Dr. David Trybus

Clearing Session

Name: ____

Date: __________ Phone: ______________________

Address: ____

Email: ____________________________________

Birth date: ____

Birth Place: City____ State ____________

Issues/Complaints: *Please use a descriptive sentence*. **Physical Examples**: I have a headache on the right side of my head every morning. Or, I have a stomach pain that goes away after eating. **Emotional Examples**: I feel a lot of worry about X. Or, I can't seem to sustain a long-term, loving partnership. Not motivated to do X. Also, from scale of 1 to 10, 1 being least 10 being worst, rate current level/degree of pain/issue, or complaint. Please email or upload this information a week prior to your appointment, thanks!

1. ____

   ____

2. ____

   ____

3. ____

   ____

4. ____

   ____

5. ____

   ____

6. ____

   ____

What do you expect to gain from this treatment, specifically? ___________________________________

____

Phone: 417.693.8821 Email completed form 48 hours prior to session to **drtrybus@gmail.com**