ModernHealthClinic

Personalized Program for an Optimum Health

Introductory Patient Information

(adults)

2000 S. Thompson Street, Suite D, Flagstaff, AZ 86001 • 928-607-2789 • anna@modernhealthclinic.org

PRACTICE POLICIES FOR PATIENTS

Our goal at the Modern Health Clinic is to provide you with the highest level of personalized care. We are committed to helping you achieve optimal health. It is important to read all the enclosed information carefully and mail or fax all attached forms to our office at least 7 days prior to your appointment. This will allow us to help solve your problems more efficiently and enhance the quality of your care. If your patient packet is late, it may take up to 30 minutes of your appointment time to review your records.

WEBSITE
Information about Modern Health Clinic and all relevant patient forms are available through our website, www.modernhealthclinic.org

MEDICAL RECORDS
Medical records can only be released with your authorization. A medical records release form is enclosed for your use. You are responsible for obtaining previous medical records from other physicians or health care providers. Please contact your physician or other health care provider to obtain these records. Your records should be mailed or faxed to Modern Health Clinic 2000 South Thompson Street, Suite D, Flagstaff, AZ 86001, Fax:928-271-8002

COPIES OF MEDICAL RECORDS & LABS FROM OUR OFFICE
You will be given a copy of your labs at each visit to keep for your records. [Should you need additional copies of your medical records; a $25 fee will be charged for copies and postage.]

CONSULTATIONS
Your initial visit will include an 80-minute medical consultation with your physician. After Dr. Wolyn's evaluation, a 30 minute consultation with nutritionist is highly recommended. Nutritional therapy and laboratory/diagnostic testing are integral components of your treatment plan. Test results are used to design your personal health care program as well as uncover the root causes of your medical condition. Nutritional supplements are often recommended and we will help you select and find the highest quality products.

LAB TESTS
You will be asked to have your blood drawn the next morning after the initial consultation at LabCorp or Quest Diagnostics. PLEASE ARRIVE FASTING! You can and should drink water during the fast (10-12 hours). Please call your insurance carrier prior to your lab draw to know what your coverage is. Some labs that involve stool, urine or saliva samples are done by you in your own home. You will be given lab kits and step-by-step instructions for at home tests at the time of your consult. You will receive all final lab results and be guided through their interpretation at your follow up visit.

CONSULTATION FEES
- Initial MD consultation 80-minutes: $300
- Nutritional Consultations with Registered Dietitian 30 minutes: $25
- Second MD Office Visit or Phone Follow-up 40-Minutes: $180
- Other MD Office Visit or Phone Follow-up 30-Minutes: $150
- Retainer program available for follow up visits (Optional)
- Pediatric wellness exams (all ages) $150
- Anti-Aging Preventive Wellness Program (full medical consultation with physical examination, full fitness evaluation, full nutritional evaluation with plan and further recommendations) – 5-6 hours $1000

SUPPLEMENTS
All of the supplements that are recommended at Modern Health Clinic are available for purchase in our office. You are ***not obligated*** to purchase supplements from our office or on our website vitamin shop. Supplements may be purchased in our office or mailed directly to you. Please send orders to supplements@modernhealthclinic.org and allow 24 hours for processing.

RETURNS/REFUNDS
Supplements (except for probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase. Functional Lab kits must be done within 1 year of purchase.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS
There is a 48 hours (2 business days) cancellation and rescheduling policy. **Your appointment must be cancelled or rescheduled at least 48 hours (2 business days) prior to your consultation time or you will be charged a cancellation fee, unless we are able to fill your appointment time.** The cancellation fee for a new patient appointment is half the cost of the appointment, the cancellation fee for all other appointments is the full cost of the appointment. You may cancel your appointment by calling the office 928-607-2789 or emailing anna@modernhealthclinic.org.

LATE ARRIVAL APPOINTMENTS
We are committed to being on time with patients' appointments in order to prevent clients from waiting. If you arrive late to the office for your consult your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

FOLLOW UP APPOINTMENTS
At the time of check out you will be scheduled for a follow up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 48 hours/ 2 business days prior to your scheduled appointment.

PAYMENT OPTIONS
Cash, checks or credit cards (MasterCard and Visa) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized and payment is due on the day of service.

Follow-up phone, or in person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account. **Credit card on file will also be used for supplements mailed unless otherwise specified.**

INSURANCE INFORMATION
Medical insurance is not accepted and our office cannot assist you with claim resolution. In addition, Dr. Wolyn is not a Medicare provider. Neither Dr. Wolyn does not submit her medical notes to insurance companies.

OFFICE HOURS
Our office hours are Monday – Thursday, 8:30 am to 4:30 pm CST. If you are going to stop by the office to pick up supplements we ask that you kindly email your order to us at supplements@modernhealthclinic.org prior to your visit. If you need lab kits or anything of that nature please call us at 928-607-2789 or email anna@modernhealthclinic.org.

PHONE CALLS AND MESSAGES
- **Phone messages left will be responded to within 24 hours (during business hours).**
- To reach the office, please call 928-607-2789
- If you call after hours, the office staff will return your call on the next business day.
- **If you have a medical emergency, call 911 or go directly to the nearest ER.**
- When leaving a message, please be brief and include the following information:
  - ✓ Full name, spell your last name, and date of birth
  - ✓ Reason for call
  - ✓ Phone number(s)
  - ✓ E-mail address (if desired)

EMAIL
If you would like to schedule an appointment or cancel an appointment, have lab kit questions or administrative questions, please email anna@modernhealthclinic.org.

If you have a *medical question* for Dr. Wolyn please email her at anna@modernhealthclinic.org. Please note that it can take Dr. Wolyn up to 48 hours to respond to emails.

FREQUENTLY ASKED QUESTIONS

What is your website address?
Information about the practice can be found at modernhealthclinic.org.

How may I purchase supplements?
Dr. Wolyn has extensively researched supplements and recommends only the highest quality of nutritional supplements. All of the supplements that are recommended at Modern Health Clinic are available for purchase in our office or website. You may purchase supplements after each visit or if you need something in the interim you are welcome to come by the office. We do ask that you please email us your order (supplements@modernhealthclinic.org) prior to coming to pick up supplements.

If you live out of town, you may email supplements@modernhealthclinic.org and we will fill your order and mail it to you within 48 hours.

Do you think you can help me with my health problem?
Dr. Wolyn use an innovative systems approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by your doctor, having blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that “all your tests are normal”. Yet, both you and your doctor know that you are sick. Unfortunately, this experience is all too common.

Most physicians are trained to look only in specific places for the answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found in these places. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies and metabolic imbalances. New gene testing can uncover underlying genetic predispositions that can be modified through diet, lifestyle, supplements or medications.

At Modern Health Clinic, on the other hand, we use innovative testing to help patients prevent illness and recover from many chronic and difficult-to-treat conditions. Dr. Wolyn is skilled in evaluating, assessing and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, Irritable Bowel Syndrome (IBS), seasonal allergies, and other chronic, complex conditions. Dr. Wolyn also focuses on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

How will lab tests be performed at Modern Health Clinic?
Some testing can be done through conventional laboratories and others are only available through functional medicine laboratories. During your medical consultation, Dr. Wolyn will determine which tests are needed and review with you testing recommendations, instructions (ex. fasting or non- fasting, etc.) and costs. Some testing requires collecting urine, saliva or stool at home. Others may require you to go to a local laboratory to have blood drawn. In all cases, we will assist you in coordinating initial and follow-up testing.

Do you take insurance?
Modern Health Clinic does not accept insurance or Medicare; we do not file insurance claims on your behalf; nor do we assist with claim resolution. For assistance with your reimbursement you may want to contact your insurance provider. We expect payment in full by check, cash or credit card due at the time services are provided.

What credit cards do you accept?
We accept the following credit cards: MasterCard and Visa. We do not accept American Express. It is important to maintain an active credit card on file with our office for billing of follow-up consultations, laboratory testing, and supplement orders.

Is Dr. Anna Wolyn a primary care physician?
Dr. Wolyn is trained in Functional Medicine, and as a pediatrician and can handle many of your primary care needs, however she requests that you maintain a primary care doctor for an annual physical exam, Pap smear, prostate exam, etc. Dr. Wolyn also does not provide acute care services. She is happy to work with you closely as a consultant and coach in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. Dr. Wolyn is also happy to confer with your primary care doctor if desired.

IMPORTANT PATIENT INFORMATION

CONSULTATIONS
Your initial visit will include an 80-minute medical consultation with your physician. After Dr. Wolyn's evaluation, a 30 minute consultation with nutritionist is highly recommended. Nutritional therapy and laboratory/diagnostic testing are integral components of your treatment plan. Test results are used to design your personal health care program as well as uncover the root causes of your medical condition. Nutritional supplements are often recommended and we will help you select and find the highest quality products.

There is a **48 hour/ 2 business day cancellation policy** (please see cancellation policy in Practice Policies for Patients). We reserve the right to charge your credit card on file for the full amount of the missed visit for a follow up appointment and half the amount for a new patient appointment if it is not canceled or rescheduled 48 hours (2 business days) prior to your appointment. By signing below you agree to our cancelation policy and authorize Anna Wolyn, M.D. to charge your credit card on file for any missed visits.

LAB TESTS
All lab results will be reviewed with you at the time of your follow up appointment. We do not email lab results to patients. The exception to this is if you have a follow up appointment by phone – we will email you your lab results prior to your appointment.

RETURNS/REFUNDS
Supplements (except probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase.

Functional Lab kits must be completed within 1 year of purchase.

RETURN CHECK FEE
A $35 fee will be assessed for all checks returned for insufficient funds

BILLING/INSURANCE
You will receive an invoice at the completion of your visit that you may submit to your insurance for reimbursement. We do not help with insurance claim resolution.

Payment for the office visit, phone consultation, or lab tests is expected at time of service. All credit card payment will be processed the same day of the visit, or phone call.

If test kits or supplements are sent to you, you will be charged the day they are mailed.

Modern Health Clinic does not accept insurance; however, you can submit your patient statement to your insurance carrier.

We will give you instructions for insurance filing, a copy of your bill and all codes necessary for insurance filing. We do not, however aid you in insurance claim resolution or respond to insurance carrier requests for more information.

PRIMARY CARE PHYSICIAN
Please note that Dr. Anna Wolyn, M.D. is NOT your primary care physician. We recommend that you have a primary care physician.

_____ _____

Patient Signature Date

ALL MEDICARE PATIENTS MUST SIGN THIS FORM

NOTICE OF POSSIBLE MEDICARE DENIAL

Medicare will only pay for services determined to be reasonable and necessary under Section 1862 (a) (1) of Medicare Law. If a particular service is considered not acceptable and unnecessary under Medicare standards, Medicare will deny payment for those excluded services.

MEDICARE NOTICE

Dr. Anna Wolyn, M.D. is NOT a Medicare provider; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent by the patient; payment reimbursement is not guaranteed and is subject to Medicare eligibility/reimbursement rules and regulations.

PATIENT ACKNOWLEDGEMENT

My physician, and/or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons stated above.

Signature _____

Print name _____

Date _____

INFORMED CONSENT REGARDING E-MAIL

I have received and read a copy of the Notice of Privacy Practices

I may use e-mail communication

- To request prescription refills
- To request appointments
- To request test results
- To request medical advice
- To share medical information with the doctor
- To discuss billing questions

I agree to comply with the following guidelines

- I will put the category of transaction in the subject line of the message for filtering: Prescription, Appointment, Test Results, Medical Advice, Medical Information, or Billing Questions
- I will put my full name and date of birth in the body of the message
- I will use an auto-reply feature to acknowledge reading the doctor's message
- I will try to keep messages concise

I understand that

- E-mail communication cannot be guaranteed to be entirely secure or confidential
- E-mail communication is not always read in a short time period after it is sent, so the telephone should be used for more 'urgent' communications
- Office staff may process my messages during usual business hours
- Turnaround time for messages received from me during business hours will typically occur with in 1 business day, except when the doctor is out of town or on vacation
- E-mails are printed and retained as a part of my medical record
- When e-mail messages become too lengthy or the correspondence is prolonged, I may be called or notified to come in to discuss the matter
- I may be reminded by the Modern Health Clinic when I do not adhere to the guidelines
- The e-mail relationship may be terminated if I repeatedly do not adhere to the guidelines
- Any liability of harm for any information loss due to technical failures is waived by Modern Health Clinic

Modern Health Clinic agrees

- To provide automatic reply to acknowledge receipt of my messages
- To send new messages to inform me of completion of my request
- Not to send group mailings where recipients are visible to each other. Blind copy features are used
- To have security systems in place, e.g., password-protected screen savers on all desktop workstations in every location that e-mail can be viewed
- E-mails will not be forwarded to any third party without my expressed permission 'D That my e-mail account will never be used in any marketing schemes, nor shared with physician's family members
- That any patient identifiable information, social security numbers or birth dates are only sent via encryption if the communication is wireless

I will receive a copy of this e-mail informed consent and another is included in my medical record

Patient Name _____ Physician Name _____

Patient Signature_____ Physician Signature_____

Date _____ Date _____

INFORMED CONSENT FOR MEDICAL SERVICES

Name: _____ *D.O.B.* _____ *SS#:* _____

Sex: ☐ Male ☐ Female *Marital Status:* ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

City: _____ *State:* _____ *Zip:* _____

Phone: _____ *Cell:* _____

Fax: _____ *Email:* _____

*Where did you hear about us?*_____

PATIENT and Modern health Clinic (PROVIDER) hereby enter into this agreement for provision of medical services specified herein (SERVICES). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge the PATIENT and PROVIDER agree as follows:

1. The PATIENT acknowledges and agrees that this agreement has been entered into before the PROVIDER has provided the SERVICES specified herein to the PATIENT.
2. The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.
3. The PATIENT acknowledges reading and receiving a copy of the Notice of Privacy Practices, and by signing this agreement, the PATIENT authorizes Modern Health Clinic and its representatives to use and share PATIENT health information as described in the Notices of Privacy Practices.
4. The SERVICES provided to the PATIENT may include:
   a. Evaluation of patient medical history, lifestyle, laboratory and other test results;
   b. Physical examination and diagnostic tests;
   c. Medical recommendations and management of the aging processes for disease prevention and healthy aging, which may include: nutrition, nutritional supplementation, exercise, lifestyle behaviors, stress management , hormone replacement therapy, and other interventions as indicated by medical history, physical examination and laboratory parameters.
5. The PATIENT agrees to be fully responsible for cost of the SERVICES. All costs including physician services are to be paid in full by the PATIENT to the PROVIDER at the time services are rendered. PROVIDER cannot assure the PATIENT that their insurance company will reimburse for SERVICES provided.
6. The PATIENT agrees not to submit (or request the PROVIDER to submit on PATIENT'S behalf) a health insurance claim to MEDICARE for the services, even if such services are otherwise covered by MEDICARE.
7. The PATIENT acknowledges that "Medigap plans" (42 V.S.C., section 1882) do not, and other supplemental insurance plans may elect not to, provide reimbursement for the SERVICES not paid for by Medicare, and that no fee limits (including those specified in 42 V.S.C., Section 1395a, 1848g) will apply to the amounts PROVIDERS charge for their SERVICES.
8. The PATIENT acknowledges that PATIENT has the right to have services provided by other PROVIDERS, for whom payment may be made under health insurance plans or MEDICARE,
9. By signing this agreement, the PATIENT acknowledges that PATIENT has read and fully understood the information contained in this agreement. The PATIENT further understands that PATIENT is foregoing his or her right to receive MEDICARE benefits for the SERVICES, but that PATIENT is not forfeiting all health insurance/MEDICARE benefits for other services from other health insurance/MEDICARE providers.
10. **Complete this section only if you are a beneficiary enrolled in Medicare Part B (required to receive medical services:** I am eligible for Medicare benefits and have signed the Medicare Private Contract between modern health Clinic and me: ☐ NO ☐ YES

Patient Signature_____ Date_____

MODERN HEALTH CLINIC SERVICE RETAINER AGREEMENT – OPTIONAL

I authorize payment in the amount of $400.00 to Modern Health Clinic for the following professional services included in this service retainer agreement:

- Duration of contract is for six (6) consecutive months
- Services are limited to:
  - Three (3) scheduled 30 min office consultation or 30 min telephone conferences with the physician, to discuss, monitor and manage matters relating to my progress.
  - Prescriptions refills and management
  - Laboratory test orders and reviews
  - Reasonable access by telephone or email for matters related to my Progress

I understand that this retainer agreement

- Is voluntary
- Excludes the following services or medical care
  - All clinical services not directly a part of my Program
  - Acute, urgent, or emergent medical care
  - Primary medical care services
- Does not involve a third party payer and no claims or itemized statements are created
- Does not alter my current subscriber-health plan relationship
- Can be terminated by either party without cause, with at least 30 days written notice to the other party
- Can be terminated without financial penalty, if terminated with proper notice. Refunds following termination of this agreement will be prorated based upon the percentage of time remaining on the agreement.

I agree to consult with my primary care physician provider for all other medical services, including acute, urgent or emergent medical care during the length of this agreement.

I have signed an e-mail communication informed consent. ☐ No ☐ Yes

I am eligible for Medicare benefits and have signed the Medicare Private Contract between Provider Name and me *(Complete this section only if you are a beneficiary enrolled in Medicare Part B, required to receive medical services):*
☐ No ☐ Yes

I authorize one of the following payment methods:
☐ Check enclosed (made payable to Business Name) Credit Card: ☐ Visa ☐ MasterCard ☐ Discover

Card Number: _____ Expiration Date: _____

Name of Cardholder (as it appears on card): _____

Relationship to Patient: _____

Cardholder Signature (if other than patient): _____ Date: _____

Billing Address: _____

Automatic Contract Renewal Authorization
☐ I agree to the automatic renewal of this Service Retainer Agreement every six (6) months. I have completed the Authorization for Auto-Debit form and I authorize Business Name to process a debit transaction to my credit card for renewal of this contract.

Patient Name_____

Patient Signature_____ Date_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (Important: All blanks MUST be filled in)

Name: _____ *D.O.B.* _____ *SS#:* _____

Sex: ☐ Male ☐ Female *Marital Status:* ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

City: _____ *State:* _____ *Zip:* _____

Phone: _____ *Cell:* _____

Fax: _____ *Email:* _____

I hereby authorize the disclosure of my protected health information form:

*Business Name:*_____ *Provider Name* _____

Address: _____

Phone: _____ *Fax:* _____

Initial all types of information to be disclosed (Mark non applicable):

☐ Any and all records ☐ Chart notes only ☐ Diagnostic reports only ☐ Consultations only ☐ Laboratory results only
☐ Records related only to the following dates of service: _____
☐ Specific records (list):_____

I give special permission to release any information regarding:
(Initial on line(s) below that you grant permission to release the information to the recipient. Mark N/A if non-applicable)

_____ Alcohol and/or drug abuse records protected under 42 Code of Federal Regulations, Part 2
_____ Communicable disease and infection information as defined by statute MCLA333.5131, including venereal disease "VD," tuberculosis "TB," hepatitis B, human immunodeficiency virus "HIV," acquired immunodeficiency syndrome "AIDS," and AIDS related complex "ARC"
_____ Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist

Initial the purposes and needs for such disclosure:
_____ Continuity of care _____ Other (specify) _____

Release of information is to:

Name: _____ *Organization:* _____ *Relationship* _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Phone: _____ *Fax:* _____ *Other:* _____

I understand, as set forth in the above named practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer, except to the extent that the person or organization that is to make the disclosure has already taken action in reliance on my authorization. I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws. I understand the Practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of the same. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. This authorization, unless revoked, expires one year from the Effective Date, as set forth below.

Patient Name: _____

Patient Signature: _____ Effective Date: _____
☐ Patient ☐ Personal Representative (if representative - relationship to patient):

MHC - Health Questionnaire

GENERAL INFORMATION

Name:

first _____ *middle* _____ *last* _____

preferred name _____

date of birth _____ age _____ *sex* ☐ male ☐ female

Genetic Background :

☐ african ☐ asian ☐ ashkenazi ☐ european ☐ native american

☐ mediterranean ☐ middle eastern ☐ other_____

Highest Education Level:

☐ high school ☐ under-graduate ☐ post-graduate

Primary Address:

number, street _____ apt# _____

city _____ state _____ zip _____

Alternate Address:

number, street _____ apt# _____

city _____ state _____ zip _____

Phone / E-mail:

home phone #1 _____ *home phone #2* _____

work phone _____ *cell phone* _____

fax _____ *email* _____

Emergency Contact:

name _____ phone number _____

address _____ apt# _____

city _____ state _____ zip _____

Physician:

name _____ phone _____ fax _____

Referred by:

☐ book ☐ website ☐ media ☐ friend or family member ☐ other _____

PHARMACY INFORMATION

Primary Address: ** It is extremely important that you list the pharmacy's fax number*

name _____ phone number _____

address _____ apt# _____

city _____ state _____ zip _____

email _____ *fax** _____

Compounding/Supplement Pharmacy: ** It is extremely important that you list the pharmacy's fax number*

name _____ phone number _____

address _____ apt# _____

city _____ state _____ zip _____

email _____ *fax** _____

CREDIT CARD INFORMATION

Patient Information:

name _____ *date* _____ *dob* _____

preferred method of payment: ☐ *cash* ☐ *check* ☐ *credit card*

if paying by credit card, we accept: visa, master card, discover

Primary Card:

name on card _____ *card type:* ☐ *visa* ☐ *master card* ☐ *discover*

account number _____ *exp. date* _____ *cvv#* _____

Secondary Card:

name on card _____ *card type:* ☐ *visa* ☐ *master card* ☐ *discover*

account number _____ *exp. date* _____ *cvv#* _____

MHC - Medical Questionnaire

ALLERGIES

Medication / Supplement/Food: _____

_____

_____

Reaction: _____

_____

_____

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us?_____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____

2. _____

3. _____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Please list current and ongoing problems in order of priority:

Describe Problem:	**Mild**	**Moderate**	**Severe**	**Prior Treatment/Approach**	**Excellent**	**Good**	**Fair**
Example: Post Nasal Drip		X		Example: Elimination Diet		X	

MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset. ☒ *= Past Condition* ☒ *= Ongoing Condition*

GASTROINTESTINAL

☐ ☐ Irritable Bowel Syndrome _____
☐ ☐ Inflammatory Bowel Disease _____
☐ ☐ Crohn's _____
☐ ☐ Ulcerative Colitis _____
☐ ☐ Gastritis or Peptic Ulcer Disease _____
☐ ☐ GERD (reflux) _____
☐ ☐ Celiac Disease _____
☐ ☐ Other _____

CARDIOVASCULAR

☐ ☐ Heart Attack _____
☐ ☐ Other Heart Disease _____
☐ ☐ Stroke _____
☐ ☐ Elevated Cholesterol _____
☐ ☐ Arrythmia (irregular heart rate) _____
☐ ☐ Hypertension (high blood pressure) _____
☐ ☐ Rheumatic Fever _____
☐ ☐ Mitral Valve Prolapse _____
☐ ☐ Other _____

METABOLIC/ENDOCRINE

☐ ☐ Type 1 Diabetes _____
☐ ☐ Type 2 Diabetes _____
☐ ☐ Hypoglycemia _____
☐ ☐ Metabolic Syndrome _____
(Insulin Resistance or Pre-Diabetes)
☐ ☐ Hypothyroidism (low thyroid) _____
☐ ☐ Hyperthyroidism (overactive thyroid)_____
☐ ☐ Endocrine Problems _____
☐ ☐ Polycystic Ovarian Syndrome (PCOS) _____
☐ ☐ Infertility_____
☐ ☐ Weight Gain_____
☐ ☐ Weight Loss _____
☐ ☐ Frequent Weight Fluctuations_____
☐ ☐ Bulimia _____
☐ ☐ Anorexia _____
☐ ☐ Binge Eating Disorder_____
☐ ☐ Night Eating Syndrome_____
☐ ☐ Eating Disorder (non-specific _____
☐ ☐ Other _____

CANCER

☐ ☐ Lung Cancer _____
☐ ☐ Breast Cancer _____
☐ ☐ Colon Cancer _____
☐ ☐ Ovarian Cancer _____
☐ ☐ Prostate Cancer _____
☐ ☐ Skin Cancer _____

GENITAL AND URINARY SYSTEMS

☐ ☐ Kidney Stones _____
☐ ☐ Gout _____
☐ ☐ Interstitial Cystitis _____
☐ ☐ Frequent Urinary Tract Infections _____
☐ ☐ Frequent Yeast Infections _____
☐ ☐ Erectile or Sexual Dysfunction _____
☐ ☐ Other _____

MUSCULOSKELETAL/PAIN

☐ ☐ Osteoarthritis _____
☐ ☐ Fibromyalgia _____
☐ ☐ Chronic Pain _____
☐ ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

☐ ☐ Chronic Fatigue Syndrome _____
☐ ☐ Autoimmune Disease _____
☐ ☐ Rheumatoid Arthritis _____
☐ ☐ Lupus SLE _____
☐ ☐ Immune Deficiency Disease _____
☐ ☐ Herpes-Genital _____
☐ ☐ Severe Infectious Disease _____
☐ ☐ Poor Immune Function _____
(frequent infections)
☐ ☐ Food Allergies _____
☐ ☐ Environmental Allergies _____
☐ ☐ Multiple Chemical Sensitivities _____
☐ ☐ Latex Allergy _____
☐ ☐ Other _____

RESPIRATORY DISEASES

☐ ☐ Asthma_____
☐ ☐ Chronic Sinusitis _____
☐ ☐ Bronchitis_____
☐ ☐ Emphysema _____
☐ ☐ Pneumonia _____
☐ ☐ Tuberculosis _____
☐ ☐ Sleep Apnea _____
☐ ☐ Other _____

SKIN DISEASES

☐ ☐ Eczema _____
☐ ☐ Psoriasis _____
☐ ☐ Acne _____
☐ ☐ Melanoma_____
☐ ☐ Skin Cancer _____
☐ ☐ Other _____

NEUROLOGIC/MOOD

☐ ☐ Depression _____
☐ ☐ Anxiety _____
☐ ☐ Bipolar Disorder _____
☐ ☐ Schizophrenia _____
☐ ☐ Headaches _____
☐ ☐ Migraines _____
☐ ☐ ADD/ADHD_____
☐ ☐ Autism _____
☐ ☐ Mild Cognitive Impairment _____
☐ ☐ Memory Problems _____
☐ ☐ Parkinson's Disease _____
☐ ☐ Multiple Sclerosis _____
☐ ☐ ALS _____
☐ ☐ Seizures_____
☐ ☐ Other Neurological Problems _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

☐ ☐ Full Physical Exam _____
☐ ☐ Bone Density _____
☐ ☐ Colonoscopy _____
☐ ☐ Cardiac Stress Test_____
☐ ☐ EBT Heart Scan _____
☐ ☐ EKG _____
☐ ☐ Hemoccult Test-stool test for blood _____
☐ ☐ MRI _____
☐ ☐ CT Scan _____
☐ ☐ Upper Endoscopy _____
☐ ☐ Upper GI Series _____
☐ ☐ Ultrasound _____

SURGERIES

Check box if yes and provide date of surgery

☐ ☐ Appendectomy _____
☐ ☐ Hysterectomy +/- Ovaries _____
☐ ☐ Gall Bladder _____
☐ ☐ Hernia _____
☐ ☐ Tonsillectomy _____
☐ ☐ Dental Surgery _____
☐ ☐ Joint Replacement –Knee/Hip _____
☐ ☐ Heart Surgery–Bypass Valve _____
☐ ☐ Angioplasty or Stent _____
☐ ☐ Pacemaker _____
☐ ☐ Other _____
☐ ☐ None _____

INJURIES

Check box if yes:

☐ Back Injury ☐ Head Injury ☐ Neck Injury
☐ Broken Bones ☐ Other _____

BLOODTYPE

☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ Unknown

HOSPITALIZATIONS ☐ None

Date	Reason

COMMENTS

_____

_____

_____

GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY (Check box if yes and provide number)

☐ Pregnancies _____ ☐ Caesarean _____ ☐ Vaginal deliveries _____
☐ Miscarriage _____ ☐ Abortion _____ ☐ Living Children _____
☐ Post PartumDepression ☐ Toxemia ☐ Gestational Diabetes
☐ Baby Over 8 Pounds ☐ Breast Feeding For how long? _____

MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length:_____ Pain: ☐Yes ☐No Clotting: ☐Yes ☐No
Has your period ever skipped?_____ For how long?_____ Last Menstrual Period:_____
Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?_____
Do you use contraception? ☐ Yes ☐ No – ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Painful Periods ☐ Heavy periods ☐ PMS
Last Mammogram:_____ Breast Biopsy/Date:_____ Last PAP Test:_____ ☐ Normal ☐ Abnormal
Last Bone Density:_____ Results: ☐ High ☐ Low ☐ Within Normal Range
Are you in menopause? ☐ Yes ☐ No – Age at Menopause_____
☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido
☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations
☐ Use of hormone replacement therapy How long?_____

MEN'S HISTORY (for men only)

Have you had a PSA done? ☐ Yes ☐ No
PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10
☐ Prostate Enlargement
☐ Prostate infection
☐ Change in Libido
☐ Impotence
☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection
☐ Nocturia (urination at night) How many times at night? _____
☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel? ☐ Yes ☐ No – Where? _____
Wilderness Camping? ☐ Yes ☐ No – Where? _____
Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea
Do you feel like you digest your food well? ☐ Yes ☐ No
Do you feel bloated after meals? ☐ Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature
Pregnancy Complications: _____
Birth Complications: _____
☐ Breast Fed. How long? _____ ☐ Bottle-fed
Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____
Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No

DENTAL HISTORY

☐ Silver Mercury Fillings How many? _____
☐ Gold Fillings
☐ Root Canals How many? _____
☐ Implants
☐ Tooth Pain
☐ Bleeding Gums
☐ Gingivitis
☐ Problems with Chewing
Do you floss regularly? ☐ Yes ☐ No

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS *(last 10 years)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS *(Vitamins/Minerals/Herbs/Homeopathy)*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe: _____
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No
Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No
Frequent antibiotics > 3 times/year ☐ Yes ☐ No
Long term antibiotics ☐ Yes ☐ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No
Use of oral contraceptives ☐ Yes ☐ No

FAMILY HISTORY

Check family members that apply.	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Thyroid Problems												
Lupus												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse *(such as alcoholism)*												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Other												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐ Yes ☐ No
Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No Describe: _____
Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic
☐ No Dairy ☐ No Wheat ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan
☐ Specific Program for Weight Loss/Maintenance Type: _____ ☐ Other _____

Height (feet/inches) _____ Current Weight _____ Usual Weight Range +/- 5 lbs _____
Desired Weight Range +/- 5 lbs _____ Highest adult weight _____ Lowest adult weight _____
Weight Fluctuations (> 10 lbs.) ☐ Yes ☐ No Body Fat% _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No – If yes, what was it? _____
Do you avoid any particular foods? ☐ Yes ☐ No – If yes, types and reason _____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? ☐ Yes ☐ No – If no, who does the shopping? _____
Do you read food labels? ☐ Yes ☐ No _____
Do you cook? ☐ Yes ☐ No If no, who does the cooking? _____
How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: _____

_____

_____

_____

_____

_____

SMOKING

Currently Smoking? ☐ Yes ☐ No – How many years? _____ Packs per day: _____
Attempts to quit: _____ Previous Smoking: How many years? _____ Packs per day? _____
Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)
☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10 If "None," skip to Other Substances
Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None
Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No
Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No
Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No
Do you ever take an eye-opener? ☐ Yes ☐ No
Do you notice a tolerance to alcohol (can you "hold" more than others)? ☐ Yes ☐ No
Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No
Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No
Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No
Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

Caffeine Intake: ☐ Yes ☐ No – Coffee cups/day: ☐ 1 ☐ 2-4 ☐ > 4 – Tea cups/day: ☐ 1 ☐ 2-4 ☐ > 4
Caffeinated Sodas or Diet Sodas Intake: ☐ Yes ☐ No
12-ounce can/bottle ☐ 1 ☐ 2-4 ☐ > 4 per day
List favorite type (Ex. Diet Coke, Pepsi, etc.): _____
Are you currently using any recreational drugs? ☐ Yes ☐ No Type_____
Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

EXERCISE
Current Exercise Program: (List type of activity, number of sessions/week, and duration)

Activity	**Type**	**Frequency Per Week**	**Duration In Minutes**
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High
List problems that limit activity: _____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No
If yes, please describe: _____

_____

Do you usually sweat when exercising? ☐ Yes ☐ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No
Are you happy? ☐ Yes ☐ No
Do you feel your life has meaning and purpose? ☐ Yes ☐ No
Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No
Do you like the work you do? ☐ Yes ☐ No
Have you ever experienced major losses in your life? ☐ Yes ☐ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No
Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

STRESS/COPING

Have you ever sought counseling? ☐ Yes ☐ No
Are you currently in therapy? ☐ Yes ☐ No – Describe: _____
Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No
Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No
Daily Stressors: Rate on scale of 1-10 Work _____ Family _____ Social _____ Finances _____ Health _____ Other_____
Do you practice meditation or relaxation techniques? ☐ Yes ☐ No How often? _____
Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: _____
Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

SLEEP/REST

Average number of hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ < 6
Do you have trouble falling asleep? ☐ Yes ☐ No
Do you feel rested upon awakening? ☐ Yes ☐ No
Do you have problems with insomnia? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Do you use sleeping aids? ☐ Yes ☐ No – Explain: _____

ROLES/RELATIONSHIP

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long Term Partnership ☐ Widow

List Children

Child's Name	**Age**	**Gender**

Who is Living in Household? Number: _____
Names:_____
Their employment/Occupations:_____
Resources for emotional support? *Check all that apply:*
☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____
Are you satisfied with your sex life? ☐ Yes ☐ No

How Well Have Things Been Going For You?	**Very Well**	**Fine**	**Poorly**	**Does Not Apply**
Overall				
At School				
In your job				
In your social life				
With your friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No
If yes, describe symptoms: _____

_____

Do you have any food allergies or sensitivities? ☐ Yes ☐ No
If yes, list all: _____

_____

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No
When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches & Pains

Do you adversely react to *(Check all that apply)*:
☐ Monosodium glutamate (MSG) ☐ Aspartame (Nutrasweet) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion ☐ Cheese
☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine ☐ Sulfite Containing Foods (wine, dried fruit, salad bars)
☐ Preservatives (ex. sodium benzoate) ☐ Other: _____

_____

Which of these significantly affect you? *(Check all that apply)*:
☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: _____

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No
Have you ever been told you have Gilbert's syndrome or a liver disorder? ☐ Yes ☐ No – Explain: _____

_____

Do you have a known history of significant exposure to any harmful chemicals such as the following:
☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides £Organic Solvents ☐ Heavy Metals
☐ Other _____
Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

SYMPTOM REVIEW

(Please check all current symptoms or those present in during the past the 6 months)

GENERAL
- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS
- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL
- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness

Muscle Twitches:
- ☐ Around Eyes
- ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

***Difficulty*:**
- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory

- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pastas)
- ☐ Sweet Cravings (candy, cookies, cakes)
  - ☐ Chocolate Cravings
  - ☐ Caffeine Dependency

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums

Bloating of:
- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals

- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea & Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:
- ☐ Lactose
- ☐ All Dairy Products
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in St

SKIN PROBLEMS
- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness

- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN
- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF
- ☐ Eyes
- ☐ Feet
  - ☐ Cracking?
  - ☐ Peeling?
- ☐ Hair
- ☐ Unmanageable?
- ☐ Hands
  - ☐ Cracking?
  - ☐ Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Dandruff?
- ☐ Skin In General

LYMPH NODES
- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:
- ☐ Fingernails
- ☐ Toenails
- ☐ White Spots/Lines

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever:
- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change Of Season

- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY
- ☐ Bed Wetting
- ☐ Hesitancy
  (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE
- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:
- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):
In order to improve your health, how willing are you to:
Significantly modify your diet ..... ☐5 ☐4 ☐3 ☐2 ☐1
Take several nutritional supplements each day ..... ☐5 ☐4 ☐3 ☐2 ☐1
Keep a record of everything you eat each day ..... ☐5 ☐4 ☐3 ☐2 ☐1
Modify your lifestyle (e.g., work demands, sleep habits) ..... ☐5 ☐4 ☐3 ☐2 ☐1
Practice a relaxation technique ..... ☐5 ☐4 ☐3 ☐2 ☐1
Engage in regular exercise ..... ☐5 ☐4 ☐3 ☐2 ☐1
Have periodic lab tests to assess your progress ..... ☐5 ☐4 ☐3 ☐2 ☐1

Comments _____

_____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):
How confident are you of your ability to organize and follow through on the above health related activities?
☐5 ☐4 ☐3 ☐2 ☐1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?_____

_____

_____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):
At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ☐5 ☐4 ☐3 ☐2 ☐1

Comments: _____

_____

_____

_____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):
How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐5 ☐4 ☐3 ☐2 ☐1

Comments: _____

_____

_____

_____

3-DAY DIET DIARY INSTRUCTIONS

PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. DO NOT WAIT AND BRING WITH YOU TO THE APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan.

Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and 1⁄2 & 1⁄2).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1⁄2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name: _____ Date: _____

DAY 1

Time	Food / Beverage / Amount	Comments

Bowel Movements (#, form,color): _____
Stress/Mood/Emotions: _____
OtherComments: _____

DAY 2

Time	Food / Beverage / Amount	Comments

Bowel Movements (#, form,color): _____
Stress/Mood/Emotions: _____
OtherComments: _____

DAY 3

Time	Food / Beverage / Amount	Comments

Bowel Movements (#, form,color): _____
Stress/Mood/Emotions: _____
OtherComments: _____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for ONLY the last 48 hours.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

DIGESTIVE TRACT
___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain
Total _____

EARS
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
Total _____

EMOTIONS
___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression
Total _____

ENERGY/ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
Total _____

EYES
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)
Total _____

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
Total _____

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
Total _____

JOINTS/MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
Total _____

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing
Total _____

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities
Total _____

MOUTH/THROAT
___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores
Total _____

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
Total _____

SKIN
___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating
Total _____

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
Total _____

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
Total _____

GRAND TOTAL: _____

SPACE FOR ADDITIONAL NOTES