SUBJECT INFORMED CONSENT
ELECTRODERMAL SCREENING AND MEASUREMENT

Practitioner's Name: Brent Taylor

Electrodermal screening measures the skin resistance at specific points located primarily on the hands and feet. We use a computerized biofeedback recording device, that uses software to collect information about the functional, energetic status of the body based upon acupuncture reference point measurements.

The screening session lasts from 60 minutes to 90 minutes or more, depending upon how many points are measured. Follow-up screenings, one to three additional sessions often of shorter duration, are usually done.

Skin measurement is obtained with a metallic probe applied to areas of high conductivity, usually on the hands or feet. Pressure is applied and a small amount of current (around 6-12 microamps — i.e., too small for you to be able to feel), enters through the skin. A recording is then taken on the response of the nervous system at these micro-dosage levels.

I certify that I have been told about the Electrodermal screening procedures, that I have been given satisfactory answers to my inquiries concerning the procedures and other matters. I understand this is not a diagnostic procedure, but a screening analysis. I have read and fully understand the above information, the elements of informed consent, my responsibilities and rights, and hereby consent to the use of the system.

Client' s Printed Name:_____ Date: _____

Client's (or Guardian's) Signature: _____

Address_____

City_____ State_____ Zip _____Phone (___) ___-_____

Email: _____

Informed Consent

Name:_____ Age: _____Weight_____ Blood Type _____

PLEASE LIST YOUR MAIN COMPLAINTS IN THE ORDER THAT YOU THINK IS MORE IMPORTANT.

_____

_____

_____

_____

_____

_____

_____

_____

Do you have/or have had issues with problematic root canals or dental fillings? Yes/No

PLEASE LIST MAJOR SURGERIES:

_____

_____

_____

_____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING AT THE PRESENT AND THE REASON FOR TAKING:

_____

_____

_____

_____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

The EAV/EDS System provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the procedure is to disclose patterns of stress and to provide feedback to help restore each system and meridian (energy pattern) back to balance.

I understand that the EAV/EDS Stress Survey does not provide a medical diagnosis, and that my testing technician may recommend further medical testing. If YOU suspect that you need further medical intervention, you should consult YOUR physician.

I give my permission for the testing technician to evaluate me on the EAV/EDS System. I understand that by doing so the testing technician is NOT becoming my primary care physician.

I understand that the testing technician will give me information about myself based on the evaluation and that the testing will make recommendations to improve my health based on what is found. Any decision to follow through with the program will be my own decision, and I will not hold the testing technician responsible.

Date:_____ Client Signature:_____

Signature of parent or guardian if child is a minor: _____

Date:_____Technician Signature:_____

INFORMED CONSENT: AN UNDERSTANDING OF HEALING

Background: There is evidence to support a relationship between both conscious and subconscious stress and the electrical resistance of the skin. Meridian Stress Assessment (MSA) systems are designed to help identify particular patterns associated with various types of stress reactions and agents, which reduce those reactions.

The procedure is totally non-invasive (the skin is not pierced) and is very safe. There are generally no risks associated with the substances recommended to bring your abnormal electrical patterns into balance as long as those substances are taken as suggested, but please report any discomfort you may experience (e.g. flu- like symptoms) from taking these substances to your examiner or your own physician. These symptoms could be related to a healing reaction. Also some herbs may not combine well with certain medications. Therefore, it is important to inform the technician about all medications you are currently taking.

MSA does not provide a medical diagnosis. If clients suspect they are in need of medical intervention, they should consult their physician, who can provide medical diagnoses and provide appropriate treatment regimes.

CONSENT: I understand that the technology being utilized in these testing procedures was not designed for, nor is being used as a means of any diagnoses. It is being used in accord with its design and registration to recognize imbalances in the body's energetic system and disclose patterns of stress. The system will then, indicate a solution to these energetic imbalances through support of various nutritional supplements, homeopathic and other natural remedies. I understand that no warranty of guarantee has been made to me as the result of these testing procedures, supplements and remedies. I also understand that it is possible to experience a healing reaction when taking homeopathic remedies. In addition, I understand that it is my responsibility to inform the technician about all medications I am currently taking.

I understand that though there may be references to body tissue, organs, organs systems during the course of this session and thereafter, these references are made only in their association with the energetic conductivity of their related meridians (energy pathways).

I further understand that this testing is not presented to me as an alternative to any kind of healthcare. It is presented to me in cooperation and conjunction with any other healthcare decisions that I deem necessary or appropriate or am simply comfortable with. If I suspect that I need further medical intervention, I should consult my own physician.

I have been given an opportunity to ask questions about the testing procedures and I believe that I have sufficient information to give informed consent. I therefore give permission for the testing technician to evaluate me on the system being used. I understand by doing so the technician is NOT my primary care physician. I understand that the testing technician will give me information about myself based on the evaluation I receive and that the testing technician will make recommendations to support increased functional health based on the evaluation. Any decision to follow through with the program will be my own decision.

Client Name (Please Print)_____

Client Signature_____ Date _____

Signature of parent or guardian if client is a minor_____ Date _____

Witness_____ Date_____

Patient Information

Patient Name_____

Please indicate below with a check mark, the symptoms you experience.

____Do you wake up feeling exhausted?

____Do you sleep 14 hours straight on weekends or wish you could?

____Do you have difficulty in sleeping or going to sleep?

____Are you worn out just thinking about doing a particular activity?

____Do you feel you have suddenly lost your energy?

____Are you usually highly motivated but feel your energy has drained away?

____Are you less able to keep up with your workload at home and/or work?

____Do you have a mild sore throat upon arising that goes away after about an hour?

____Does your sore throat feel dry, scratchy and irritated as though you had been smoking or exposed to very dry air?

____Have you noticed if the glands under your jaw are slightly swollen and tender?

____Do you run a low grade fever?

____Do you have headaches that come and go or settle in your temples behind one or both eyes?

____Do you have stiffness that moves from joint to joint?

____Do you suffer from persistently aching muscles?

____Do periods of depression come over you for no apparent reasons?

____Have you been told your problems are all in your head?

____Have you been treated for depression?

____Do you sometimes feel confused or unable to make decisions?

____Are you irritated by sharp, repetitive noises?

____Are your symptoms cyclic, occurring about the same time each year?

____Do you have problems concentrating?

____Do you experience mood swings? Do you have unexplained fits of anger?

____Episodes or weeping for no apparent reason over minor things?

____Any tingling or numbness over parts of your body?

____Do you have recurrent ear problems?

____Have you taken repeated rounds of antibiotic drugs?

____Have you been troubled by premenstrual tension, abdominal pain, vaginitis, prostatitis or loss of sexual interest?

____Does exposure to tobacco, perfume and other chemical odors provoke moderate to severe symptoms?

____Do you crave sugar, breads or alcoholic beverages?

____Do you crave other foods? What?

____Are you bothered by recurrent digestive problems?

____Are you bothered by hives, psoriasis or other chronic skin problems?

____Do you feel bad all over, yet the cause hasn't been found?

____Do you have other symptoms or additional comments?

GUIDELINES FOR TAKING REMEDIES

Name:_____ Date:_____

You must drink 1/2 YOUR BODY WEIGHT IN OUNCES of Pure Water Daily.

Homeopathics- *You may take anytime during the day, as long as you are 15- 20 minutes away from food.*

1)_____ ____ Drops UNDER tongue_____ times daily for_____
Then____ Drops UNDER tongue_____ times daily for_____
Then____ Drops UNDER tongue_____ times daily for_____

2)_____ ____ Drops UNDER tongue_____ times daily for_____
Then____ Drops UNDER tongue_____ times daily for_____
Then____ Drops UNDER tongue_____ times daily for_____

3)_____ ____ Drops UNDER tongue_____ times daily for_____
Then____ Drops UNDER tongue_____ times daily for_____
Then____ Drops UNDER tongue_____ times daily for_____

Other:

1)_____ _____
2) _____ _____
3)_____ _____

HERBALS - Take any time of day. -- May be added to a glass of water or juice and remedies may be combined. I)

1) _____ ____Drops___ times daily for days____, then____ drops____ Xs daily for_____
2) _____ ____Drops___ times daily for days____, then____ drops____ Xs daily for_____
3) _____ ____Drops___ times daily for days____, then____ drops____ Xs daily for_____
4) _____ ____Drops___ times daily for days____, then____ drops____ Xs daily for_____

ENZYMES and NUTRITIONALS Supplements

I) _____ ____Pill(s) between meals (1 hour before or 2 hours after)_____ Xs daily.
2) _____ ____Pill(s) between meals (1 hour before or 2 hours after)_____ Xs daily.

1) _____ ____Pill(s) BEFORE AFTER WITH each meal _____ Xs daily.
2) _____ ____Pill(s) BEFORE AFTER WITH each meal _____ Xs daily.
3) _____ ____Pill(s) BEFORE AFTER WITH each meal _____ Xs daily.
4) _____ ____ Pill(s) BEFORE AFTER WITH each meal _____ Xs daily.
5) _____ ____ Pill(s) BEFORE AFTER WITH each meal _____ Xs daily.
6) _____ ____ Pill(s) BEFORE AFTER WITH each meal _____ Xs daily.

Please bring all remaining remedies PLUS your empty bottles with you on your next visit. Also bring anything else you are taking. Most revisits are in about 6 weeks.

GUIDELINES FOR TAKING REMEDIES The successful use of Homeopathic preparations requires the knowledge of some basic rules for their administration.

1) Take nothing by mouth 10 to 20 minutes prior to or following dosage. That includes food, drink, cigarettes, chewing gum, toothpaste, etc. Place drops in mouth under tongue for 30 seconds, then swallow. You may drink water.

2) No caffeine with in a 1Hr. of taking homeopathic, (Coke, Tab, Mountain Dew, Surge, coffee, chocolate) in any form.

3) Omit mint with in a ½ Hr. of taking homeopathic (breath mints, candy, toothpaste, mouthwash, ice cream, gum, etc.). You may only brush with kitchen baking soda or mint free health food store Toothpaste. Use Pur chewing gum no mint.

4) Omit camphor as in muscle and joint rubs. (Ben-Gay, Campho-phenique, Tiger Balm)

Use Arnica cream, Arnica extract or Lavender oil.

5) Limit intake of strong odors, such as paint thinners, eucalyptus, cigarettes, moth balls

and especially menthol.

6) Avoid raw garlic. Cooked is ok.

7) Alcoholic sensitives: Put drops in three ounces of water and allow one minute for alcohol to evaporate.

8) Keep formulas at room temperature, in a dark place and away from microwaves and electrical

appliances, (alarm clocks, radios, televisions, etc.).

9) "Do not X-ray" when going through an airport, or any security device that uses x-rays.

Put remedy bottles in your pockets, or hand to attendants. Metal detector is OK.

10) Aspirin, Tylenol, Advil, etc. are ok to take with the remedies.

* IF YOU EXPERIENCE UNDESIRED SYMPTOMS such as headaches, slight fever, etc., stop the remedies for 24 hours. Go back at half the recommended dosage. If symptoms do not subside, or become unmanageable use the recommended antidotes and/or call me.

ANTIDOTES: A) MINT - candy, tea, gum B) CAFFEINE - coffee, Coke C) INHALE CAMPHOR - smelling salts

DO NOT EAT, DRINK OR USE THESE ANTIDOTES UNLESS YOU WANT TO STOP THE REMEDIES EFFECT.

After antidoting, wait 24 hours and go back at half the recommended dosage.

If you need to slow the remedies down or antidote, your healing process will not be affected.

BY FOLLOWING THESE GUIDELINES, YOU WILL GIVE THE REMEDIES AND YOURSELF THE GREATESTOPPORTUNITY TO SUCCEED.

4/2000