Your Source for Optimal Health

Introductory Patient Information

227 North El Camino Real #203
Encinitas, CA 92123
(760) 632-0100
Fax (760) 632-0102
www.linaehealthsapn.com
info@linaehealthspan.com

PATIENT CHECKLIST
DID YOU REMEMBER TO?

☐ Read all of the practice documents

☐ Obtain your medical records and/or test results from previously seen physicians and have them sent to Linae Healthspan Institute, arriving at least 4 days prior to your appointment date.

☐ Provide your preferred shipping/mailing address; if listing a P.O. Box please indicate a street address for receiving packages, UPS or FED EX.

☐ Provide us with your pharmacy name, address, phone and FAX number.

FILL OUT AND/OR SIGN THE FOLLOWING FORMS

☐ Important Patient Information
☐ Authorization for release of Medical Information
☐ Informed Consent Regarding Email or the Internet Use Of Protected Personal Information
☐ Research Consent Form
☐ Notice of Medicare Denial
☐ General Information
☐ Medical Questionnaire
☐ 3-Day Diet Diary
☐ MSQ- Medical Symptom/Toxicity Questionnaire

Thank you

Dear Patient,
Welcome to Linae Healthspan Institute. We look forward to meeting you.

WHAT TO EXPECT AT LINAE HEALTHSPAN INSTITUTE

Please arrive 15 minutes before your appointment time.

ADMINISTRATION OFFICE-*Check In*
(15 minutes)

Welcome to Linae Healthspan Institute
Update personal forms and sign consent forms
Vital Signs & Picture for medical chart

MD CONSULTATION
Linette Williamson, MD
(60 minute appointment)

Medical Assessment & Initial Treatment Plan

LABS/TESTING REVIEW: Lab Technician
(10 minute appointment)

Review of lab orders, test descriptions and test prices

NUTRITION & LIFESTYLE CONSULTATION:
Steven Williamson, CNC, CPT
(50 minute appointment)

Nutrition Assessment & Initial Nutrition Plan,
Exercise Plan

PROGRAM WRAP UP & REVIEW
(15 minute appointment)

Review of MD's treatment plan
Review of medications prescribed-if needed.
How to obtain prescribed nutritional supplements
Exit plan and information reviewed and discussed

ADMINISTRATIVE OFFICE-*Check Out*
(10 minutes)

Schedule follow-up appointments
Obtain superbill to send to your insurance company for possible reimbursement

PRACTICE POLICES FOR PATEINTS

Our goal at Linae Healthspan Institute is to provide you with the highest level of personalized care. We are committed to helping you achieved optimal health.

It is important to read all the enclosed information carefully and mail or fax all attached forms to our office a least 4 days prior to your appointment. These processes will all us to help solve your problems more efficiently and enhance the quality of our 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 the Linae Healthspan Institute and all relevant patient forms can be accessed through our website www.linaehealthspan.com.

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 provider. Please contact your healthcare provider to obtain these records. Your records should be faxed, mailed or emailed to our office.

CONSULTATIONS

Your initial visit will include a 60-minute medical consultation with your physician and a 50-minute nutrition and lifestyle consultation. Nutritional therapy and laboratory /diagnostic testing are integral components of your treatment plan. Test results are used to design your personal health care program and reveal the root causes of you medical condition. We often recommend nutritional supplements. We assist you in finding the highest quality products at the best possible price.

INITIAL VISTS

When coming from out of town, you may need to stay overnight after your consultation to have our blood drawn the next morning as many of our tests require an 10-hour fast. You should drink water during this fast.

The costs of all testing will be reviewed with you by one of our staff after your medical consultation before labs are drawn. You will receive all final lab results with interpretation during your follow-up visits.

CONSULTATION FEES

- Initial MD Consultation 60-Minutes: $395
- MD Office Visit or Phone Follow-up 60-Minutes: $395
- MD Office Visit or Phone Follow-up 30-Minutes: $200
- MD Office Visit or Phone Follow-up 15-Minutes: $85
- Initial Nutrition & Lifestyle Consultation 50-Minutes: $150
- Nutrition & Lifestyle Visit or Phone Follow-up 50-Minutes: $150
- Nutrition & Lifestyle Visit or Phone Follow-up 30-Minutes: $75

CONFIRMATION AND CANCELLATION OF APPOINTMENTS
Because of the multiple requests for consultation, there is a 48-hour cancellation policy. Your appointment must be cancelled at least 48 hours prior to your scheduled appointment or you will be charged for the visit. You may cancel your appointment by calling the office. If calling after hours, please leave a message.

PAYMENT OPTIONS
Our office accepts cash, checks or credit cards (MasterCard, Visa and Discover). When you schedule your 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 your appointment without proper notice. On the day of your scheduled appointment, all charges for the consultations, laboratory testing and supplement costs will be reviewed with you. Payment is due at the time of service.

Follow-up phone consultations will be billed to your credit card on file unless you provide other payment information and instruction prior appointment. If additional lab tests are required and our office sends the test kits, the appropriate fees will be charged to your account.

INSURANCE INFORMATION
Linae Healthspan Institute does not accept insurance and we cannot assist you with claim resolution. In the same way, we are not Medicare providers. You will be proved with a billing summary which you can submit to your insurance carrier.

PHONE CALLS, MESSAGES & FAXES
1. Our office hours are Monday through Thursday 8:00 am to 5:00 pm PST and Friday 8:00 am to 4:00 pm PST.
2. Our phone number is: (760) 632-0100.
3. Our fax number is: (760) 632-0102.
4. If you call after hours, our office staff will return your call on the next business day.
5. If you have a medical emergency, call 911 or go directly to the nearest emergency room.
6. When leaving a message, please be brief and include the following information:
    a. Full name (spell your last name) and date of birth.
    b. Reason for the call.
    c. Best time to be called back.
    d. Phone number or numbers.
    e. Email address (if applicable).

PRSCRIPTION REFILL REQUESTS
It may take up to 48 hours to process a prescription refill. Please plan ahead to avoid interruptions in your medications. Prescription refill can be faxed to our office pharmacy.

OFFICE LOCATION
Our office is located in Encinitas, California. Our offices are located on the second floor of the building. Please advise our staff if you need assistance as there is no elevator available. We will make arrangements to accommodate you down stairs in Family Practice.

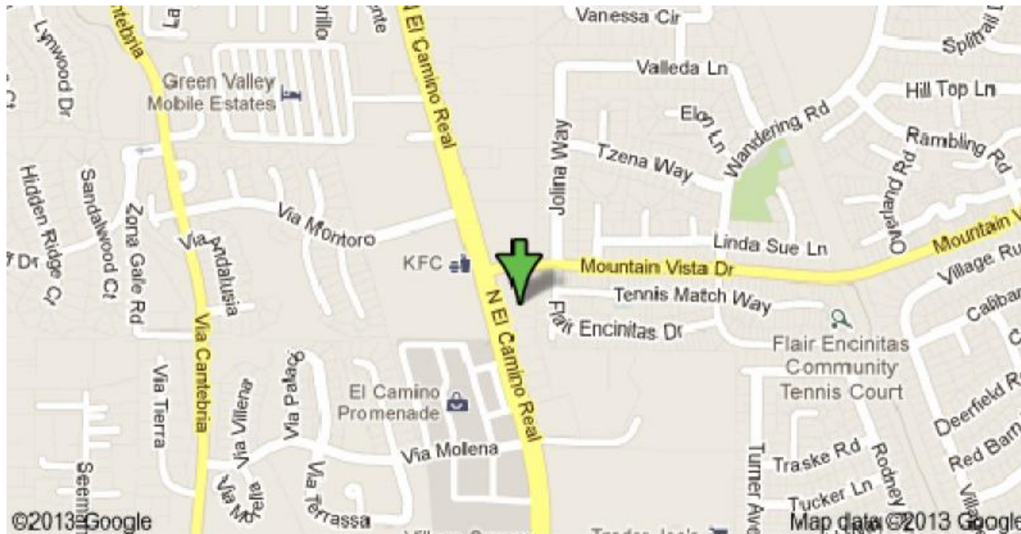
PLACES TO STAY IN THE ENCINITAS AREA

- Cardiff by the Sea Lodge
  - Address: 142 Chesterfield Dr, Cardiff by the Sea, CA 92007
  - Phone: (760) 944-6474
- Howard Johnson Encinitas Near Legoland Area
  - Address: 607 Leucadia Blvd, Encinitas, CA 92024
  - Phone: (800) 553-5339
- Residence Inn by Marriott Carlsbad
  - Address: 2000 Faraday Ave, Carlsbad, CA 92008
  - Phone:(760) 431-9999
- Ramada Carlsbad by the Sea
  - Address: 751 Macadamia Drive, Carlsbad, CA 92011
  - Phone: (760) 438-2285

LOCAL RECOMMENDED RESTAURANTS

- Healthy Creations
  - Address: 376 N El Camino Real, Encinitas, CA 92024
  - Phone: (760) 479-0500
- Naked Café
  - Address: 288 N El Camino Real, Encinitas, CA 92024
  - Phone: (760) 635-7866
- Whole Foods Market – Encinitas
  - Address: 687 S Coast Highway 101, Encinitas, CA 92024
  - Phone: (760) 274-1580
- Jimbo’s Naturally Market – Carlsbad
  - Address: 1923 Calle Barcelona, Carlsbad, CA 92009
  - Phone: (760) 334-7755
- Tin Leaf Fresh Kitchen
  - Address: 6985 El Camino Real, Carlsbad, CA 92009
  - Phone: (760) 431-5323
- Bistro West
  - Address: 4960 Avenida Encinas, Carlsbad, CA 92008
  - Phone: (760) 930-8008
- Ki’s Restaurant at the Beach in Cardiff
  - Address: 2591 S Coast Highway 101, Encinitas, CA 92007
  - Phone: (760) 436-5236

DIRECTIONS TO LINAE HEALTHSPAN INSTITUTE
Address:
227 N. El Camino Real
Suite 203
Encinitas, CA 92024



Directions from Interstate-5:

- Exit east onto Encinitas Boulevard (away from the ocean).
- After about 1.5 miles you will turn left onto El Camino Real. There is a shopping center with Sprouts Farmer's Market and a Shell fuel station on the right-side at the light on the corner of Encinitas Boulevard and El Camino Real.
- The building is on the right-hand side of the street. Turn into the driveway immediately after Mattress Discounters and Jiffy Lube.

FREQUENTLY ASKED QUESTIONS

What is your website address? And how can I order the supplements I need?
Information about Linae Healthspan Institute can be found at www.LinaeHealthspanInstitute.com. Our website also provides an online store for your nutritional and supplement needs. Our team has researched the highest quality products available that are independently assayed for quality, purity, and effectiveness. To access the store your user name is your email address and your password is "functional".

We encourage you to log on to our site and learn more about our services, resources, links to our recommended sites for cutting edge articles and blogs for the ever emerging world of Functional lifestyle medicine, as well as our trusted partners in the vast array of modalities that encompasses our whole systems approach to healthcare.

Do you think you can help me with my health problems?
We use a revolutionary whole systems approach to accessing and treating your health conditions. So many people have had the experience of being examined by a doctor, and having had blood work and may tests only to be told that everything is normal.

Most doctors were trained to look only in specific places for the answers chronic illness. They use the same routine tests repeatedly. Several causes of illness may be subclinical and cannot be found with traditional testing. The usual

standard tests do not look for hidden infections, environmental toxins, food allergies, mold exposures, metabolic imbalances, and nutritional deficiencies. Intercellular testing reveals nutritional deficiencies. Genetic testing can uncover many genetic predispositions that can be modified through diet, lifestyle, supplements and medications if needed.

At Linae Healthspan Institute we use these cutting-edge diagnostics to prevent illness, obtain optimal health and help patients recover from many chronic and difficult to treat conditions. We place an emphasis on the prevention and treatment of the most common chronic diseases of our day, such as heart disease, diabetes, dementia, hormonal imbalances, and digestive problems. We are highly skilled in evaluating, accessing, and treating many of the chronic conditions of our day that have become such an epidemic such as autoimmune diseases, inflammatory conditions, mood and behavioral disorders, fibromyalgia, chronic fatigue, memory problems, and many other complex conditions.

Can all the tests I need be done at Linae Healthspan Institute?
Some of the testing can be performed at Linae Healthspan Institute. Some testing can be done through conventional laboratories and others are available through specialty laboratories. During your medical consultation, your physician will determine which tests are needed and then our nurses/medical office assistants will review testing recommendations, instructions (ex. Fasting or non-fasting, etc.) and costs. Some testing can be performed at home with test kits to collect urine, saliva or stool. Others may require you to a local laboratory to have blood drawn. In all cases, we will assist you in coordinating initial and follow-up testing.

Occasionally, we may recommend certain tests that are not performed at our offices (i.e. heart scans, cardiac stress tests, bone density, sleep studies, etc.) In those instances, we can provide you with an order that you can take to a facility near your home or we can schedule an appointment to have them done near our office.

Will I see other practitioners at Linae Healthspan Institute?

Nutritional therapy is a vital component of your treatment plan. Following your initial medical consultation, you will meet with one of our nutritionists. They will provide recommendations based on your health concerns and tailor your diet based on medical evaluation and test results. You will follow-up with your nutritionist in person, by phone, or email consultations.

Do you take Insurance?
Linae Healthspan Institute does not accept insurance or Medicare. We do not file insurance claims on your behalf and we do not assist with claim resolution. However, we will provide a super bill or a detailed receipt of services performed for you to submit to your insurance carriers. 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, Visa and Discover. It is important to maintain an active credit card on file with our office for billing of follow-up consultations, laboratory testing, and other services.

Is Dr. Williamson a primary care physician?
Dr. Williamson is trained in Emergency and primary care medicine. You may see Dr. Williamson as your primary care physician as her family practice is down stairs in the same professional building. You may also retain your primary care physician and she can confer with your doctor if required. At LHI we will work closely as consultants and coaches in preventative, nutritional and functional medicine to help you address the roots of chronic health problems.

Do I have to see the physician in person for my medical consultation?
Yes the doctor's medical licenses require that they meet with the patient in order to provide an initial consultation. However, follow-up appointments can be arranged by phone or in the office.

Who do I contact?
Our office phone number is: (760) 632-0100.
All questions and concerns can also be communicated via email to: Info@LinaeHealthspanInstitute.com

Administration: Practice Manager, (Veronica@LinaeHealthspanInstitute.com)
Lab Results, Prescription Refills: (Kelli@LinaeHealthspanInstitute.com)
Patient Concerns: Practice Administrator, (Steven@LinaeHealthspanInstitute.com)

Where are you located?
Linae Healthspan Institute is located in North San Diego County in the beautiful city of Encinitas, California.

Your Source for Optimal Health

Consent Forms

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Encinitas, CA 92123
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Fax (760) 632-0102
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info@linaehealthspan.com

PATIENT PLEDGE

Your health and healing depend on our commitment to doing the best we can and your commitment to:

- The LHI Approach
  We strongly recommend that you fully commit to LHI's medical approach in order to succeed. Working with multiple centers or physicians, other than your primary care physician, may create contradiction, confusion and frustration – ultimately delaying your progress.

- A Partnership and a Process
  Some chronic illnesses can take weeks, months or even longer to improve. If you don't see immediate results don't give up. At Linae Healthspan Institute healing is based on a partnership and a process. It takes time, patience and persistence to find and treat the root causes of your illness. You will have to work hard and so will we.

- Prescribed Changes
  Your commitment to comply with prescribed dietary changes, supplements, and medications, as well as other treatment recommendations, is the key to healing. If you don't follow the plan with reasonable consistency, your progress will likely be stalled.

- Nutritionist Appointments
  Our medical nutritionists are your support system for making the necessary lifestyle changes. If you maintain regular ongoing appointments with your LHI nutritionists, you'll benefit from guidance for overcoming challenges, ideas for implementing those changes and helpful resources.

- Patient / Physician Commitment
  Establishing and maintaining a good working relationship with your physician here at LHI, is the key element in your success. Once treatment is initiated with your physician, it is important that you remain in that physician's care and stay in regular communication with your clinical team.

- Ongoing Support
  Functional lifestyle medicine is a different approach from the existing health care model. Chronic illness can contribute to challenges with focus, cognition, energy and mood. Some of the changes that we ask of you may seem overwhelming at times. We suggest that every patient finds support at home. If your family or friends cannot provide that support we recommend that you find professional help: cognitive/behavior psychotherapist or a life coach.

I have read and agree to the statements above.

____ __________________________

Please Print Your Name Date

____

Patient Signature

IMPORTANT PATIENT INFORMATION

APPOINTMENTS

- There is a 48 hour cancellation policy (please see cancellation policy in Practice Policies for Patients).
- As a courtesy, we call to confirm the appointment prior to your scheduled time: ultimately it is your responsibility to keep the scheduled appointment or reschedule.
- Initial 60 minute Evaluation: $395.00
- Follow-up appointments to review lab results or treatment programs: 30 minutes/$200.00 or 15 minutes $85.00.
- Nutrition appointments are $150.00 for 50-minutes and $75.00 for 25-minutes.

LAB TESTS

- After your initial and follow-up consultations, lab tests and /or diagnostic tests may be ordered.
- Testing recommendations and cost(s) per test will be reviewed.
- Lab tests are performed “fasting”, which means nothing except water 10 hours before your visit.
- Some lab test take up to 4 weeks to be finalized. The results will be mailed or emailed to you when they are finalized. If your follow-up appointment was net booked at the time of your initial visit, then you should contact the office to schedule a follow-up appointment.

BILLING/INSURANCE

- Payment for the office visit, phone consultation or lab tests is expected at time of service. We accept cash, check or credit cards. All credit card payments will be processed the same day of the visit or phone call.

- If test kits are sent to you, you will be charged the day the kit is mailed.

- We do not accept insurance and we cannot assist you with claim resolution. We will provide you with a billing summary which you con submit to your insurance carrier.

PRIMARY CARE PHYSICIAN

- Please note that Dr. Williamson is not your primary physician. We recommend that you have a primary care physician at home.

____ ________________________

Patient Signature *Date*

NOTICE OF POSSIBLE MEDICARE DENIAL

Medicare will only pay for services determined to be reasonable and necessary under Section 1862 (a) 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. Linette Williamson is not a Medicare provider; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent to Medicare 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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Facility or Person:

____

Address:

____

Telephone Number: (   ) _______ - ____________
Fax Number: (   ) _______ - ____________

THE PURPOSE FOR THIS RELEASE:
You are hereby authorized to furnish and release to Linae Healthspan Institute all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent therto.
In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records;

Alcohol or Drug Abuse: () Yes () No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: () Yes () No

Genetic Testing: () Yes () No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.
I hereby release Linae Healthspan Institute its employees, agents, managing members, and the attending physician (s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original. I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

Print Name: ____ DOB: _________________________

Signature: ____ Date: _________________________

PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM

Information Released: ____ Date: __________________________

Signature: ____

Please send records to: Linae Healthspan Institute 227 N. El Camino Real suite 203, Encinitas, CA 92024

INFORMED CONSENT REGARDING EMAIL OR THE
INTERNET USE OF PROTECTED PERSONAL INFORMATION

Linae Healthspan Institute provides patients the opportunity to communicate with their physicians, health care providers, and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
   b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.
2. It is the policy of Linae Healthspan Institute that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Linae Healthspan institute will use reasonable means to protect the security and confidentiality of e-mail or internet communication.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
   a. All emails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Linae Healthspan Institute's physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. Linae Healthspan Institute may forward e-mail messages within the practice as necessary for diagnosis and treatment. Linae Healthspan Institute will not, however, forward the email outside the practice without the consent of the patient as required by law.
   c. Linae Healthspan Institute will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
   d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
   e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
   f. Linae Healthspan Institute cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication but Linae Healthspan institute is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
   g. If consent is given for the use of e-mail, it is the responsibility of the patient's to inform Linae Healthspan Institute of any types of information you do not want to be sent by e-mail.
   h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from Linae Healthspan Institute to protect confidentiality. Linae Healthspan Institute is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Linae Healthspan Institute.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail.

I agree to assume all risks associated with the use of e-mail.

Name: ____ Date: _________________________

Signature: ____

RESEARCH CONSENT AGREEMENT

Patients Name: ____

Patient's Address: ____
____

THE STUDIES

You are being asked to provide your consent for Linae Healthspan Institute to use the information from your medical records in research studies the goal of which is to improve the practices of the functional medicine approach. No personal identifying information will be used in the study. The Principal Investigator of these research studies is Linette Williamson M.D.

If you consent to the use of your medical records in these research studies, your personal information will be kept confidential to the extent permitted by law and will not be released without your written permission except as described in this paragraph. In all study forms, you will be identified only by a randomly selected patient number. Your name will not be reported in any publication; only the data obtained as a result of the use of your medical records in these studies will be made public.

Your decision as to whether or not to consent to the use of your medical records is completely voluntary (of your own free will). If you decide not to consent to the use of your medical records it will not affect the care you receive.

If you decide to consent to the use of your medical records in connection with these studies, you may withdraw consent at any time without affecting the care you receive. You should contact the Principal Investigator and let him know about your decision if you decide to withdraw consent.

AGREEMENT TO PARTICIPATE

I have read the description of the research studies and general conditions. Anything I did not understand was explained to me by: ________________________________, any questions I had were answered by: ________________________________. I hereby give my consent to Linae Healthspan Institute to use my medical records as described herein in connection with the research studies described herein. I will receive a copy of this consent form.

________________________________ ________________________

Signature of Patient/Legal Representative *Date*

________________________________ ________________________________

Print Name of Person *Name of Person Obtaining Consent*

Your Source For Optimal Health

Health Questionnaires

227 North El Camino Real #203
Encinitas, CA 92123
(760) 632-0100
Fax (760) 632-0102
www.linaehealthsapn.com
info@linaehealthspan.com

GENERAL INFORMATION

Name *First* *Middle* *Last*

Preferred Name

Date of Birth

Age

Gender ◯ Male ◯ Female

Genetic Background
☐ African ☐ European ☐ Native American ☐ Mediterranean
☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐ Other____________

Highest Education Level ◯ High School ◯ Under-Graduate ◯ Post-Graduate

Job Title

Nature of Business

Primary Address *Number, Street* *Apt. No.*

City *State* *Zip*

Alternate Address *Number, Street* *Apt. No.*

City *State* *Zip*

Home Phone 1

Home Phone 2

Work Phone

Cell Phone

Fax

Email

Emergency Contact *Name* *Phone Number*

Address *Apt No.*

City *State* *Zip*

Physician *Name* *Phone Number*

Fax

Referred by ◯ Book ◯ Website
◯ Media ◯ Friend or Family Member ◯ Other ____________

PHARMACY INFORMATION

Primary Pharmacy

Name ______________________ *Phone Number* ______________________

Address ____

City ______________ *State* ______________ *Zip* ______________

Email: ______________________ ***Fax**** ______________________

***It's extremely important that you list the pharmacy's fax number.**

Compounding/
Supplemental Pharmacy

Name ______________________ *Phone Number* ______________________

Address ____

City ______________ *State* ______________ *Zip* ______________

Email: ______________________ ***Fax**** ______________________

***It's extremely important that you list the pharmacy's fax number.**

CREDIT CARD INFORMATION

Patient ______________________________ Date ______________________

DOB ______________________________

Preferred Method of Payment *(please circle one):* Cash / Check / Credit Card

If paying by credit card, we accept VISA, MasterCard and Discover

**Note: If Discover is your primary card, please provide another card (i.e., MasterCard or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover.*

PRIMARY CARD

Name on Card ______________________

Card Type ○ *Visa* ○ *MasterCard* ○ *Discover*

Account Number ______________________

Expiration Date (mm/yy) ______________

CVV# ______________________

SECONDARY CARD

Name on Card ______________________

Card Type ○ *Visa* ○ *MasterCard* ○ *Discover*

Account Number ______________________

Expiration Date (mm/yy) ______________

CVV# ______________________

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	*Success* Excellent	Good	Fair

MEDICAL HISTORY

☒ = *Past Condition* ☒ = *Ongoing Condition*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset.*

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 ________
- ☐ ☐ Arrhythmia (irregular heart beat) ________
- ☐ ☐ 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 ________
- ☐ ☐ Other ________

GENITAL AND URINARY SYSTEMS

- ☐ ☐ Kidney Stones ________
- ☐ ☐ Gout ________
- ☐ ☐ Interstitial Cystitis ________
- ☐ ☐ Frequent Urinary Tract Infections ________
- ☐ ☐ Frequent Yeast Infections ________
- ☐ ☐ Erectile Dysfunction ________
- ☐ ☐ 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 ________

MEDICAL HISTORY (Continued)

☒ = *Past Condition* ☒ = *Ongoing Condition*

NEUROLOGIC/MOOD

Past	Ongoing	Condition	Date
☐	☐	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	

PREVENTATIVE 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 ________________

BLOOD TYPE: ○ 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 of*

☐ Pregnancies ___________ ☐ Caesarean ___________ ☐ Vaginal deliveries ___________

☐ Miscarriage ___________ ☐ Abortion ___________ ☐ Living Children ___________

☐ Post-Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby over 8 lbs.

☐ Breast Feeding For how long? _______________

MENSTRUAL HISTORY

Age at First Period _______ Menes Frequency _______ Length _____ Pain ◯ Y ◯ N Clotting ◯ Y ◯ N

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 ☐ 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

Age at Menopause ___________________

☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido

☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐ Loss of Urine Control ☐ 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: ◯ Gastroentertis ◯ 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 of introduction of Solid Foods: ________ Dairy: ____________ Wheat: ____________

Did you eat a lot of sugar or candy as a child? ◯ Yes ◯ No

DENTAL HISTORY

DENTAL SURGERY

☐ Silver Mercury Fillings How many? ______________

☐ Gold Fillings ☐ Root Canals ☐ 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)

Supplication/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 us 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 (is still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as 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												

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 ☐ Ultrametabolism

☐ 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 ◯ Monthly ◯ Rarely ◯ Never

Have you ever had your metabolism (resting metabolic rate) checked? ◯ Yes ◯ No If yes, what is 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% of my 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 or 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 of 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 on 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 like 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 a scale of 1-10

Work _______ Family ______ Social _______ Finances ________ Health ________ Other _______________

Do you practice mediation or relaxation techniques? ◯ Yes ◯ No How Often? _______________

Check all the 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/RELATIONSHIPS

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 close 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 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 ☐ Onions

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. Sodium benzoate)

☐ Other ____________________

Which of these significantly affects 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 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 exposure? ◯ Yes ◯ No

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

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 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 Noise
- ☐ Vision Problems (other than
- ☐ 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 Cravings (breads)
- ☐ Sweet Cravings (candy, cookies)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating:
  - ☐ Lower Abdomen
  - ☐ Whole Abdomen
  - ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Soars
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating
- ☐ 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
  - ☐ Wheat
  - ☐ Gluten
  - ☐ Corn
  - ☐ Eggs
  - ☐ Fatty Foods
  - ☐ Yeast
- ☐ Liver Disease/Jaundice (yellow eyes or skin)
- ☐ Abnormal Liver Function Test
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

SKIN PROBLEMS

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne of 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
    - ☐ Any Cracking?
    - ☐ Any Peeling?
- ☐ Hair
    - ☐ And Unmanageable?
- ☐ Hands
    - ☐ Any Cracking?
    - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
    - ☐ Any 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 Seasons
- ☐ 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
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting
- ☐ 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
    - ☐ Carbohydrate
    - ☐ Chocolate Craving
    - ☐ 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, email 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

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 cream).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces., ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon of honey, potato with 2 teaspoons butter, etc.
- Record all beverage, 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 Movement (#, form, color) ______________________________

Stress/Mood/Emotions ______________________________

Other Comments ______________________________

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movement (#, form, color) ______________________________

Stress/Mood/Emotions ______________________________

Other Comments ______________________________

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movement (#, form, color) ______________________________

Stress/Mood/Emotions ______________________________

Other Comments ______________________________

MSQ – MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: ______________________ **DATE:** ____________

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying cases 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 the last 48 hours ONLY.

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

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, aggressiveness
_______ Depression
Total _______

ENERGY/ACTIVITY
_______ Fatigue, sluggishness
_______ Apathy, lethargy
_______ Hyperactivity
_______ Restlessness
Total _______

EYES
Watery or itchy eyes
Swollen, reddened, 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 limited movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total _______

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
Total _______

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

MOUTH/THROAT
_____ Chronic coughing
_____ Gagging, clearing throat
_____ Sore throat, hoarseness,
_____ Swollen/discolored tongue,
_____ 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 flashes
_____ Excessive sweating
Total _______

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

OTHER
Frequent illness
Frequent or urgent urination
Genital itch or discharge
Total _______

GRAND TOTAL _______________

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