Comprehensive Health Appraisal

Please fill this packet out in its entirety.
The packet contains a two day diet analysis and therefore must be filled out two days before your appointment.

What Should I Expect?

Your experience through the Comprehensive Health Assessment will put you on a journey to a new level of health. We have designed this program for those people who are committed to changing their health and willing to become an active participant in the process.

INITIAL CONSULTATION:
The initial consultation will outline a holistic method of approach for your problem by understanding more about you, your lifestyle, your genetic make up, your health history and your diet. Instead of focusing on the condition the person has, we focus on the PERSON that has the condition. The underlining cause of most health problems is usually an organ or system of your body that has lost its "organ reserve". Let's use the analogy of an automobile. What happens when your gas tank goes lower than the tank reserve? Your car begins to hesitate and drive below its normal performance and eventually…your car stops. When you stress an organ system for decades due to excess stress, poor dietary choices, lack of nutrition, deficient sleep, lack of exercise and a build up of toxins you will lose your organ reserve which will result in organ dysfunction (disease) and eventually a symptom. Our goal is not to solely focus on the symptom, but the underlining cause of the condition.

LABORATOR TESTING:
The doctor may recommend special laboratory testing to further evaluate your condition. Testing may be completed from blood, urine, saliva or stool and most testing can be completed in the comfort of your home. After the testing is received and evaluated, an individual program will be designed to assist your body in obtaining health. Depending on your case, the doctor may set up follow consultations to evaluate and discuss your progress.

PAYMENTS:
In regards to the nutritional services in this office, payment is due at the time of service. For your comfort, all fees will be explained before any services are rendered.

QUESTIONS:
It is important to ask as many questions as possible. Our goal is to empower you to understand that your body was designed to be healthy! We will focus on your body's natural ability to heal and we look forward to taking this journey with you.

I understand the above information: _____ _____
(Signature) (Date)

Terms of Acceptance for Nutritional Care

We solely provide any suggested nutritional advice or dietary advice, and the adjunctive schedule of nutrition to upgrade the quality of foods and nutrients in your diet and to support the normal processes of your body.

We use diagnostic testing to find dysfunction in the organ systems of the body. We will not use any of the diagnostic testing to diagnose and/or treat disease, but only to enhance the function of the human body. Regardless of what the disease is called, we do not offer to treat it.

A vitamin, mineral, trace element, amino acid or herb is not a drug. Although any of these substances may have an effect on any disease process or symptom, this does not mean that anyone can be misrepresent or classify them as drugs.

I understand *the objectives pertaining to my nutritional care in this office. Therefore, I accept nutritional care on this basis.*

_____ _____
(Signature) (Date)

PATIENT PRIVACY CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____ hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

____ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Date:_____

Patient's Name (Printed) _____

Patient Name (Signed)_____

Patient DOB:_____

Patient Information

Name: _____ Date: _____

Street Address: _____

City: _____ State:_____Zip: _____

Home Phone: _____ Work Phone: _____

E-Mail Address: _____

Birth Date: _____ Gender: M F Marital Status: _____

How did you hear about our office:_____

Would you like to receive ☐ Email Reminders ☐ Text Reminders

To Receive Text Reminders please provide cellular carrier: _____

Medical Physician: _____ Chiropractor: _____

Where are you presently employed? _____

Do you or have you ever worked 2nd or 3rd shift? ☐ Yes ☐ No

Have you any military experience? ☐ Yes ☐ No

Have you ever worked in law enforcement? ☐ Yes ☐ No

Name all pills that you take (prescriptive, over the counter, vitamins, herbs, etc.):

1. _____ 11. _____
2. _____ 12. _____
3. _____ 13. _____
4. _____ 14. _____
5. _____ 15. _____
6. _____ 16. _____
7. _____ 17. _____
8. _____ 18. _____
9. _____ 19. _____
10._____ 20. _____

Last Blood Test _____ Doctor's Name _____

[Bring all blood tests that you have had done over the last 1-2 years.]

Have you ever had any allergy testing? Yes_____ No _____

If Yes, circle any that apply: Skin Scratch Test Blood Test

Are you aware of any allergies to foods or airborne compounds? If so, please list them below.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Primary Complaints

Please list below the five or more main complaints you have in the order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____

Goals:

What do you hope to accomplish at our office?

1. _____
2. _____
3. _____

Put an X in those boxes applicable to you in the "yes" or "no" space. If lines are provided, write your answer.

Family History																		
	Dad	**Mom**	**Brothers**				**Sisters**				**Spouse**	**Children**						
Age (if living)																		
Health (G) good (B) bad																		
Cancer																		
Tuberculosis																		
Diabetes																		
Heart trouble																		
High blood pressure																		
Stroke																		
Asthma, hives, hay fever																		
Blood disease																		
Age (at death)																		
Cause of death																		

Personal History								
Have you ever had?	**Yes**	**No**	**Have you ever had?**	**Yes**	**No**	**Have you ever had?**	**Yes**	**No**
Heart Disease			Fibromylagia			Concussion		
High Cholesterol			Prader Willi Syndrome			Head Injury		
High blood pressure			Prostate Cancer			Ever knocked unconscious		
Low blood pressure			Crohn's Disease			□ Food □ Chemical □ Drug Poisoning		
Cancer			Celiac Disease			Explain:		
Ulcers			Bladder Infections					
Thyroid Disease			Diagnosed Obesity					
Lung Disease			Anemia					
Diabetes			Jaundice			Any other diseases:		
Depression			Migraine headaches					
Epilepsy			Insomnia					
Hormone Related Issues			Nervous breakdown					
Kidney Stones			□ Hay fever □ Asthma			**Weight** Now: _____		
Fatigue			□ Hives □ Eczema			One year ago: _____ Max: _____ When: _____		

List any other conditions that you currently receive treatment for (medical, chiropractor, physical therapist, etc.).

_____

_____

_____

Surgery								
Have you had removed?	**Yes**	**No**	**Have you had removed?**	**Yes**	**No**	**Have you had?**	**Yes**	**No**
Tonsils			□ Ovary □ Ovaries			Hernia repaired		
Appendix			Hemorrhoids			Hospital for illness		
Gall Bladder			Ever have a transfusion?			Explain:		
Uterus			□ Blood □ Plasma					
Other operations			Explain:					

X-Rays				
Ever have X-Rays of:	**Yes**	**No**	**Date**	**Disease Present**
Chest				
Stomach Colon				
Gall Bladder				
Extremities				
Back				

Habits							
Do you…	**Yes**	**No**	**Do you use…**	**Never**	**Occasionally**	**Frequently**	**Daily**
Exercise adequately?			Laxatives				
How?			Vitamins				
			Sedatives				
Do weight resistance exercises?			Tranquilizers				
( ) days a week			Sleeping Pills				
( ) hours a day			Alcoholic beverages				
Like your work?			Aspirin				
( ) hours a day			Cortisone				
Watch television?			Caffeinated beverages				
( ) hours a day			( ) cups a day				
Read? ( ) hours a day			Tobacco □ cigarettes				
			( ) packs a day				
Vacation?			□ Cigars □ Pipe				
( ) weeks a year			□ Chewing tobacco				
Ever treated for drug abuse?			Appetite depressants				

Sleep: ___ hours a night Hours of sleep: from _____ to _____ Take naps **Y N**

Trouble getting asleep **Y N** Trouble staying asleep **Y N** Use sleep aids **Y N** Awaken rested **Y N**

Quality of Sleep (circle) 1 2 3 4 5 6 7 8 9 10 Comments _____

Stress: Circle one - "10" is the greatest stress.

Stress at work 1 2 3 4 5 6 7 8 9 10 Stress at home 1 2 3 4 5 6 7 8 9 10

Water Intake: Type: Distilled Reverse Osmosis Spring Carbon filtered Well Tap **Number 8 oz. a day** _____

Nutrition & Digestion	Yes	No
Do you include fast food in your diet?		
Are you on a vegan diet (vegetarian, with no eggs or dairy)?		
Do you have more than 3 alcoholic drinks per week?		
Do you experience belching, bloating, or persistent fullness after eating? (Circle all that apply)		
Do you have a poor appetite?		
Have you had a partial or complete loss of taste? (Circle all that apply)		
Do you have intolerance to specific foods?		
Do you have a history of anemia?		
Do you see undigested food in your stool or a greasy film on the toilet water? (Circle all that apply)		
Do you have difficulty gaining weight?		
Do you experience acid reflux/heartburn?		
Do you use acid blocking drugs (e.g., Pepcid AC) or antacids? (Circle all that apply)		
Are your fingernails soft brittle, or dotted with white spots? (Circle all that apply)		
Are you prone to muscle cramps?		
Do you have poor night vision?		
Do you suffer from constipation and/or diarrhea? (Circle all that apply)		
Do you have dry, hard, or small stool?		
Is your skin dry, easily bruised, or slow to heal when injured? (Circle all that apply)		

Are Your Health Problems Yeast Connected?	Yes	No
Have you taken repeated “rounds” of antibiotic drugs?		
Have you been troubled by premenstrual tension, abdominal pain, menstrual problems, vaginitis, prostatitis? (Circle all that apply)		
Does exposure to tobacco, perfume and other chemical odors provoke moderate to sever symptoms? (Circle all that apply)		
Do you crave sugar, breads, or alcoholic beverages? (Circle all that apply)		
Do you suffer from fatigue, depression, poor memory, or “nerves”? (Circle all that apply)		
Do you suffer from hives, psoriasis, eczema or other chronic skin rashes? (Circle all that apply)		
Have you ever taken birth control pills?		
Do you suffer from headaches, muscle and joint pains or incoordination? (Circle all that apply)		
Do you feel bad all over, yet the cause has not been found?		
If you have 3 or 4 “yes” answers, yeasts possibly play a role in causing your symptoms. If you have 5 or 6 “yes” answers, yeasts probably play a role in causing your symptoms. If you have 7 or more “yes” answers, your symptoms are almost certainly yeast-connected. Copyright 1983, William G. Crook, M.D.		

Immune Balance	Yes	No
Do you easily catch colds or flu bugs? (Circle all that apply)		
Are you slow to recover from infections?		
Do you have swollen lymph nodes in neck, armpit, or groin? (Circle all that apply)		
Do you have seasonal allergies?		
Do you experience chronic sinus congestion or post-nasal drip? (Circle all that apply)		
Do you feel worse (within a few hours to two days) after eating certain foods?		
Do you have dark circles under you eyes?		
Do you experience asthma?		
Have you ever been diagnosed with an autoimmune disease?		
Do you experience joint pain?		
Do you suffer from itching of eyes, nose, palate, throat, or skin? (Circle all that apply)		
Are you sensitive to molds, dust, pets, or other parts of the environment? (Circle all that apply)		
Is there a history of cancer in your family?		
Does your diet consist of intake of any wheat products (breads, pastas, cereals)?		
Do you crave sugar?		
Have you had prolonged or repeated courses of antibiotics at any time in your life?		
Are you having diminished energy or “foggy thinking” processes? (Circle all that apply)		

Detoxification & Elimination	Yes	No
Do you have a history of exposure to chemical or toxic metals at your work or home?		
Do you have amalgam (silver) fillings?		
Do you include large fish in your diet (tuna, swordfish, and halibut)?		
Are you sensitive to smells such as car exhaust, perfumes, household cleaners, and cigarettes? (Circle all that apply)		
Do you currently take more than one regular medication?		
Are you prone to side effects from medication?		
Do you have trouble with thinking or memory?		
Have you become more sensitive to alcohol?		
Do you have a history of liver disease, hepatitis or mononucleosis? (Circle all that apply)		
Do you have frequent headaches?		
Do you have oral sores, dental caries, or gingivitis?		
Do you experience frequent gas or bloating?		
Have you had 2 or more courses of antibiotics in the past year?		
Has there been any foreign travel?		
Have you ever had water from a well or stream?		

General Musculoskeletal					
Do you experience?	**Yes**	**No**	**Do you experience?**	**Yes**	**No**
Muscle aches			Tendonitis		
Joint pain			Sciatica		
Joint stiffness			Migraines		
Neck pain			Tension Headaches		
Middle back pain			TMJ		
Lower back pain			Chronic Sinusitis		
Rib pain			Chronic middle ear infections		
Chest pain			Hip pain		
Foot pain			Tingling/numbness of extremities		
Swelling of joints			Weakness of extremities		
Facial pain			Decreased range of motion		
Shoulder pain			Bursitis		
Other:					

Thyroid	Yes	No
Do you notice that you have brittle nails?		
Do you commonly complain of cold hands and feet or an intolderance to cold?		
Do you often have constipation?		
Do you suffer from irritability or depression?		
Do you notice difficulty swallowing or pain in the throat?		
Do you often have dry skin?		
Has your doctor told you that you have elevated cholesterol?		
Do you notice swelling around your eyelids?		
Do you notice that you are losing hair on your head and/or hair at the end of your eyebrows? (Circle all that apply)		
Do you feel that you are constantly fatigued?		
Have you been told you have a slow heartate or low blood pressure? (Circle all that apply)		
Do you suffer with an inability to concentrate or poor memory? (Circle all that apply)		
Do you struggle with infertility?		
Do you have menstrual irregularities?		
Do you often experience muscle cramps/ weakness?		
Are you struggling with weight gain or an inability to lose weight?		
Taking any of these meds? (Circle all that apply) Estrogen, Antidepressant, Birth Control, Lithium, Dopamine Amiodarone, Adenosine, Dexamethasone, Bromide, Methimazolelodide, Propranolol, Propylthiouracil, Methimazole		

Progesterone - Estrogen (Women Only)	Yes	No
Progesterone		
Do you have heavy menstrual flow?		
Do you have fibroids and / or endometriosis?		
Do you have hypothyroidism?		
Estrogen		
Have you been told you have reduced bone density?		
Are you having painful sex?		
Have you noticed an increase in urinary tract infections (UTIs)?		
Are you having irregular or absent periods?		
Are your breasts tender or have they atrophied? (Circle all that apply)		
Progesterone and Estrogen		
Are you suffering from hot flashes?		
Do you commonly experience headaches and /or migraines?		
Do you notice you are having mood changes, including anxiety or depression?		
Do you have reduced libido (sex drive)?		

Tesosterone	Yes	No
Do you notice that you are losing muscle mass/strength?		
Do you have reduced libido (sex drive)?		
Have you notice that you have an increase in your body fat?		
Have you been suffering from mood changes such as irritability, lack of focus or depression?		
MEN ONLY: Are you having a harder time getting an erection?		

Adrenal (Cortisol – DHEA)	Yes	No
Do you get dizzy or see spots when standing up rapidly from a sitting or lying position?		
Do you have chronic fatigue?		
Do you have difficulty getting up in the morning despite adequate sleep?		
Do you have low energy before lunch or dinner?		
Do you usually feel better after 6:00 p.m.?		
Do you often feel the best late at night because you get a 'second wind'.		
Do you have trouble getting to sleep?		
Do you tend to wake early (approx. 3 to 5 a.m.) and have trouble getting back to sleep?		
Do you need to rest after times of mental, physical, or emotional stress?		
Do you feel more tired after exercise or physical exertion, either soon after or the next day?		
Do you am allergic to many things, such as food, animals, and pollens?		
Do you have low blood pressure?		
Do you become hungry, confused, or shaky if you miss a meal?		
Do you crave sugar, sweets, or desserts?		
Do you use stimulants, such as tea or coffee, to get started in the morning?		
Do you need caffeine (chocolate, tea, coffee, colas) to get me through the day?		
Do you often crave salt and / or foods high in salt, such as potato chips?		
Do you have taken steroid medications for a long term or at high doses?		
Do you have symptoms that improve after you eat?		
Do you have feelings of hopelessness and despair or have been diagnosed with depression?		
Do you lack motivation because I do not feel I have the energy to get things done?		
Do you have decreased tolerance towards other people and tend to get irritated by them?		
Do you get more than 2 colds or flus per year?		
Do you have a history of large amounts of stress in your life?		
Do you tend to be a perfectionist?		
Is your ability to focus mentally generally impaired?		
Does stress cause you to become overly anxious?		
Have you gained weight around your middle?		
Are your relationships at work and / or home tend to be strained?		
Does your life contain insufficient time for fun and enjoyable activities?		
Do you have little control over your life where you feel 'stuck'?		
Do you tend to get addicted easily to drugs, alcohol, or food?		

Questionnaire - Your Health View

1. In general would you say your health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. *Compared to one year ago, how would you rate your health in general now verse one year ago?*

☐ Much better ☐ Somewhat better ☐ About the same ☐ Much worse

3. The following items are about activities you might do during a typical day. Does *your health now limit you* in these activities? If so, how much?

☐ Yes, Limited a lot ☐ Yes, Limited a little ☐ No, Not limited at all

4. During the *past 4 weeks* have you had any of the following problems with your work or other regular daily activities *as a result of your physical health*?

a. ☐ Yes ☐ No Cut down the *amount of time* you spent on work or other activities.

b. ☐ Yes ☐ No *Accomplished* less than you would like.

c. ☐ Yes ☐ No Were limited in the *kind* of work or other activities.

d. ☐ Yes ☐ No Had difficulty performing at work or other activities (for example, it took extra effort).

5. During the past *4 weeks*, have you had any of the following problems with your work or other regular activities *as a result of any emotional problems* (such as feeling depressed or anxious)?

a. ☐ Yes ☐ No Cut down the *amount of time* you spent on work or other activities.

b. ☐ Yes ☐ No *Accomplished* less than you would like.

c. ☐ Yes ☐ No Were limited in the *kind* of work or other activities.

d. ☐ Yes ☐ No Had difficulty performing at work or other activities (for example, it took extra effort).

6. During the past *4 weeks* to what extent has your physical health, emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Severe ☐ Very severe

7. How much bodily *pain* have you had during the *past 4 weeks*?

☐ None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

8. During the *past 4 weeks*, how much did *pain* interfere with your normal work (including both work outside the home and housework)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. These questions are about how you feel and how things have been with you *during the past 4 weeks*. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time *during the past 4 weeks*

a. Did you feel full of pep?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

b. Have you been a nervous person?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

c. Have you felt so down in the dumps that nothing could cheer you up?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

d. Have you felt calm and peaceful?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

e. Did you have a lot of energy?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

f. Have you felt downhearted or blue?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

g. Did you feel worn out?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

h. Have you been a happy person?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

i. Did you feel tired?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

10. During the *past 4 weeks* how much of the time has your *physical health or emotional problems* interfered with you social activities (like visiting either friends, relatives, etc.)?

☐ All the time ☐ Most of the time ☐ Some of the Time ☐ A little of the time ☐ None of the time

11. How TRUE or FALSE is *each* of the following statements for you?

a. I seem to get sick easier than other people

☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

b. I am as healthy as anybody I know

☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

c. I expect my health to get worse

☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

d. My health is excellent

☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

DIET ANALYSIS

- Keep an **accurate** record of every food and beverage you consume. Write it down as you eat to help you remember exactly what you ate.
- Be honest. It is important to note everything, including water, to get the most accurate results.
- If eating fast or prepared food, write down the name of the restaurant or brand name with the type of food, e.g., McDonald's Big Mac or Kraft Macaroni and Cheese.
- Try to get an idea of portions by looking at labels. This will make the analysis as accurate as possible. You need to measure meat in ounces, and vegetables, sauces and most other foods in cups (¼, ½, ¾ or 1). See below for serving size estimating techniques. You can just count eggs.
- Write down how it was cooked (fried, baked, steamed, etc.).
- Keep a two-day record, one day on the weekend and the other on a weekday. Try to pick "normal days" so we can get a true picture of your diet.
- Mail or bring in the diet, and after we complete the analysis we will call you to set up a convenient time for a consultation.

Examples of recording the food

Date / Time	Food / Beverage	Quantity	Preparation Method
1/5/19 6:45AM	Eggs	4	Scrambled
1/5/19 5:30PM	Chicken Breast	3.5 oz	Baked
1/5/19 5:30PM	Mixed Vegetables (carrots, broccoli, cauliflower)	2 Cups	Steamed
1/6/19 12:00PM	McDonald's Big Mac	2	

Serving Size Estimating Techniques

- 3 ounces of meat is about the size and thickness of a deck of playing cards or an audio cassette tape.
- A medium apple or peach is about the size of a tennis ball.
- 1 ounce of cheese is about the size of 4 stacked dice.
- 1/4 cup of ice cream is about the size of a racquetball or tennis ball.
- 1 cup of mashed potatoes or broccoli is about the size of your fist.
- 1 teaspoon of butter or peanut butter is about the size of the tip of your thumb,
- 1 ounce of nuts or small candies equals one handful.

If you have any questions, please don't hesitate to call our office.

First Name:	**Last Name:**
Circle One: Male Female	**Height:** ft. In **Weight:** lbs.
Activity Level: Sedentary Light Moderate Heavy	**Age:**

Date / Time	Food / Beverage	Quantity	Preparation Method