JCAM
Derma Kare

Patient Information and Consent Form

Thank you for choosing our clinic to assist you in improving your gut health. To provide you with the best possible care, we kindly ask you to complete the following information. Your responses will help us understand your medical history and tailor a personalized treatment plan for you.

1. Personal Information:

Full Name:Your text here
Date of Birth:Your text here
Address:Your text here
Phone Number:Your text
Email Address:Your text here

2. Medical History:

Briefly describe any past medical conditions:

Your text here

Your text here

List all current medications and supplements you are taking:

Your text here

Your text here

Are you currently under the care of any other healthcare providers?

Yes ☐ No☐

3. Gut Health Challenges:

How long have you been experiencing gut health issues?

Your text here years, Your text here months.

Please describe the types of gut health challenges you are experiencing (e.g., bloating, diarrhea, constipation, etc.

Your text here

Your text here

4. **I agree to the following:**

- **I am willing** to make dietary changes and follow the lifestyle guidance as part of my treatment plan? Yes ☐ No☐
- **I am committed** to attending all 6 recommended treatments and appointments.
  Yes ☐ No☐
- **If I don't start** receiving results by the 3rd session, I agree to leave the challenge and, if I choose to, I can do a consultation with the JCAM doctor to find out what the deeper issue is, which may include doing further investigations to get to the root of the issue. Standard fees would apply.
  Yes ☐ No☐
- **I am willing** to provide a genuine audio or video testimonial at the end of the challenge, as long as I get good improvements. Yes ☐ No ☐

  ***(Your audio or video testimonial is tied to your chance to win the weekend Villa stay but if you opt out of this part, you'd still get to enjoy improved gut health and the learnings about how to maintain your results).*

- **I agree** to allowing my testimonial to be used for promotional purposes, including but not limited to online platforms and clinic publications.
  Yes ☐ No ☐

By either signing in the designated signature field below or typing your initials, you acknowledge that you have read and understand the information provided. Your signature or initials will serve as your official signature.

Name: Your text here **Signature**:Your text here **Date**: Your text here

If you have any questions or concerns, please do not hesitate to contact us. Thank you for joining our challenge! We look forward to assisting you on your journey to harmonious digestive health!

Send the completed form back to us via email to **info@mydermakare.com** **OR** *print and return it to us at your next visit. You may also complete this form during your next visit, as we can provide it for you at that time.*