HEALING THE EYE & WELLNESS CENTER

Dr. Edward Kondrot, MD (H), CCH, DHT
Dr. Oddveig Myhre NMD, MS
7100 East Cave Creek Road Suite # 111
Cave Creek, AZ 85331 480 595 3181

PATIENT REGISTRATION FORM
PLEASE PRINT

____
DATE SOCIAL SECURITY #

____
LAST NAME FIRST NAME M.I.

____
STREET ADDRESS

____
CITY STATE ZIP

____
DAYTIME PHONE EVENING PHONE CELL PHONE

____
DATE Of BIRTH MALE FEMALE AGE

____
E-MAIL ADDRESS

WOULD YOU LIKE TO RECEIVE OUR E-MAIL NEWSLETTER?

____
YES NO INITIALS

HOW DID YOU HEAR ABOUT HEALING THE EYE AND & WELLNESS CENTER (Dr. Edward Kondrot):

If a referral, whom may we thank?______________________________

____

IN CASE OF EMERGENCY CONTACT INFORMATION:

NAME OF CONTACT:_______________________________________
PHONE#________________________

NAME OF CONTACT:_______________________________________
PHONE #________________________

MAY WE LEAVE A MESSAGE ON YOUR HOME PHONE NUMBER REGARDING YOUR CARE AT HEALING THE EYE AND WELLNESS CENTER?

____

YES **NO** **INITIALS**

PLEASE LIST ANY OTHERS: SPOUSE OR FAMILY MEMBER TO WHOM WE MAY RELEASE YOUR PRIVATE INFORMATION.

NAME: **PHONE:** **RELATIONSHIP:**

____
____
____
____

PRIMARY REASON/COMPLAINT FOR SEEING THE DOCTOR:

____
____
____

____
SIGNATURE (PATIENT/GUARDIAN) **DATE**

HEALING THE EYE AND WELLNESS CENTER

Dr. Edward C. Kondrot, MD,(H),CCH, DHt
Dr. Oddveig Myhre, NMD, MS

FINANCIAL AGREEMENT

NAME: ___________________________________

I understand that payment in full is expected at the time of services are rendered unless prior financial arrangements have been made. I understand that Healing the Eye and Wellness Center, the office of Dr. Edward Kondrot and Dr. Oddveig Myhre will NOT PROCESS OR ASSIST IN ANY INSURANCE OR MEDICAL BILLING OR CLAIMS.
I understand it is my sole financial responsibility to Healing the Eye and Wellness Center and Dr. Edward Kondrot, Dr. Oddveig Myhre for ALL charges incurred.

I also understand that Healing the Eye and Wellness Center has the right to assess a cancellation charge to my billing information of up to ½ of my consultation fee for all appointments not cancelled within 1 week (business) of my appointment.

NAME:(PRINTED)_________________________

____
PATIENT SIGNATURE DATE

Signature of responsible party if not the same as

above:_________________________________

HEALING THE EYE AND WELLNESS CENTER

Dr. Edward C. Kondrot MD, (H),CCH,DHt
Dr. Oddveig Myhre, NMD, MS

Doctor/Patient Contract

I understand that in seeking medical treatment from Edward C Kondrot, MD(H), CCH, DHt. FCOS, Oddveig Myhre, NMD., who will hereinafter be referred to as the "Doctor", whether speaking of one or more of them. I am not required to use him/her as my doctor for myself or my family as there are other doctors as well qualified who practice medicine in the specialty of ophthalmology, optometry, naturopathy, acupuncture and homeopathy that he/she is willing to refer me to them.
I understand that if I waive any liability for his/her care of me and my family. I will help the Doctor keep down the expenses of his/her practice of medicine due to savings in avoiding malpractice insurance and malpractice lawsuits, the expenses of which would otherwise be passed on to me and his/her other patients in higher fees. I enter into this contract voluntarily and I understand I am waiving my right to bring a claim against the Doctor for any negligent act or omission he may commit in his treatment of me or for any breech of the contractual obligation to me to render to me that standard of medical care which is rendered in this contract applies to all of his/her medical care to me.

I specifically release the Doctor from any liability to me and I hereby release, discharge and acquit the Doctor from any and all claims for loss, damage or injury of any nature whatsoever to my person, my family, or estate, resulting in any way from or in any fashion arising from, connected with or resulting from the Doctor's medical treatment of me or my family whether caused by malpractice or negligent acts of the Doctor, his/her agents, or employees or servants or otherwise. This contract is clearly intended to protect the Doctor against his own negligence and I so understand it.

I voluntarily enter into this contract in order to induce the Doctor to render to me medical as well as alternative therapies at his or her most reasonable cost.

Additionally, if the aforementioned release and or waiver is determined by any court to be void and not binding upon me, I am willing to submit any claim for loss, damage or injury of any nature whatsoever to my person or estate resulting I any way from or in any fashion arising from connected with or resulting from the Doctor's treatment of me whether caused by malpractice, breach of contract or negligent acts of the Doctor, his agents, employees, servants or otherwise, to binding arbitration. In such arbitration I agree that there shall be three arbitrators, two of them shall be medical doctors with qualifications similar to Dr. Kondrot in Homeopathy, Ophthalmology or Optometry and Dr. Oddveig Myhre in Naturopathy. Each party shall choose one arbitrator and the two arbitrators shall choose the third. The decision of the arbitrators shall be final and binding upon me with respect to the decision of liability and amount.

IN WITNESS WHEREOF; I HAVE SIGNED THIS CONTRACT,
THIS _____ DAY OF____________20___

WITNESS: ____

____

PATIENT NAME: (PRINT) **DATE:**

____

PATIENT SIGNATURE

HEALING THE EYE AND WELLNESS CENTER
PATIENT RECORD RELEASE FORM

PATIENT INFORMATION:

NAME: ____

STREET: ____

CITY: ______________ **STATE:** ______________ **ZIP CODE:** ______________

PHONE #: ______________________ **CELL PHONE:** ______________________

RELEASE OF INFORMATION TO:

NAME: ____

ADDRESS: ____

CITY: ______________ **STATE:** ______________ **ZIP CODE:** ______________

____TELEPHONE: FAX:

I AUTHORIZE THE RELEASE OF MY RECORDS TO THE ABOVE LISTED NAME AND ADDRESS.

____PATIENT SIGNATURE DATE

HEALING THE EYE AND WELLNESS CENTER

Dr. Edward C. Kondrot MD,(H),CCH,DHt
Dr. Oddveig Myhre, NMD, MS

TREATMENT CONSENT

I AUTHORIZE THE PERFORMANCE UPON ____________________ (MYSELF, NAME OF PATIENT) AN ALTERNATIVE MEDICINE EVALUATION WHICH CONSISTS OF HOMEOPATHIC, MICROCURRENT, NURTRITIONAL, COLOR, VISION AND IV THERAPIES.

I MAY OR MAY NOT BE A CANDIDATE FOR THE THERAPIES LISTED AND I AM SEEKING ADVICE FROM DR. EDWARD C. KONDROT AND DR. ODDVEIG MYHRE.

THESE HAVE NOT BEEN PROVEN THROUGH SCIENTFIC RESEARCH. WHILE TRYING THE SUGGESTED APPROACH, I WILL REMAIN UNDER THE CARE OF MY MEDICAL DOCTOR AND WILL HAVE MY HEALTH/VISION CHECKED PERIODICALLY.
HE OR SHE MAY RECOMMEND OTHER TREATMENT, SOME MAY NOT BE AVAILABLE AT THE TIME OF CONSENT. IF THIS IS THE CASE I WILL EVALUATE MY OPTIONS.

I UNDERSTAND THE NATURE AND RISK OF ALTERNATIVE THERAPIES AND THE POSSIBLE COMPLICATIONS. I WILL BE USING ALTERNATIVE THERAPIES AS A COMPLIMENT TO MY REGULAR MEDICAL PROGRAM AND I WILL NOT DISCONTINUE ANY MEDICATION OR TREATMENT WITHOUT THE PRIOR APPROVAL OF MY EXISTING DOCTOR.

I ALSO UNDERSTAND THAT THERE IS NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN BY ANYONE AS TO THE RESULT THAT MAY BE OBTAINED.

____

PATIENT/GUARDIAN **DATE**

____

WITNESS **DATE**

HEALING THE EYE AND WELLNESS CENTER

DR. Edward C. Kondrot MD, (H),CCH,DHt,FCOS
Dr. Oddveig Myhre NMD, MS

PATIENT AUTHORIZATION RELEASE

I,______________________,AUTHORIZE THE FOLLOWING PERSON (S) TO SPEAK TO DR.KONDROT, DR. ODDVEIG MYHRE AND THEIR OFFICE STAFF ABOUT MY CASE.

THIS WILL INCLUDE PHYSICIANS ANY FAMILY MEMBERS YOU GIVE PERMISSION TO CALL THE OFFICE OR REQUEST WRITTEN OR VERBAL INFORMATION REGARDING YOUR CASE.

IF THEIR NAMES DO NOT APPEAR ON THIS RELEASE, WE WILL NOT BE ABLE TO DISCUSS OR RELEASE ANY INFORMATION.

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PATIENT SIGNATURE **DATE**

Naturopathic Assessment Form

Name: ______________________________ Age: __________ Date: _____________

Please list the 3 major health concerns you have besides vision problems:
1.____
2.____
3.____

Please list **all current medications** that you are taking (use back of paper if necessary):
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Please list any natural supplements you are currently taking and for what condition (use back of paper if necessary):
1. ____
2. ____
3. ____
4. ____
5. ____
6.____

Have you been diagnosed with any of the following diseases:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth defects
- ☐ Bone disease
- ☐ Bleeding disorder
- ☐ Cancer: __________
- ☐ Cardiovascular disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye disorder
- ☐ Gallbladder disease
- ☐ Heart attack
- ☐ Hypertension
- ☐ Irritable bowel
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental illness
- ☐ Migraines
- ☐ Pneumonia
- ☐ Prostate disorder
- ☐ Stroke
- ☐ Suicide
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other diseases ___________

Do you have any allergies to medication or food? If so, which one(s)?
____

Have you had any surgeries? If so, what type and when?
____
____

Social Status:
Are you?: Single ____ Married ___ Divorced ____ Separated ______
Do you have children? If so, how many?: ______ Grandchildren? ______________
Occupation? _______________ If retired, what did you use to do? _______________

General health:
How many hours do you sleep at night? ______ Do you wake up rested? ________
Do you wake up at night? ________ If so, how many times and why?
____

Please describe what you typically eat throughout the day:

Breakfast: ____
Lunch: ____
Dinner: ____
Snack: ____
Which, if any particular food do you strongly crave? __________________________
How many times do you eat out a week? _______ Where? _____________________
How often do you eat fish or seafood? ______/week. Type of fish? ____________
How much do you drink in a day of the following:
Water: _________ Coffee/Caffeinated drinks:_______________ Milk:____________
Alcoholic drinks: ____________ what type? _______________

List the 3 healthiest foods you eat on an average week:	List the 3 worst foods you eat on an average week:
1.	1.
2.	2.
3.	3.

Do you exercise? _________ What type and how often? _______________________
What is your current stress level? 1 lowest – 10 highest: _______________________
What are you stressed about? ____

Please check mark the appropriate number "0-3" on all questions below.
0 as the least/never, 1 being rarely, 2 meaning sometimes and 3 most/always.

Category I: Co S	**0**	**1**	**2**	**3**
Feeling that bowel doesn't not empty completely				
Lower abdominal pain improves by passing stool or gas				
Alternating diarrhea and constipation				
Diarrhea alone				
Constipation alone				
Hard, dry, or small stool				
More than 3 bowel movements a day				
Having to use laxatives frequently				
Category II: St S – HCl-L	**0**	**1**	**2**	**3**
Excessive belching, burping, or bloating				
Gas immediately after eating a meal				
Difficult moving the bowel				
Sense of fullness during and after meals for a long time				
Difficulty digesting fruits and vegetables/undigested food in the stool				
Category III: St S – HCl-H	**0**	**1**	**2**	**3**
Stomach pain, burning, aching 1-4 hours after eating				
Frequently use of antacids for heartburn				
Feeling hungry shortly after eating a meal within 1-2 hrs				
Heartburn when lying down or bending forward				
Temporary relief from antacids, food, milk or carbonated beverages				
Digestive problems relieved by rest and relaxation				
Heartburn from spicy foods, chocolate, citrus, peppers, alcohol, coffee				
Category IV: SI S	**0**	**1**	**2**	**3**
Fiber and raw vegetables cause constipation				
Indigestion and fullness lasts for 2-4 hours after eating				
Pain, tenderness, soreness on left side under rib cage				
Excessive passage of gas				
Nausea and/or vomiting				
Undigested food in stool that is foul smelling with mucus, greasy, and unformed				
Frequent urination				
Increased thirst and appetite				
Difficulty losing weight				

Category V: Bi S	0	1	2	3
Greasy or fatty food cause GI upset				
Gas in lower bowel or bloating several hours after eating				
Metallic taste in mouth, especially in the morning				
Unexplained itchy skin				
Stool color alternates between brown and lighter, clay color				
Reddened palms, sole of feet and/or skin looks “flushed”				
Dry or flaky skin and/or hair				
History of gallbladder attacks or stones?	Yes / No			
Have you had your gallbladder removed?	Yes / No			
Category VI: BS – RH	**0**	**1**	**2**	**3**
Crave sweets during the day				
Irritable if skipping meals				
Lightheaded and/or headaches if skipping meals				
Feels jittery, shaky, tremors if skipping meals				
Depends on coffee to keep yourself going or started				
Eating relieves tiredness				
Easily agitated, nervous, upset				
Poor memory, forgetful				
Blurry vision that comes and goes				
Category VII: BS S - IR	**0**	**1**	**2**	**3**
Tired after eating a meal				
Craves sweets, especially after meals				
Eating sweets doesn’t relief the cravings for it				
Frequent urination				
Increased thirst and appetite				
Weight gain that doesn’t respond to diet				
Your waist is equal to or bigger than your hips	Yes / No			
Category VIII: ASI - L	**0**	**1**	**2**	**3**
Craves salt				
Slow in the morning. Can’t seem to get started.				
Tired in the afternoon. “Afternoon slump” between 2-4 pm				
Dizziness if standing up to fast				
Headaches in the afternoon				
Headaches if stressing or with exertion				
Weak nails				

Category IX: ASI - H	**0**	**1**	**2**	**3**
Cannot fall asleep at night				
Perspire easily, and/or excessive perspiration with little/no activity				
Under high amount of stress				
Weight gain when stressing				
Weak up tired even if having slept 6 hrs or more				
Category X: T-L	**0**	**1**	**2**	**3**
Feels tired and sluggish				
Cold hands and feet, and/or cold all over				
Requires more than 8 hours of sleep to function properly				
Increase in weight even when on a low-calorie diet				
Gain weight easily				
Difficult, infrequent bowel movements				
Lack of motivation, feeling as if everything is "blah"				
Headaches in the morning that gets better as the day goes by				
Thinning of outer part of eyebrow				
Thinning of hair of scalp, face, genitals or increased hair loss				
Dryness of skin and/or scalp				
Mental sluggishness/slowness				
Category XI: T- H	**0**	**1**	**2**	**3**
Heart palpitations				
Inward trembling				
Increased pulse even when at rest				
Nervous and emotional, anxious				
Insomnia: difficulty falling asleep and/or staying asleep				
Night sweats				
Difficulty gaining weight				

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DR. ODDVEIG MYHRE, NMD, MS

PLEASE LIST ALL VITAMIN, SUPPLEMENTS AND MEDICATIONS

NAME:	DOSAGE;

QUALITY OF LIFE

READING THE NEWSPAPER	
WALKING IN THE DARK	
SEEING IN THE DARK	
WALKING ON UNEVEN GROUND	
ADJUSTING TO BRIGHT LIGHTS	
ADJUSTING TO DIM LIGHTS	
GOING INTO A DARK ROOM OR VICE VERSA	
TRIPPING OVER OBJECTS	
SEEING OBJECTS COME FROM THE SIDE	
CROSSING THE ROAD	
WALKING ON STEPS	
BUMPING INTO OBJECTS	
JUDGING DISTANCE OF THE FOOT TO THE STEP OR CURB	
FINDING DROPPED OBJECTS	
RECOGNIZING FACES	

NONE-1, A LITTLE BIT -2, SOME-3, QUITE A LOT- 4, SEVERE- 5