The following questionnaire, although somewhat long and detailed, is an invaluable source of information about you as a unique person. It will allow us to know the Total you, not just you as a collection of symptoms of an illness.

If, for any reason, you object to fill out any or all of it, you may leave that part blank and provide us with the information you feel comfortable sharing with us.

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

Would you be willing to sign a release to obtain medical records from your previous doctor(s) and hospital(s), if this information would be helpful for your treatment?

Yes_____ No_____

If yes, then sign below.

AUTHORIZATION FOR MEDICAL INFORMATION

This will authorize (Dr.)_____ of
(Clinic)_____ _____

to provide Prof. Dr. **Jan Stange**, or his representative, with any and all information in regards to any form of treatment applied to me, including blood tests, X - rays, findings and diagnoses.

A copy of this authorization is valid as well as an original.

Date:_____ Signature:_____