, cold laser therapy, family and pediatric wellness, and Sports Medicine for both professional and amateur athletes. These techniques create a holistic practice focusing on the individual patient. Their vision is to guide and mentor patients to "COMPLETE WELLNESS".

At your appointment:

We appreciate the fact that our patients have schedules to maintain, so **we do our best to run on time**. This insures that you know when your appointment begins and ends and can make plans accordingly. This also insures that you get the full time with the doctor.

Office Fees:

Our fees are based on the time that you spend with the doctor. A new patient office visit or phone consult is 45 minutes with the doctor and existing patient office visits or phone consults are 15 minutes.

New patient (45 min. In-office visit or phone consultation):	$150.00
Existing patient (15 min. In-office visit or phone consultation):	$ 50.00
Footbath (Iontophoresis or Detoxification excluding botanicals/minerals):	$ 30.00
Laser therapy:	$ 15.00
Interpretation Fee (Dr. time to review any diagnostics):	$ 30.00

*Supplements and laboratory work are NOT included in the price of the visit. This amount will vary based on your evaluation.

*We are happy to mail supplements for a flat shipping fee of $5. An order over $100 is free shipping. Overnight shipping excluded. Outside of U.S. shipping is charged at the rate it costs to ship.

Payment:

Payment is due at the time of services rendered. We accept cash, check, and credit cards. We provide you with information so that you may file with your insurance.

I have read and understand the above information and I accept the policies of CWA.

Patient/Legal Guardian (17 or younger) Signature:_____

Patient/Legal Guardian Print:_____ **Date:**_____

Complete Wellness Associates
New Patient Evaluation

Patient's Name:_____ Date:_____

Referral:_____Affiliation w/Referral:_____

Age:_____ Gender: M / F Birthday:___/___/___ Marital Status:_____# of Children:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____Occupation:_____

Height: ____Weight: _____Blood Type: A AB B O - + E-Mail:_____

Primary phone:_____ Secondary phone:_____

Emergency Contact Name:_____Phone #:_____

1. **PURPOSE OF THIS APPOINTMENT:** (Why are you coming to this office?)

_____

_____

2. **HEALTH CONDITIONS AND COMPLAINTS:** (Number & list in order of severity)

_____

_____

3. **MEDICATIONS:** (List by name, dose, what for, how long include birth control & aspirin etc..)

_____

_____

4.SURGERIES: (List surgeries/operations, plastic surgery &trauma. Date when they occurred)

_____

_____

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

_____

6. **SUPPLEMENTS or HERBS:** (List name and why you are taking them)_____

_____

_____

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

_____

My signature confirms that this information is true.

Patient/Legal Guardian (17 or younger) Signature:_____
Patient/Legal Guardian Print:_____**Date:**_____

CWA Health Overview

Diet: How many times a day do you eat?_____How often do you eat out?_____

Digestion:circle (good, adequate, poor, acid reflux, burping, bloating, burning, pain, cramping)

Other Complaints:_____

Bowels: How many bowel movements a day_____a week_____

Consistency: normal, hard, soft, diarrhea **Color:** tan, brown, black, green

Other:gas, mucus, smell **Amount:**normal, too big, too small

Other Complaints:_____

Drinking: What kind of water do you drink? tap, filtered, spring, reverse osmosis, distilled

Mark what you drink and how many a day (d) or week(w) you drink them:

milk_____ coffee_____ tea_____ herbal tea_____

soda_____ beer_____ wine_____ liquor_____

Urination: circle (too frequent, sense of urgency, burning, dribbling, urinate at night)

Other Complaints:_____

Sleep: Circle all that apply: (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?_____

Sunlight: How many hours of sunlight do you get daily?_____weekly?_____

How many hours daily do you spend under fluorescent lights?_____

Stress: Please rate your current stress level on a scale of 1 to 10, 10 being the highest stress:_____

What are the main reasons for you stress?_____

How do you reduce stress?_____

Smoking: Do you smoke? Y / N If yes, how much?_____How long have you smoked?_____

Drug Use: *(CONFIDENTIAL)* Do you use any recreational drugs?Y/N (if yes, circle marijuana,

Cocaine, heroin, uppers, downers) Others:_____How often?_____

Electromagnetic pollution: ***How many hours do you spend daily*** Watching TV?_____

Working on a computer?_____Talking on a phone?_____Wearing a watch?_____

Wearing a hearing aid?_____Riding in a car?_____Do you live by power lines?_____

***Woman Only:** Are you Pregnant?__Are you breastfeeding?__Do you have monthly periods?____

Last period date_____Are you in menopause?_____Do you have periods?_____

***Menstrual Cycle:** Number of days of flow____heavy, light, spotting, normal

Circle: cramping, bloating, weak, mood swings, cravings, pain, bright blood, dark clotting

Other menstrual complaints:_____

My signature confirms that this information is true.

Patient/Legal Guardian (17 or younger) Signature:_____
Patient/Legal Guardian Print:_____Date:_____

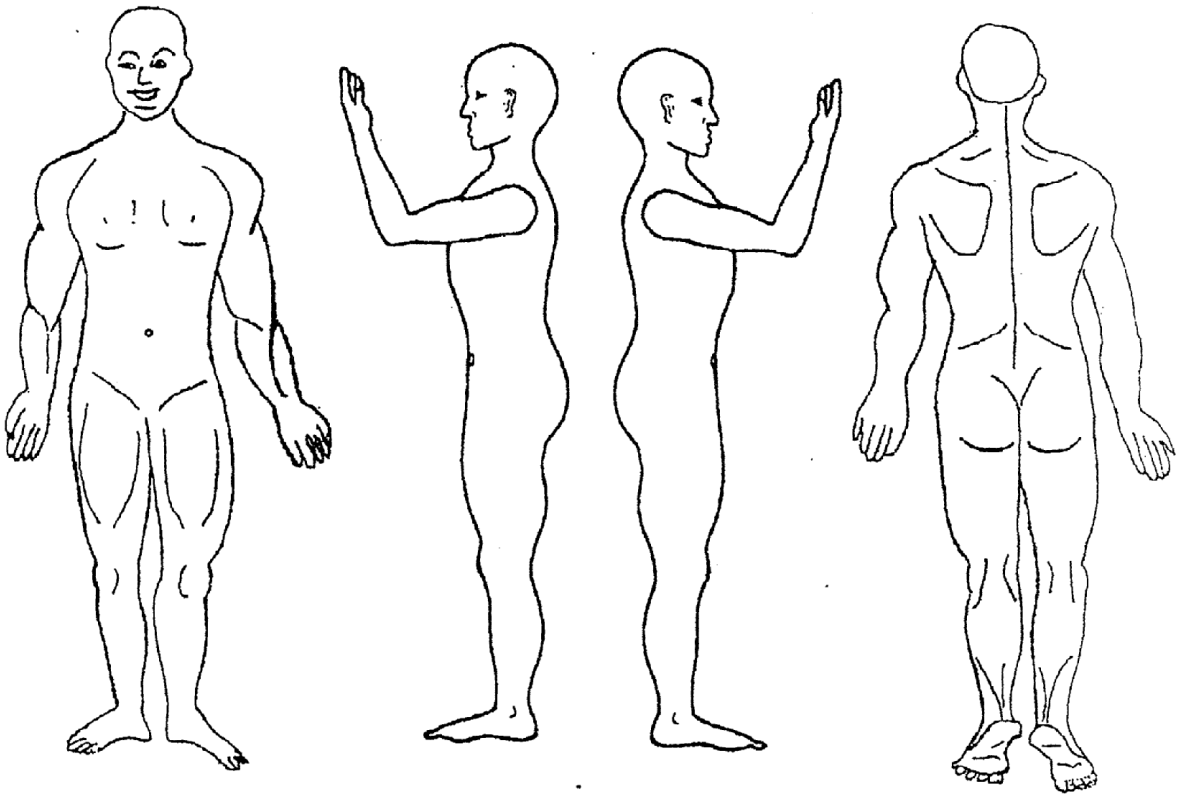
CWA Scar/Trauma Chart

SCARS: Please draw a line on the drawing where you have scars, even if they are very old. Don't forget c-sections, episiotomies, surgeries, vasectomies, vaccination scars, punctures, stitches, cuts etc…

TRAUMA AREAS: Please put an "X" where you have had trauma even if is very old. Don't forget burns, falls, sprains, whiplash, radiation etc…

INTERNAL METAL: Please draw a circle on the drawing if you have any type of internal metal objects. Such as, surgical pins, metal plates, hip or knee replacement, surgical wire mesh, screws, spinal rods etc…

Please date and briefly describe each incident. Ex: Car accident, 1988



My signature confirms that this information is true.

Patient/Legal Guardian (17 or younger) Signature:_____
Patient/Legal Guardian Print:_____**Date:**_____

CWA Pediatric Form

(only fill out if patient is 5 years old or under)

Prenatal History:

Did you take prenatal vitamins while pregnant?_____When did you start them?_____

Did you take any medications while pregnant?____Why?_____

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

Birthing History:

How long were you pregnant?_____weeks.

Who delivered your baby? Circle: obstetrician, midwife, Other:_____

How was your baby delivered? vaginal, c-section, forceps, vacuum, other:

Did you receive any medications during labor?_____

What was your baby's APGAR score?_____

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 apply to your child:

Eyes, Ears, Nose, Throat, Heart, Lungs, Breathing, Gassy, Diarrhea, Constipation, Vomiting, Seizures, Skin, Learning Disorders, Emotional Disorders, Behavioral Disorders, Genetic Disorders, ADD, ADHD

What does your child's diet consist of?

_____

Is there anything else that may be important?

_____

Mother's Information:

How many past pregnancies?____How many were delivered?____

Do you take vitamins?_____What kind?_____

Do you smoke?_____How many packs/day?_____ How long?_____

*** 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 per day?_____

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

What food do you eat regularly?_____

My signature confirms that this information is true.

Patient/Legal Guardian (17 or younger) Signature:_____

Patient/Legal Guardian Print:_____Date:_____

CWA Athlete Form

(only fill out if patient is participating in any exercise or athletic routine)

Are you a professional athlete (Paid to play or have a sponsor): Y/N

Your sport is:_____ Your team name is:_____

Are you an amateur athlete: Y/N

Your sport is:_____

Your purpose for your routine is (Examples: career, lose/gain weight, be faster/stronger, destress)

_____

_____

Please describe your routine:

Day	*Duration*	*Type of training*
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____
Sunday	_____	_____

Greatest Strengths:_____

_____

Greatest Weaknesses:_____

_____

My signature confirms that this information is true.

Patient/Legal Guardian (17 or younger) Signature:_____
Patient/Legal Guardian Print:_____Date:_____

Toxicity Questionnaire

Please circle a number in each of the following categories based on your health in the last 30 days.
0=Rarely/never experience the symptom 1=Occasionally experience but effect 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:	
Gas, Belch, Bloating	0 1 2 3 4
Heartburn, Reflux	0 1 2 3 4
Nausea	0 1 2 3 4
Straining on bowel mvmt	0 1 2 3 4
Day without bowel mvmt	0 1 2 3 4
Diarrhea or Vomiting	0 1 2 3 4
Hemorrhoids	0 1 2 3 4
Total for section:	_____
Heart:	
Shortness of breath	0 1 2 3 4
Tightness in chest	0 1 2 3 4
Chest pain	0 1 2 3 4
Rapid, Skipped heartbeat	0 1 2 3 4
High, Low Blood Pressure	0 1 2 3 4
Total for section:	_____
Emotions:	
Mood Swings	0 1 2 3 4
Anger, Irritability	0 1 2 3 4
Anxiety, Fear , Nervous	0 1 2 3 4
Panic Attacks	0 1 2 3 4
Sense of Despair	0 1 2 3 4
Depression	0 1 2 3 4
Total for section:	_____
Energy:	
Restlessness	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Brain fog	0 1 2 3 4
Sluggishness	0 1 2 3 4
Fatigue, Tired	0 1 2 3 4
Swelling hands & 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,Hearing loss	0 1 2 3 4
Earaches, 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,Muscle,Bone:	
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 ache	0 1 2 3 4
Muscle pain	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, Nightmares	0 1 2 3 4
Night sweats	0 1 2 3 4
Total for section:	_____

Name:_____**Date:**_____ **TOTAL FOR PAGE =** _____

Complete Wellness Associates

Doctor-Patient Informed Consent

HEALTH AND WELLNESS

We want our patients to be informed about our goals, philosophies, and expectations at Complete Wellness Associates 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 patient accordingly).We do this by balancing nutritional needs and restoring optimal neurologic and electrical communication with a myriad of techniques. We believe by supplying our patients 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 doctors at Complete Wellness Associates provide a specialized, unique, non-duplicating health service and are licensed in their special areas of practice.

ANALYSIS AND APPROACH

Your doctor will conduct a clinical analysis for the express purpose of determining the nutritional, neurologic, and/or energetic deficiencies or any interference that hinders you from achieving optimal wellness. Your doctor specializes in Applied Clinical Nutrition, Applied Kinesiology, joint mobilization, Neuro-Emotional Technique, diet and weight loss, detoxification, cold laser therapy, family and pediatric wellness, and Sports Medicine for both professional and amateur athletes. They will utilize the aforementioned safe and non-invasive techniques to achieve your **Complete 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 each patient, it is difficult to predict the healing time. Most often the response is incredible as to how quickly the body begins to heal, however, in some cases there is a 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 that the medical field has not found much improvement, have found significant benefit through the approach we use at Complete Wellness Associates. Our doctors work with you to help you make an informed decision prior to being accepted as a patient.

DIAGNOSIS

Although the doctors at Complete Wellness Associates 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. Patients that require additional testing (MRI, XRAY, Blood, etc…) will be informed and have access to those reports at any time.

INFORMED CONSENT

By signing this page the patient gives the doctor permission and authority to use any or all of the aforementioned analyses and techniques. The patient gives permission to utilize the patient information, according to HIPAA guidelines (no use of names/complete anonymity etc…), for research, research presentations, and other office applications should the doctor deem the case appropriate. It is the responsibility of the patient to make any diagnosed or observed deformities, injuries, illnesses, or other pathological conditions known to the doctor in order to receive the most optimal care. If you have any further questions concerning our office please feel free to ask!

Patient/Legal Guardian (17 or younger) Signature:_____

Patient/Legal Guardian Print:_____ **Date:**_____

CWA Office Policies

Office policy on supplements:

As you may already know, the supplements that we use are VERY powerful. 95% of the supplements that we carry can only be sold by a doctor. This is a huge responsibility that we take very seriously at CWA. In order to insure that you are taking the supplements that works ideally for you, we will only sell you the supplements that the Doctor has prescribed for you. In addition, if you have not had an appointment in the last 90 days, we are unable to sell you any supplements. This is to insure that the supplements that you are taking will only better your health. If you stay on such powerful supplements without being evaluated to make sure that you need them, it could create a negative situation. We would never want anyone to waste their money on a supplement that they don't even need. Just think about how quickly your body can heal and rejuvenate! By complying with the 90 day evaluation we help to protect you from any negative situations and supply you with the up-to-date regimen that will assist you in reaching your wellness goals! Obviously, for optimal results, we ask that you come in at the recommended intervals.

Office policy on visits:

We do require a full reevaluation if it has been more than 180 days since your last visit. We enforce this because so much can change in 6 months. It is our duty to give you the best care possible and if you have not seen the doctor in more than 6 months, a regular office visit would be inadequate time to reevaluate your health. Therefore, if you have not had an office visit or phone consultation in the past 6 months, you will need to fill out paperwork and plan for a 45 minute office appointment in which you will be charged $150. We believe that your health is very important and would never want to give you subpar care or inadequate time. If you have an appointment within the 6 month period of your last visit, you are considered an active patient and may schedule regular appointments for the times of your convenience.

Office policy on payment, rescheduling or cancellations:

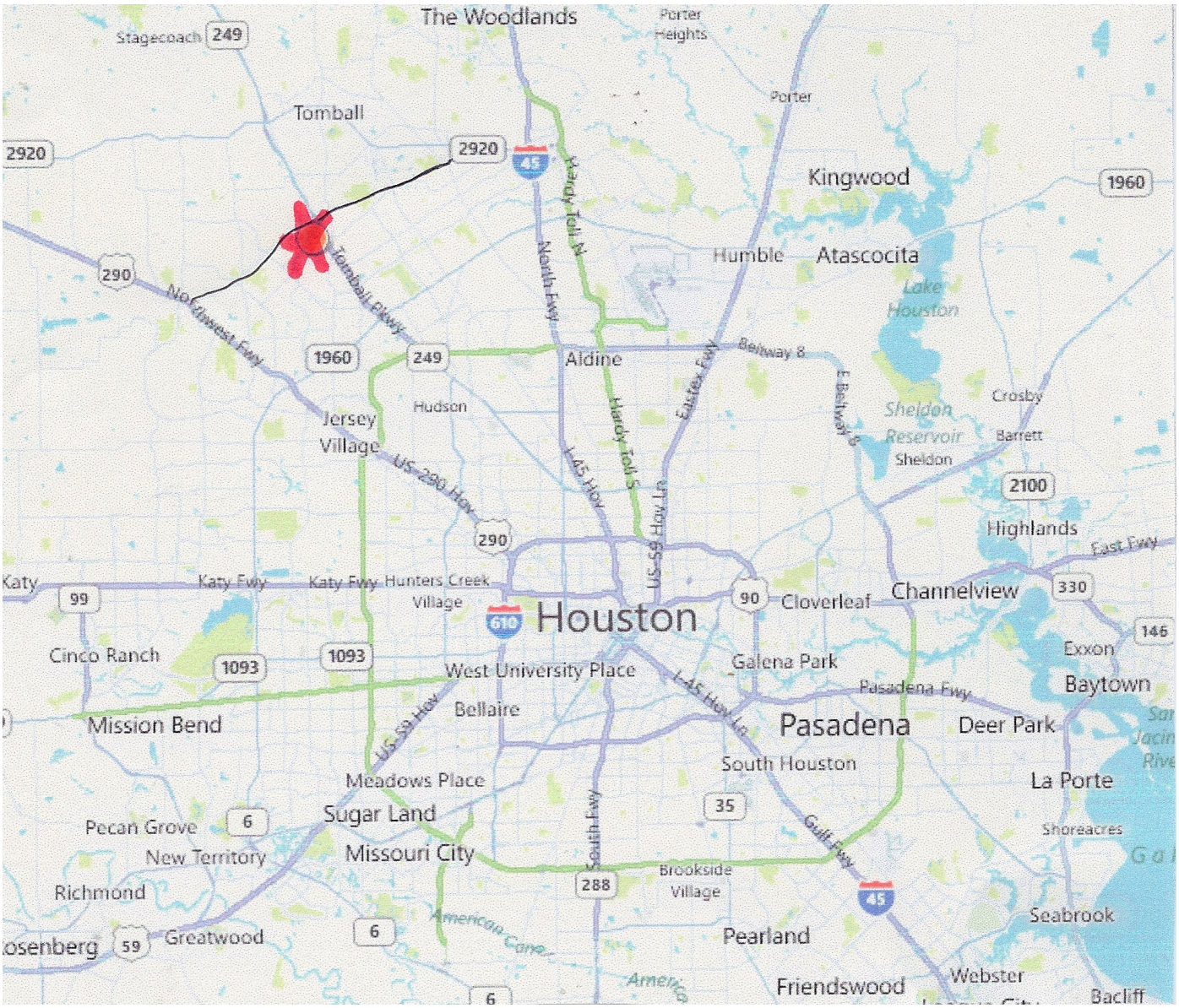
Payment for all in-office appointments is due at the time the service is rendered. If for any reason you have to reschedule your in-office existing patient appointment we require 24 hours notice. (If we do not answer the phone, please leave your name and number with the answering service.) By giving 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 you will be charged in the amount of the appointment missed. ($50 for existing patient, $150 for new patient) Note: The in-office new patient reschedule or cancellation policy is at least 1 weeks notice. Payment for all phone consultation appointments (new & existing) is due at the time of scheduling and is nonrefundable.

Thank you for your help in making sure that your health is appropriately tended to!!!
We are excited to have the opportunity to serve you and your wellness.

Patient/Legal Guardian (17 or younger) Signature:_____

Patient/Legal Guardian Print:_____ **Date:**_____

Map to get to 11613 Spring Cypress A
Houston, Tx 77377



Please call 281-655-WELL (9355)or visit www.yoursecrettowellness.com if you need further instructions prior to your appointment date.