

ModernHealthClinic
Personalized Program for an Optimum Health

live
younger



Introductory Patient Information (pediatric)

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 cancellation 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 within 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 _____

Parent Names (person(s) completing this questionnaire):

mother's name _____ occupation _____

father's name _____ occupation _____

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# _____

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 Disease _____
- Elevated Cholesterol _____
- 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) _____
- Weight Gain _____
- Weight Loss _____
- Frequent Weight Fluctuations _____
- Bulimia _____
- Anorexia _____
- Binge Eating Disorder _____
- Night Eating Syndrome _____
- Eating Disorder (non-specific) _____
- Other _____

CANCER

- _____

GENITAL AND URINARY SYSTEMS

- Kidney Stones _____
- Urinary Tract Infections _____
- Yeast Infections _____
- Other _____

MUSCULOSKELETAL/PAIN

- Arthritis _____
- Fibromyalgia _____
- Chronic Pain _____
- Other _____

INFLAMMATORY/AUTOIMMUNE

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

RESPIRATORY DISEASES

- Frequent Ear Infections _____
- Frequent Upper Respiratory Infections _____
- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Sleep Apnea _____
- Other _____

SKIN DISEASES

- Eczema _____
- Psoriasis _____
- Acne _____
- Other _____

NEUROLOGIC/MOOD

- Depression _____
- Anxiety _____
- Bipolar Disorder _____
- Schizophrenia _____
- Headaches _____
- Migraines _____
- ADD/ADHD _____
- Sensory Integrative Disorder _____
- Autism _____
- Mild Cognitive Impairment _____
- ALS _____
- Seizures _____
- Arthritis _____
- Other Neurological Problems _____

IMMUNIZATIONS

Is your child up to date with immunizations? Yes No
Do you feel immunizations have had an impact on your child's health? Yes No
If relevant, attach a copy of your child's immunization record or see addendum.

PSYCHOSOCIAL

Has your child experienced any major life changes that may have impacted his/her health? Yes No
Has your child ever experienced any major losses? Yes No

STRESS/COPING

Have you ever sought counseling for your child? Yes No
Is your child or family currently in therapy? Yes No Describe: _____
Does your child have a favorite toy or object? Yes No
Check all that apply: Yoga Meditation Imagery Breathing Tai Chi Prayer Other: _____
Has your child ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

SLEEP/REST

Average number of hours your child sleeps at night: >12 10-12 8-10 <8
Does your child have trouble falling asleep? Yes No
Does your child feel rested upon awakening? Yes No
Does your child snore? Yes No

ROLES/RELATIONSHIP (List Family Members):

Family Member and Relationship	Age	Gender

Who are the main people who care for your child? _____
Their Employment/Occupation: _____
Resources for emotional support?
Check all that apply: Spouse Family Friends Religious/Spiritual Pets Other: _____

GYNECOLOGIC HISTORY (for women only)

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

GI HISTORY

Has your child traveled to foreign countries? Yes No – Where? _____
Wilderness Camping? Yes No – Where? _____
Have you ever had severe: Gastroenteritis Diarrhea

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

PATIENT BIRTH HISTORY

MOTHER'S PAST PREGNANCIES

Number of: Pregnancies _____ Live births: _____ Miscarriages: _____

MOTHER'S PREGNANCY

(Check box if yes and provide date)

- Difficulty getting pregnant(more than 6 months) _____
- Infertility drugs used Specify: _____
- In vitro fertilization _____
- Drink alcohol _____
- Smoke tobacco _____
- Take Progesterone _____
- Take prenatal vitamins _____
- Take antibiotics During Labor? _____
- Take other drugs Specify: _____
- Excessive vomiting, nausea (more than 3 weeks) _____
- Have a viral infection _____
- Have a yeast infection _____
- Have amalgam fillings put in teeth _____
- Have amalgam fillings removed from teeth _____
- Number of fillings in teeth when pregnant? _____
- Have bleeding (which months?) _____
- Have birth problems _____
- Group B strep infection _____
- Have c-section because of _____
- Use induction for labor (such as Pitocin) _____
- Have anaesthesia – what was used? _____
- Use oxygen during labor _____
- Have Rhogam, if so how many shots _____
- How many when pregnant? _____
- Gestational Diabetes _____
- High blood pressure(pre-eclampsia) _____
- High blood pressure/toxemia _____
- Have chemical exposure _____
- Father have chemical exposure _____
- Move to newly built house _____
- House painted indoors _____
- House painted outdoors _____
- House exterminated for insects _____

PREGNANCY

Total weight gain during pregnancy: _____lb Total weight loss during pregnancy: _____lb

Please describe diet during pregnancy:

Please describe labor:

PERINATAL

Pregnancy duration: *X* following the week of gestation

- 24 25 26 27 28 29
- 30 31 32 33 34 35
- 36 37 38 39 40 (full term)
- 41 42 43 44 Weeks

- Very active before birth? Yes No
- Hospital/Birthing Center? Yes No
- Needed Newborn Special Care? Yes No
- Appeared healthy? Yes No
- Easily consoled during first month? Yes No
- Antibiotics first month? Yes No
- Experienced no complications first month of life? Yes No

BIRTH WEIGHT AND APGAR

Weight at birth: _____lbs Apgar score at one minute: _____ Apgar score at 5 mins: _____

EARLY CHILDHOOD ILLNESSES

Number of earaches in the first two years: _____

Number of other infections in the first two years: _____

Number of times you had antibiotics in the first two years of life: _____

Number of courses of prophylactic antibiotics in first 2 years of life: _____

First antibiotic at _____ months.

First illness at _____ months.

DESCRIPTION OF DEVELOPMENTAL PROBLEMS

If your child has developmental problems, at what age did they occur?

0-1 months 2-6 months 6-15 months 16-24 months After 24 months

Is this impression shared among parents and others caring for the child? Yes No

Does this impression, as the timing of onset, differ among parents and others caring for the child? Yes No

Is the impression, as to the timing of onset, weak? Yes No

Or is this impression strong? Yes No

DEVELOPMENTAL HISTORY

Please indicate the approximate age in months for the following milestones(example: walking 14 months):

Sitting up _____ months Never

Crawl _____ months Never

Pulled to stand _____ months Never

Potty trained _____ months Never

Walked alone _____ months Never

Dry at night _____ months Never

First words ("mama, dada" etc) _____ months Never

Spoke clearly _____ months Never

Lost language _____ months Never

Lost eye contact _____ months Never

SOCIAL HISTORY

NUTRITION HISTORY

Has your child ever had a nutrition consultation? Yes No

Have you made any changes in your child's diet because of health problems? Yes No Describe: _____

Does your child follow a special diet or nutritional program? Yes No

Check all that apply:

- Yeast Free Feingold Weight Management Diabetic Dairy Free Wheat Free Ketogenic
- Specific Carbohydrate Gluten Free/Casein Free Gluten Restricted Vegetarian Vegan Low Oxalate
- Food Allergy (Ex. Peanuts, Eggs, etc.): _____

Height (feet/inches) _____ Current Weight _____ Longest Weight Fluctuations Yes No

Does your child avoid any particular foods? Yes No – If yes, types and reason? _____

If your child could eat only a few foods daily, what would they be? _____

Who does the shopping in your household? _____

Who does the cooking in your household? _____

How many meals does your child 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:

- | | |
|---|---|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Every meal is a struggle |
| <input type="checkbox"/> Erratic eating pattern | <input type="checkbox"/> Most family meals together |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Use food as a bribe or reward |
| <input type="checkbox"/> Dislike healthy food | <input type="checkbox"/> Erratic mealtimes |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Most meals eaten at the table |
| <input type="checkbox"/> Eat more than 50% meals away from home | <input type="checkbox"/> High juice intake |
| <input type="checkbox"/> Poor snack choices | <input type="checkbox"/> Low fruit/vegetable intake |
| <input type="checkbox"/> Sensory issues with food | <input type="checkbox"/> High sugar/sweet intake |
| <input type="checkbox"/> Picky eater | <input type="checkbox"/> Gestational Diabetes _____ |
| <input type="checkbox"/> Limited variety of foods < 5/day | <input type="checkbox"/> High blood pressure(pre-eclampsia) _____ |
| <input type="checkbox"/> Prefers cold food | <input type="checkbox"/> High blood pressure/toxemia _____ |
| <input type="checkbox"/> Prefers hot food | <input type="checkbox"/> Have chemical exposure _____ |

BREASTFED HISTORY

Breastfed? Yes No

Introduction of cow's milk at _____ months.

First foods introduced at _____ months.

Choke/ Gas/ Vomit on milk? Yes No

List mother's known food allergies or sensitivities: _____

Type of formula: Soy Cow's Milk Low Allergy

Introduction of solid foods at _____ months.

Introduction of wheat or other grain at _____ months.

Refused to chew solids? Yes No

Please describe any other eating concerns you have regarded with your child: _____

EXERCISE & ACTIVITY

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

Activity	Type	Frequency Per Week	Duration In Minutes

How much time does your child spend watching TV? _____

How much time does your child spend on the computer or playing video games? _____

ENVIRONMENTAL HISTORY

Please check appropriate box = Past = Current

EXPOSURES

- | | |
|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Mold in bathroom | <input type="checkbox"/> <input type="checkbox"/> Mold in cellar, crawl space, or basement |
| <input type="checkbox"/> <input type="checkbox"/> Damp cellar | <input type="checkbox"/> <input type="checkbox"/> Moldy, musty school/daycare |
| <input type="checkbox"/> <input type="checkbox"/> Pest extermination – Inside | <input type="checkbox"/> <input type="checkbox"/> Tobacco smoke |
| <input type="checkbox"/> <input type="checkbox"/> Pest extermination – Outside | <input type="checkbox"/> <input type="checkbox"/> Well water |
| <input type="checkbox"/> <input type="checkbox"/> Forced hot air heat | <input type="checkbox"/> <input type="checkbox"/> Carpet in bedroom |
| <input type="checkbox"/> <input type="checkbox"/> Had water in basement | <input type="checkbox"/> <input type="checkbox"/> Carpet in most parts of the house |
| <input type="checkbox"/> <input type="checkbox"/> Mold visible on exterior of house | <input type="checkbox"/> <input type="checkbox"/> Feather or down bedding |
| <input type="checkbox"/> <input type="checkbox"/> Heavily wooded or damp surroundings | |

SOME THINGS ABOUT YOUR PARENTS

When were your parents married? _____ If separated, when? _____

If divorced, when? _____ If remarried, when? _____

Custody arrangements: _____

MOTHER – PERSONAL

Age at your birth _____

Education _____

Ethnicity _____

Blood type _____

FATHER – PERSONAL

Age at your birth _____

Education _____

Ethnicity _____

Blood type _____

SYMPTOM REVIEW

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

STRENGTHS

- Especially attractive
- Accepts new clothes
- Cuddly
- Physically coordinated
- Happy
- Pleasant/ easy to care for
- Sensitive/ affectionate
- Wants to be liked
- Responsible
- Draws accurate pictures
- Sensitive to people's feelings
- Okay if parents leave
- Answers parent
- Follows instructions
- Pronounces words well
- Good with math
- Good with computers
- Good with fine work
- Good throwing and catching
- Good climbing
- Strong desire to do things
- Swimming
- Bold, free of fear
- Likes to be held
- Like to be swaddled

SLEEP

- Sleeps in own bed
- Sleeps with parent(s)
- Awakens screaming/ crying
- Awakes at night
- Difficulty falling asleep
- Early waking
- Insomnia
- Sleeps less than normal
- Daytime sleepiness
- Jerks during sleep
- Nightmares
- Sleeps more than normal

PHYSICAL

- Looks sick
- Glazed look
- Overweight
- Underweight
- Pupils usually large
- Unusually long eyelashes
- Pupils unusually small
- Dark circles under eyes
- Red lips
- Red fingers
- Red toes
- Webbed toes
- Red ears

- Double jointed
- Lymph nodes enlarged in neck
- Head warms
- Head sweats
- Night sweats
- Abnormal fatigue
- Failure to thrive
- Cold all over
- Cold hands and feet
- Cold intolerance
- Hands/ feet – very sweaty
- Perspiration – odd odor

SKIN

- Paleness, severe
- Fungus/ fingernails
- Fungus/ toenails
- Dandruff
- Chicken skin
- Oily skin
- Patchy dullness
- Seborrhea on face
- Thick calluses
- Athletes foot
- Feet – stinky
- Diaper rash
- Odd body odor
- Strong body odor
- Acne
- Dark circles under eyes
- Ears get red
- Eczema
- Flushing
- Red face
- Sensitive to insect bites
- Stretch marks
- Blotchy skin
- Bugs love to bite you
- Cradle cap
- Dry hair
- Dry scalp
- Hair unmanageable
- Bites nails
- Nails brittle
- Nails frayed
- Nails pitted
- Nails soft
- Skin pale
- Dark birth mark(s)
- Easy bruising
- Inability to tan
- Light birth mark(s)
- Ragged cuticles
- Thickening fingernails
- Thickening toenails
- Vitiligo

- White spots of lines in nails
- Dry skin in general
- Feet cracking
- Hand peeling
- Lower legs dry
- Skin lackluster
- Itchy skin in general
- Itchy scalp
- Itchy ear canals
- Itchy eyes
- Itchy nose
- Itchy roof of mouth
- Itchy arms
- Itchy hands
- Itchy feet
- Itchy anus
- Itchy penis
- Itchy vagina

DIGESTIVE

- Breath bad
- Increased salivation
- Drooling
- Cracking lip corners
- Cold sores on lips, face
- Geographic tongue (map-like)
- Sore tongue
- Tongue coated
- Canker sores in mouth
- Gums bleed
- Teeth grinding
- Tooth cavities
- Tooth with amalgam fillings
- Mouth thrush (yeast infection)
- Sore throat
- Fecal belching
- Burping
- Nausea
- Reflux
- Spitting up
- Vomiting
- Abdominal bloating
- Lower abdominal bloating
- Colic
- Abdomen distended
- Abdominal pain
- Intestinal parasites
- Pinworms
- Cramping pain with pooping
- Constipation
- Diarrhea
- Farting – regular
- Farting – stinky
- Anal fissures
- Red ring around anus

- Stools bulky
- Stools light color
- Stools very stinky
- Stools with blood
- Stools with mucous
- Stools with undigested food
- Flatulence
- Stool odor foul
- Stool odor yeasty
- Stools pale
- Stools slimy
- Stools watery

EATING

- Poor appetite
- Thirst
- Extreme water drinking
- Bingeing
- Bread craving
- Craving for carbohydrates
- Craving for juice
- Craving for salt
- Diet soda craving
- Pica (eating non-edibles)
- Abnormal food cravings
- Carbohydrate intolerance
- Starch/ disaccharide intolerance
- Sugar intolerance
- Salicylate intolerance
- Oxalate intolerance
- Phenolics intolerance
- MSG intolerance
- Food coloring intolerance
- Gluten intolerance
- Casein intolerance
- Specific food(s) intolerance
- Lactose intolerance
- Behavior worse with food
- Behavior better when fasting

BEHAVIOR

- Behavior purposeless
- Unusual play
- Uses adults hand for activity
- Aloof, indifferent, remote
- Doesn't do for self
- Extremely cautious
- Hides skill/ knowledge
- Lacks initiative
- Lost in thought, unreachable
- No purpose to play
- Poor focus, attention
- Sits long time staring
- Uninterested in live pet
- Watches TV for a long time
- Won't attempt/ can't do
- Poor sharing
- Rejects help
- Curious/ gets into things

- Erratic
- Unable to predict actions
- Destructive
- Hyperactive
- Constant movement
- Melts down
- Tantrums
- Self mutilation
- Runs away
- Jumps when pleased
- Whirls self like a top
- Climbs to high places
- Insists on what wanted
- Tries to control others
- Head banging
- Falls, gets hurt running climbing
- Does opposite of asked
- Silly
- Shrieks
- Holds hands in strange pose
- Spends time with pointless task
- Stares at own hands
- Toe walking
- Arched back with bright lights
- Imitates others
- Finger flicking
- Flaps hands
- Licking
- Likes spinning objects
- Likes to flick finger in eye
- Likes to spin things
- Rhythmic rocking
- Slapping books
- Tooth tapping
- Visual stims
- Wiggle finger front of face
- Wiggle finger side of face
- Bites or chews fingers
- Bites wrist or back of hands
- Chews on things

MOOD

- Apathy
- Blank look
- Depression
- Detached
- Disinterest
- Eye contact poor
- Isolates
- Negative fright without cause
- Always frightened
- Anguish
- Disconnected
- Does not want to be touched
- Inconsolable crying
- Irritable
- Looks like in pain
- Moaning, groaning
- Phobias

- Restless
- Severe mood swings
- Unhappy
- Agitated
- Anxious

SENSORY

- Bothered by certain sounds
- Covers ears with sound
- Ear pain
- Ear ringing
- Hearing acute
- Hearing loss
- Likes certain sounds
- Sensitive to loud noise
- Sounds seem painful
- Tinnitus
- Acute sense of smell
- Examines by smell
- Intensely aware of odors
- Blinking
- Bother by bright lights
- Distorted vision
- Conjunctivitis
- Eye crusting
- Eye problem
- Lid margin redness
- Examines by sight
- Fails to blink at bright light
- Likes fans
- Likes flickering lights
- Looks out of the corner of eye
- Poor vision
- Puts eye to bright light or sun
- Strabismus (crossed eye)
- Fearful of harmless object
- Fearful of unusual events
- Unaware of danger
- Unaware of peoples' feelings
- Unaware of self as person
- Upset if things change
- Upset if things aren't right
- Adopts complicated rituals
- Car, truck, train obsession
- Collects particular things
- Draws only certain things
- Fixated on one topic
- Lines objects precisely
- Repeats old phrases
- Repetitive play/ objects
- Finger tip squeezing
- Hates wearing shoes
- Insensitive to pain
- Likes head burrowed
- Likes head pressed hard
- Likes head rubbed
- Likes head under blanket
- Likes to be help upside down

- Likes to be swung in the air
- Very insensitive to pain
- Very sensitive to pain

NEUROMUSCULAR

- Clumsiness
- Coordination
- Fine motor poor
- Gross motor poor
- Holds bizarre posture
- Hyperactivity
- Physically awkward
- Rocking
- Stiffens body when held
- Calf cramps
- Foot cramps
- Muscle pain
- Muscle tone tense
- Muscle twitches
- Fist clenching
- Jaw clenching
- Poor muscle tone/ limp
- Tics
- Muscle tone low trunk
- Muscle weakness, atrophy
- Muscle tone low all over
- Tremors
- Cognitive delays
- Memory poor
- Poor attention, focus
- Slow and sluggish
- Expressive language delay

SPEECH

- Never spoke
- Occasional words when excited
- Expressive language poor
- No answers simple questions
- Points to objects/ can't name
- Speech apraxia
- Does not ask questions
- Babbling
- Asks using "you" not "I"
- Answers by repeating question
- Receptive language poor
- Says "I"
- Says "no"
- Says "yes"
- Lost language at 12-24 months
- Lost language after 24 months
- Scripting
- Stuttering
- Talks to self
- Poor auditory processing
- Unusual sound of cry
- Uses one word for another
- Rigid behaviors
- Poor confidence
- Timid
- Corrects imperfections

RESPIRATORY

- Pneumonia
- Bad odor in nose
- Breath holding
- Bronchitis
- Congestion change with season
- Congestion in the fall
- Congestion in the spring

- Congestion in the summer
- Congestion in the winter
- Cough
- Post nasal drip
- Runny nose
- Sighing
- Sinus fullness
- Wheezing
- Yawning

REPRODUCTIVE

- Girls: Early first period
- Boys: Large testicles
- Early breast development
- Early pubic hair
- Girls: Vaginal odor

URINARY

- Frequent urination
- Bed wetting after age 4
- Odd urinary odor
- Urinary hesitancy
- Urinary tract infections
- Urinary urgency
- Dry at night
- Seizures – focal
- Seizures – generalized
- Seizures – grand mal
- Seizures – petit mal
- Usual fast heart beat
- Heart murmur
- Headaches
- Joint pains
- Leg pains
- Muscle pains

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your child's health, how willing is the patient in:

- 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):

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 child's 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
- ___ Bloating 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: _____

