

Preparing for Your Appointment

Dear Patient:

Welcome!

We look forward to helping you with our specialized, therapeutic lifestyle program called FirstLine Therapy (FLT). It is very different from today's common medical approach. The FLT program works to more clearly identify and overcome the cause of ill health, and then improve total body function naturally by nourishing, balancing and revitalizing the whole individual. It is powerful, effective, and rewards you with improved health and function that is long lasting!

Get Maximum Benefit From Your Appointment

Our consultation time with you is important! We analyze your personal and family health history, appropriate test results, current lifestyle and state of health, and clarify your health goals. We then guide you through a comprehensive, highly personalized, step-by-step program to achieve those goals. You can **get maximum benefit from the time reserved for your consultation by being prepared!**

How To Prepare

1. Please fill out any requested paperwork before coming to our office, or arrive 15 minutes early and fill it out here.
2. Prepare for your Bioimpedance Analysis (BIA Test) by adhering to the following guidelines:
 - a. Do not eat for 4 hours prior to testing.
 - b. Do not exercise for 12 hours prior to testing.
 - c. Do not consume alcohol for 24 hours prior to testing.
 - d. Drink your usual amount of water the night before and the day of your appointment. You will be asked to empty your bladder just before the test.
 - e. Do not drink caffeine the day of your test.
 - f. Insure access to your right foot with removable footwear (no pantyhose).
3. Please value the time reserved for you by being punctual so as to benefit fully from your consultation.

IMPORTANT: There is a \$100 NO SHOW fee if cancellation is not made at least 24 hours prior to your appointment. Due to the popularity of the FirstLine Therapy program all appointment times are often filled several weeks in advance with no openings for those desiring earlier appointments. Cancellation made at least 24 hours in advance allows us to accommodate others. We thank you in advance for your cooperation.

Appointment Reminder

Your appointment is scheduled for:

Date _____, ____ / ____ / ____ Time _____ AM / PM

Patient Signature _____ Date _____

Thank You! We look forward to helping you successfully achieve your personal health goals!

Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Email _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit _____ Date began _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health overall:

- Diet modification Fasting Vitamins/minerals Herbs Homeopathy Chiropractic Acupuncture Conventional drugs
- Other _____

Do you experience any of these general symptoms on a regular basis?

- Debilitating fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation
- Depression Panic attacks Nausea Fecal incontinence Bleeding
- Disinterest in sex Headaches Vomiting Urinary incontinence Discharge
- Disinterest in eating Dizziness Diarrhea Low grade fever Itching/rash

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

Outcome: _____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): _____

Do you consider yourself: Underweight Overweight Healthy weight Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)? _____

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer
- Decreased sex drive

- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Age of first period _____
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
 - Cigarettes: # /day _____
 - Cigars: # /day _____
- Alcohol:
 - Wine: # glasses/d or wk _____
 - Liquor: # ounces/d or wk _____
 - Beer: # glasses/d or wk _____
- Caffeine:
 - Coffee: # 6 oz cups/d _____
 - Tea: # 6 oz cups/d _____
 - Soda w/caffeine: # cans/d _____
 - Other sources _____
- Water: # glasses/d _____

Exercise

- 5-7 days/wk
- 3-4 days/wk
- 1-2 days/wk
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk: #days/wk _____
- Run, jog, other aerobic - #days/wk _____

- Weight lift: #days/wk _____
- Stretch: #days/wk _____
- Other _____

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction

Specific food restrictions:

- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip meals (which ones) _____
- _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals (describe) _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

I Would Like to:

Energy, Vitality

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

Body Composition

- Lose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

Stress: Mental and Emotional

- Learn how to reduce stress
- Think more clearly and be more focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

Life Enrichment

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

Name _____ Date _____

Rate each of the following symptoms based on how you've been feeling for the: Past 48 hours Past Week Past 30 days

Point Scale

- 0 — Never or almost never have the symptoms
- 1 — Occasionally have it, effect is not severe
- 2 — Occasionally have it, effect is severe
- 3 — Frequently have it, effect is not severe
- 4 — Frequently have it, effect is severe

Head _____ Headaches
 _____ Faintness
 _____ Dizziness
 _____ Insomnia
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 farsightedness)
Total _____

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

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

Mouth/Throat _____ Chronic coughing
 _____ Gagging, frequent need to clear throat
 _____ Sore throat, hoarseness, loss of voice
 _____ Swollen or discolored tongue, gums or lips
 _____ Canker sores
Total _____

Skin _____ Acne
 _____ Hives, rashes, dry skin
 _____ Hair loss
 _____ Flushing, hot flashes
 _____ Excessive sweating
Total _____

Heart _____ Irregular or skipped heartbeat
 _____ Rapid or pounding heartbeat
 _____ Chest pain
Total _____

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

Digestive Tract _____ Nausea, vomiting
 _____ Diarrhea
 _____ Constipation
 _____ Bloating feeling
 _____ Belching, passing gas
 _____ Heartburn
 _____ Intestinal/stomach 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 _____

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

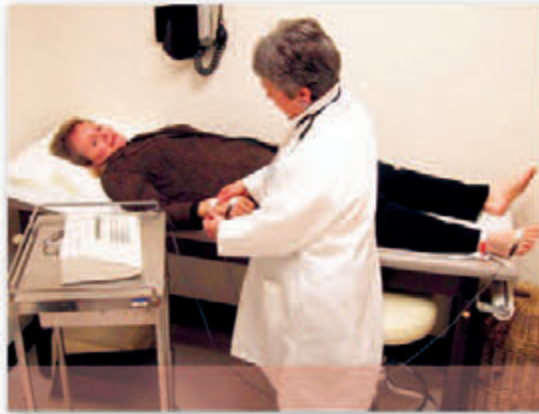
Energy/Activity _____ Fatigue, sluggishness
 _____ Apathy, lethargy
 _____ Hyperactivity
 _____ Restlessness
Total _____

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

Emotions _____ Mood swings
 _____ Anxiety, fear, nervousness
 _____ Anger, irritability, aggressiveness
 _____ Depression
Total _____

Other _____ Frequent illness
 _____ Frequent or urgent urination
 _____ Genital itch or discharge
Total _____

Grand Total _____



What Is a BIA?

(And why do you need one?)

Bioelectrical Impedance Analysis or Bioimpedance Analysis (BIA) is a method of assessing your “body composition”—the measurement of body fat in relation to lean body mass. It is an integral part of a health and nutrition assessment.

Why Is Body Composition Important to My Health?

Research has shown that body composition is directly related to health. A normal balance of body fat is associated with good health and longevity. Excess fat in relation to lean body mass, known as altered body composition, can greatly increase your risks to cardiovascular disease, diabetes, and more. BIA fosters early detection of an improper balance in your body composition, which allows for earlier intervention and prevention. BIA provides a measurement of fluid and body mass that can be a critical assessment tool for your current state of health.

BIA also measures your progress as you improve your health. Improving your BIA measurement, or maintaining a healthy BIA measurement, can help keep your body functioning properly for healthy aging. Your BIA results can help guide us in creating a personalized dietary plan, including nutritional supplements

when appropriate, and exercise to help you maintain optimal health and well-being for a lifetime.

How Does a BIA Work?

BIA is much more sophisticated than your bathroom scale, but just as simple—and almost as quick. BIA is performed in our office with the help of a sophisticated, computerized analysis.

This analyzer “calculates” and estimates your tissue and fluid compartments—using an imperceptible electrical current passed through pads placed on your hand and foot as you lie comfortably clothed on an exam table. In just minutes, we’ll have detailed measurements to help create an effective, personalized program for you.

Follow-up Tests

We can conduct a series of follow-up BIA tests to monitor your health and measure your progress.

Guidelines for Assessment

For the most accurate results, the following guidelines should be followed:

1. **Do not eat for 4 hours prior to testing.**
2. **Do not exercise for 12 hours prior to testing.**
3. **Do not consume alcohol for 24 hours prior to testing.**
4. **Drink at least 1 quart of water one hour before your test.**
5. **Do not drink caffeine the day of your test.**
6. **Do not wear pantyhose.**
7. **Do not put lotion on your hands and feet.**

Follow-up Appointment: