



SHANTI AYURVEDA

"Ancient Healing Wisdom for our Modern World"

14726 Ramona Ave., Suite 410-S10
Chino, California 91710

Marisa Laursen
Clinical Ayurvedic Specialist

Dear Prospective Client:

Congratulations on taking this very important step in your healing journey! Thank you for considering Shanti Ayurveda for your holistic health care needs. In preparation for your consultation, I am enclosing an Intake Packet for you to review, complete and return to Shanti Ayurveda prior to your intake appointment. The Consultation Intake Packet includes:

- Cover letter (2 pages)
- Health Information and History (7 pages)
- Financial Policy Agreement (1 page)
- Informed Consent (1 page)
- Directions to Shanti Ayurveda (1 page)

Please read the attached information, complete all forms, and return them to Shanti Ayurveda prior to your appointment date. Please keep this cover letter and the directions page for your own records.

- Your appointment date and time is: Date: _____ Time: _____
- Date this packet is due back to Shanti Ayurveda: _____
- You may return the completed forms by fax, email, or mail to the following address:

Shanti Ayurveda
14726 Ramona Ave., Suite 410-S10
Chino, CA 91710
FAX (815) 572-5394
Marisa@ShantiAyurveda.com

Ayurveda is a profoundly effective healing science that has been around since the dawn of humankind. It is the foundational healing wisdom of our planet, the wisdom that explains the workings of nature and our interconnectedness with it. By coming to understand the principles of Ayurveda, one achieves an understanding of the forces at work within one's body, mind and soul and how we are governed by the same patterns and rhythms that govern all of nature. This amazing knowledge allows us to take control of our own health and healing, as we gain an understanding of that which brings us balance and that which brings disharmony and imbalance. By learning to maintain harmony within ourselves, we are effectively closing the door on physical, emotional and mental disease, disallowing it to have a foothold within our selves. Thus, healing occurs at the deepest, most causal level. Ayurveda works not by just pacifying symptoms but by removing obstacles to health.

It is my pleasure to serve as your guide, healer, coach and teacher on this journey. I devote a great deal of time to each client, as I come to understand both your natural state of balance and your current imbalanced state. Ayurveda utilizes an endless number of holistic healing modalities, and along your healing journey I will introduce many of these to you, providing you the tools necessary to achieve and maintain your health and well-being. Although many results occur quite rapidly, more long-standing imbalances are resolved gradually, over a period of six months to one year.

You will undoubtedly find the attached questionnaire to be quite in-depth; this is because Ayurveda is truly holistic, and a complete understanding of you, your health history, lifestyle patterns, and health concerns is an important part of the process.

CLIENT NAME: _____

Page 1

At the first appointment, I will collect additional information as I strive to gain a deep understanding of your states of balance and imbalance. Plan to allow about two hours for this first appointment.

Approximately one week after the initial appointment, we will meet again for your "Report of Findings". At this appointment I will explain to you your inherent state of balance and your current state of imbalance. I will also present to you my general treatment plan. Depending on what is required, you will be given herbs, dietary and lifestyle recommendations, or other healing practices.

After these first two meetings, it is important that we continue to meet on a regular basis during the early stages of your healing in order to support you on your journey, review your progress and integrate new lifestyle practices as appropriate. At the beginning, it is best to meet approximately every one to two weeks. As time goes on and you gain an ever-deepening understanding of how balance is achieved and maintained within your body, these meetings will become less frequently until they occur only seasonally.

My fees are as follows:

- Initial Consultation - \$175
This visit generally lasts about two hours.
- Report of Findings Visit and Follow-Up Visits - \$85
These visits generally last about one hour.
- Herbal Formulations
All herbal formulations are custom-made specifically for you. Pricing is based on ingredients, quantity and shipping. On average, a one-month supply is \$40.00 per formula plus tax and shipping if required.

I realize that your health is deeply personal and profoundly important. Please be assured that I do not undertake this lightly; I work closely with each of my clients in a respectful, confidential, dedicated manner. Thus, your healing becomes a joint effort, utilizing my expertise and insight along with your willingness and commitment.

I very much look forward to working with you. It is my honor to bring the time-honored wisdom of Ayurveda to you as I assist you on your healing journey.

In Love and Light,



Marisa Laursen
Clinical Ayurvedic Specialist
Pancha Karma Specialist
Ayurvedic Yoga Therapist
Ayurvedic Educator

CLIENT NAME: _____

Page 2

Shanti Ayurveda

Marisa Laursen, Clinical Ayurvedic Specialist
 14726 Ramona Ave., Suite 410-S10, Chino, CA 91710
 (909) 896-2004 / FAX (815) 572-5394 / Marisa@ShantiAyurveda.com
 www.ShantiAyurveda.com

CONFIDENTIAL CLIENT HISTORY

Name: _____

Address: _____

City, State, Zip: _____

Telephone – Home: _____ Work: _____ Cell: _____

Email: _____ Birth date: _____ Age: _____

Partner status: _____ # of children: _____ Ages: _____ Occupation: _____

Is there a possibility that you are pregnant? Yes No Possible Are you nursing? Yes No

What do you want to achieve or change in terms of your health and wellness? _____

MEDICAL HISTORY

Personal History

Do you or your parents, grandparents, brothers or sisters have a history of: (check ailments that apply)

	<u>Family Member</u>				<u>Family Member</u>		
	Myself	Maternal	Paternal		Myself	Maternal	Paternal
Allergies to Foods or Drugs	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Heart Surgery	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Hepatitis A	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Hepatitis B	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Asthma, Pneumonia, TB	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Hepatitis Non-A / Non-B	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Blood Pressure, High / Low	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	HIV Exposure	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Implant, Prosthesis	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Chemotherapy / Radiation	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Kidney or Bladder Disease	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Chest Pain / Angina	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Mental disorder	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Cholesterol, elevated	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Mononucleosis, Jaundice, Gallstone...	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Dental Treatment Complications	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Ear pain or ringing	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Jaw pops, clicks or locks	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Dizziness	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Prolonged Bleeding When Cut	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Epilepsy, Convulsions, Seizures	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Fainting	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Shortness of Breath	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Feet or Ankles, Swelling	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Stroke/Cerebro Vascular Accident.....	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Glaucoma, Eye Surgery	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Thyroid Disease or Medication	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Ulcers, Intestinal Bleeding	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart Disease / Heart Murmur ...	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Venereal Diseases	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

Please explain any items checked: _____

CLIENT NAME: _____

Any other disease or problems?

Serious illnesses/dates: _____

Hospitalizations/dates: _____

Operations/dates: _____

Other conditions/dates: _____

Have you been under the care of a licensed health care practitioner in the past year? Yes No If so, for what reasons:

Date of last physical exam: _____

Any current or past history of:

- Serious injuries
- Trauma
- Emotional/mental stresses
- Troubled lifestyle conditions
- Changes in weight
- Aches, pains
- Stress
- Fatigue
- Mental clarity/concentration
- Vision problems, including dry eyes
- Hot flashes
- Cosmetic surgery

Please describe any items checked: _____

GENERAL HEALTH AND LIFESTYLE PATTERNS

1. *Do you exercise regularly?* Yes No Length of time: _____ Times per week: _____

Type(s) of exercise: _____

2. *Do you currently smoke?*

Yes How many cigarettes per day? _____ How long have you smoked? _____

No Have you ever smoked? Yes No If yes, when did you quit? _____

3. *Any current or past use of addictive substances?* Yes No

Substance: _____ Amount: _____ If quit, when? _____

Substance: _____ Amount: _____ If quit, when? _____

4. *Do you experience allergic reactions to any substances (food, environmental, etc.)?* Yes No If yes, please explain:

5. *Please describe your work or school life* (1 = least, 5 = most):

Level of stress: (please circle): 1 2 3 4 5 Level of work/school satisfaction: 1 2 3 4 5

6. *Please describe your primary intimate relationship:*

Level of stress: (please circle): 1 2 3 4 5 Level of satisfaction: 1 2 3 4 5

7. *Are you currently experiencing stress in any other close relationship?* _____

8. *Are you sexually active?* Please include masturbation. Yes No Total times per week / month _____

Level of satisfaction with sexual activity: 1 2 3 4 5

9. *Do you have any specific spiritual practices?* Please describe: _____

CLIENT NAME: _____

CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, or supplements are you currently taking?
Please include significant remedies that you have recently stopped taking.
Please also include birth control and hormone replacement therapy.

Substance	For each substance, indicate if over-the-counter, M.D. prescription, etc.	Prescribed by whom?	Taken for what purpose?	Taken for how long?	What is your current dosage?	What have been the benefits?	Notes (Practitioner Use Only)
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug						
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug						
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug						
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug						
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug						
	<input type="checkbox"/> OTC <input type="checkbox"/> Prescription <input type="checkbox"/> Currently taking <input type="checkbox"/> No longer taking <input type="checkbox"/> Herb <input type="checkbox"/> Vit <input type="checkbox"/> Drug						

CLIENT NAME: _____

DIETARY PATTERNS

Please indicate your primary food choices and meal times:

Meal	Times(s)	Typical Foods and Beverages
Breakfast		
Lunch		
Dinner		
Snacks		

1. *Do you have any routines around eating?* Please explain: _____

2. *Any current or past chronic eating disorders or other food related issues?* Yes No

Comments: _____

3. *How much of the following do you drink?:*

Water: # cups per day: _____
 Non-caffeinated beverages: # cups per day: _____ Type(s): herbal tea / milk / juice / other _____
 Caffeinated beverages: # cups per day: _____ Types(s): coffee / tea / soda
 Alcohol: # cups _____ per: day / week / month; Beer / wine / hard alcohol / other _____

DAILY SCHEDULE

Please describe your activities from the time you wake up until you go to sleep (eating, sleeping, exercise, work, school, other activities). Please include approximate times.

	Time	Activities	
Awaken			<u>Variations</u>
Breakfast			
Activities			
Lunch			
Activities			
Dinner			
Activities			
Evening Activities			
Bed-time			

List regular practices that are not included in the above schedule, e.g. exercise, meditation, spiritual practices, etc.

CLIENT NAME: _____

AYURVEDIC PROFILE

Please circle the descriptions that best describe you *at this time in your life*

(Please disregard items in gray)

Therapist Use
Prakruti

FUNCTIONAL PROFILE

Digestion / Appetite

	VATA	PITTA	KAPHA
Describe your hunger level	Variable	Strong	Low
Reaction to missing meals	Anxious, lightheaded	Irritable	Not significant
Typical quantity of meals	Medium or varies	Large	Small
Frequency of meals	Irregular	Regular	Regular
Eating speed	Quick	Medium	Slow
Digestion after eating (circle all that apply)	Gas, bloating, belching, pain	Heartburn, acid indigestion, smelly gas	Heavy, sluggish, sleepy, nausea, vomiting
Timing of after eating response	2+ hours after eat	1 hour after eat	Immediate
Trigger/problem foods:	_____		

Notes: _____

Digestion:	Vata _____	Pitta _____	Kapha _____
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V P K

Elimination

Frequency of bowel movements	Less than 1 time per day	2 or more times per day	1 time per day
Bowel movement tendency	Constipation	Loose, unformed	Thick, sluggish
Level of comfort of BM	Straining, painful	Burning	Slow
Consistency and color of stool	Dry, pellets, food particles in stool	Bloody stool, unusual color	Oily, mucousy

Notes: _____

Elimination:	Vata _____	Pitta _____	Kapha _____
--------------	------------	-------------	-------------

V P K

Creativity and Sex Drive

Sex drive	Variable or low	Moderate	Strong
Creative Practices (music, art, dance, gardening, etc.)	_____		

Sex Drive:	Vata _____	Pitta _____	Kapha _____
------------	------------	-------------	-------------

V P K

CLIENT NAME: _____

Temperature/Sweating

VATA

PITTA

KAPHA

Body temperature tendency	Cold, variable	Warm	Cool
How much do you sweat?	Hardly at all	Profuse	Medium, profuse
Exertion/heat needed to sweat	Lots	Hardly any	Moderate
Odor of sweat	Hardly any	Potent	Sweet

Notes: _____

Temperature:	Vata _____	Pitta _____	Kapha _____
--------------	------------	-------------	-------------

V P K

Skin

What is the condition of your skin?	Dry, variable	Somewhat oily	Damp
Any skin irritations, rashes, acne, boils, hives, eczema, etc.? Please describe _____			

Notes: _____

Skin:	Vata _____	Pitta _____	Kapha _____
-------	------------	-------------	-------------

V P K

Menstruation / Menopause

Menstruation patterns. If menopausal, please describe patterns while still menstruating.

Regularity	Irregular, variable	Regular	Regular
Quantity of flow	Light, variable	Heavy	Moderate, heavy
Level of menstrual discomfort	Painful	Moderate	Painless

Are you taking HRT (hormone replacement therapy)? yes no *Birth Control?* yes no
Have you had a hysterectomy? yes no Date: _____ *Are you post-menopausal?* yes no

Notes: _____

Menses:	Vata _____	Pitta _____	Kapha _____
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V P K

Sleep

Type of sleep	Light	Medium	Heavy
Ease in falling asleep	Variable, difficult	Medium	Easy
Ease in waking up	Easy	Medium	With difficulty

CLIENT NAME: _____

At this time in your life, which of the following are you most challenged by?

Please indicate Frequency with a letter and Intensity with a number, as follows:

Frequency: R = Rarely M = Monthly W = Weekly D = Daily C = Constantly

Intensity: 1 to 3 = mild 4 to 7 = moderate 8 to 10 = severe

	Fre- quency	Inten- sity		Fre- quency	Inten- sity		Fre- quency	Inten- sity
Worry			Irritability			Depression		
Anxiety			Anger			Lethargy		
Fear			Rage			Resentment		
Over- whelm			Jealousy			Procras- tination		
Spacey			Envy			Greediness		
Indecisive			Self- critical			Sadness		
Poor memory			Critical of others			Over- attachment		
Stress			Intense			Poor mental clarity		
Grief			Sharp tongue					
	Vata			Pitta			Kapha	

Please take a moment and review your answers above. **Please circle anything that is a long-term tendency** (meaning a life-long pattern, or something that has been happening for longer than about 6 months).

Notes: _____

Practitioner's Use:
 R=0; M=1; W=2; D=3; C=4
 1 to 3=1; 4 to 7=2; 8 to 10=3

CLIENT NAME: _____

Financial Policy Agreement

for

SHANTI AYURVEDA

1. There is a \$175 charge for each initial consultation with a Clinical Ayurvedic Specialist (approx. 1½ to 2 hours). This fee is for consultation and information only and does not include any other services or products.
2. There is a \$85 charge for each Follow-Up Visit (approx. one hour) and for the Report of Findings Visit (approx. one hour).
3. There is an additional charge for herbal formulas and other services or products. Fees will be explained to you prior to your purchase. Additional shipping charges may apply. Fees for herbs and products must be paid in advance at the time they are ordered.
4. Fees are due at the time the services are rendered. Shanti Ayurveda does not provide monthly billing.
5. Payment may be made by cash, credit card or check.
6. Shanti Ayurveda does not bill insurance companies for services, herbs or products.
7. If you miss an appointment without giving 24 hours notice, a \$25.00 fee will be charged to your account.

I have read and understood the financial policies outlined above.

Client's Signature: _____ Date: _____

INFORMED CONSENT

to receive Complementary or Alternative Health Care through

SHANTI AYURVEDA

All clients who participate in Ayurvedic health care should be advised of the following information:

1. Ayurveda is the traditional healing system of India, and is based on the idea that each person's path toward optimal health is unique. Your program is based on understanding your unique constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aromatherapy, massage therapy, and other natural therapeutics. The goal of all programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.
2. Shanti Ayurveda is not a Medical Facility.
3. **Employees of Shanti Ayurveda are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.**
4. Marisa Laursen, the principle of Shanti Ayurveda, is a Clinical Ayurvedic Specialist. She is not a Medical Doctor. She is a graduate of the California College of Ayurveda, Grass Valley, CA
5. The National Institute of Health Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the United States. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003. Ayurvedic consultations are considered alternative or complementary to healing arts that are licensed by the State of California.
6. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If you are referred to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.
7. No one in association with Shanti Ayurveda may recommend altering your prescriptions without the approval of your medical doctor. Your practitioner may suggest that you speak to your doctor about reducing medication when he/she feels that it is appropriate.
8. While your practitioner may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, your practitioner is evaluating their findings from an Ayurvedic perspective only and not from a Western medical perspective. **This examination does not take the place of a medical evaluation. If, as a result of their examination, any findings suggestive of a possible medical imbalance is found, your practitioner will refer you to a Medical Doctor for further evaluation.**
9. **Services not offered by Shanti Ayurveda:**
 - a. **Diagnosis of pathological condition**
 - b. **Treatment for pathological conditions**
 - c. **Prescription drugs or medicine**
 - d. **Advice or counseling regarding the diagnosis or treatment of pathological conditions**

I have read the above information and I hereby give my permission to begin a program of Ayurvedic health care with Shanti Ayurveda. (If under 18, must be signed by a parent or legal guardian).

Client's Signature: _____

Date: _____

CLIENT NAME: _____

Page 12

Directions

SHANTI AYURVEDA

14726 Ramona Ave., Suite 410-S10
Chino, California 91710
(909) 896-2004

Shanti Ayurveda is located in the four-story office building between Chino Hills Pkwy and Eucalyptus Ave., across from JC Penny, next to Inland Hills Church (the only four-story office building in the area). Our office is on the 4th floor. Please take the elevator to the 4th floor, take a right upon exiting the elevator, and follow the hallway to the right to Suite S10.

Getting There

From Los Angeles:

Take the 10 Freeway east. Merge onto the 60 Freeway east. Merge onto the 71 Freeway south towards Corona. Exit at Chino Hills Parkway. Turn left, go under the freeway, and take a left onto Ramona Ave. Shanti Ayurveda is on the left in the four-story office building next to Inland Hills Church.

From Pasadena:

Take the 210 Freeway east. Merge onto the 57 Freeway south toward Santa Ana. Merge on the 71 Freeway south toward Corona. Exit at Chino Hills Parkway. Turn left, go under the freeway, and take a left onto Ramona Ave. Shanti Ayurveda is on the left in the four-story office building next to Inland Hills Church.

From Orange County:

Take the 57 Freeway north towards Pomona. Merge onto the 60 Freeway east towards Pomona/Riverside. Merge onto the 71 Freeway south towards Corona. Exit at Chino Hills Parkway. Turn left, go under the freeway, and take a left onto Ramona Ave. Shanti Ayurveda is on the left in the four-story office building next to Inland Hills Church.

From the Inland Empire:

Take the 10, 60, 15, 210 and/or 91 Freeway(s) to the 71 Freeway. If heading north on 71, exit at Ramona Ave./142/Chino Hills Parkway. Take a right on Ramona Ave. Shanti Ayurveda is on the left between Chino Hills Parkway and Eucalyptus Ave. (look for the four-story office building next to Inland Hills Church).

You can also visit  or  for additional maps and directions.

CLIENT NAME: _____

Page 13