NEW PATIENT PAPERWORK

Dear Patient,

Welcome! Thank you for choosing us as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1:

During your initial consultation we will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 2:

Once you have completed your lab tests, we will explain the meaning of your test results to you in a follow up consultation. We will create an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

STEP 3:

Subsequent consultations are scheduled to monitor your progress. We will also design an ongoing wellness program to be reviewed and updated with our staff at no charge every six months.

We invite you to contact us via email or phone should you have any questions during the course of your treatment.

We look forward to assisting you in achieving your current wellness goals. We will help by guiding you into maintaining wellness throughout your life.

New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize you to release my personal medical information to me.

Patient's Signature: _____ Date: _____

Name:				Date:
Address:			Country:	
City:		State:		Zip/Postal Code:
Home Phone:	Work Phone:		Fax:	
E-mail:			Cell Phone:	
Please mark your preference for occasional follow up communication from our office: Email Phone				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Employer:
Person responsible for this account:			Referred by:	
What is your major complaint?				
Other complaints?				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight_____ Height _____Blood Pressure (if known _____) % Body Fat (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____

Please list (attach sheet if necessary)

_____

2. In the past, have you used birth control pills and/or antibiotics? _____

a. For how long? _____

3. If you have dental fillings, please list material(s) used (if known): _____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions? _____

_____

7. Do you smoke, drink alcohol or use recreational drugs? _____

a. How much, how often? _____

b. How often do you drink caffeinated beverages? _____

8. Please list foods you tend to overeat or crave (sweets, breads, fatty foods, meats, milk, etc.):

_____

9. Are there foods that you eat on a daily basis, almost daily basis? _____

_____

a. Do you "miss" these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

_____

What do you feel triggered your weight fluctuation? (circle)

heredity stress eating habits boredom

a. Was your weight gain/loss: (circle)

sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity: _____

_____

12. What methods have you tried to lose/gain weight?

_____

13. How is your energy level?

_____

a. Are there times in the day that you feel best? _____ worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress: _____

_____

16. How do you deal with your stress? _____

_____

Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes ____ No_____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes ___ No_____

c. I get tired and/or hungry in the mid-afternoon. Yes____ No ____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert.
Yes _____No _____

e. Now and then I think I am a secret eater. Yes_____ No _____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes ____ No_____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes ____ No_____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes_____No _____

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i. I feel shaky if I don't eat on time or if I don't snack. Yes ____No _____

j. I often find myself irritable or angry. Yes___ No _____

18. Check off any of the following that have applied to you within the last 30 days:

Do you feel nauseous?	Do you have abdominal/intestinal pain?
Do you have bloating?	Do you get bloated after meals?
Do you get heartburn?	Do you have diarrhea?
Do you have constipation?	Do you travel outside of the U.S.?
Do you have gas?	Are your stools compact/hard to pass?
Do you belch following meals?	Do you have gurgles in your stomach?
Do your bowel movements alternate between constipation and diarrhea?	

24. In your estimation, how physically fit are you right now?

Unfit_____ Below average _____ Average_____ Above average____ Very-fit__

25. How often do you exercise? _____

a. What is your regimen? _____

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

_____

27. What are your fitness goals? (check all that apply)

General fitness endurance	Muscle toning
Weight loss/maintain weight	Muscle strengthening
Osteoporosis prevention	Muscular coordination/balance
Specific sport enhancement	Other
Flexibility	

28. Surgeries, starting with most recent: _____

29. Hospitalizations: _____

30. Briefly describe where you have lived since childhood: _____

_____

_____

31. What is your heritage? (Irish, German, Spanish, etc.) _____

32. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	**Do you often**:
Now Past Satisfactory	Now Past Feel depressed
Now Past Boring	Now Past Have anxiety
Now Past Demanding	**Do you often**:
Now Past Unsatisfactory	Now Past Have irrational fears
Do you worry over:	Now Past Feel upset
Now Past Home life	Now Past Feel things go wrong
Now Past Marriage	Now Past Feel shy
Now Past Children	Now Past Cry
Now Past Job	Now Past Feel inferior
Now Past Income	**Have you**:
Now Past Money problems	Now Past Seriously considered suicide
	Now Past Attempted suicide

POLICIES AND PROCEDURES

(please retain for your records)

New Patients:

First Appointment:

Your first consultation will be 45 minutes — 1 hour. During this time we will determine the appropriate lab tests you should order to address your specific health concerns.

1. Payment is due at time of consultation
2. Methods of payment are: Check or money order (in advance) Visa, MasterCard or American Express.
3. All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments:

- Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time.
- We encourage you to book your appointments 2 weeks in advance.
- As a courtesy to you, our office will call you to confirm your appointment one day in advance. You may also receive a reminder via email.

Lab Tests:

- The results of your lab test(s) will be sent to us 2 to 4 weeks after mailing your specimens to the lab.
- We will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.

Cancellations:

- If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Returned Products:

- PRE-APPROVAL is REQUIRED on ALL RETURNS!!
- Refrigerated items CANNOT be returned
- 15% restock fee of purchase price less shipping and handling may be refunded on unopened and non-refrigerated items
- No supplement returns will be accepted after 30 days on all regularly stocked items. Special orders CANNOT be returned!

- Prepaid tests can be returned for credit within one year of purchase.

Important Notes:

- We do not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911!
- Please contact the office if you are not clear on any of our policies or procedures.

I_____ have read and understood the policies and procedures. (Please print name)

Date_____

Signature_____

Please complete this form if you would like us to share information about your progress with another person.

Authorization to Release Medical Information

To: _____

Address: _____

I _____ request the following information:

_____ Test results _____ History _____ Records _____ Diagnosis

_____ Treatment _____ Reports _____ Progress

Concerning my: _____ Accident _____ Injury _____ Illness

Other _____

To be released to: _____

(Name of Practitioner, Doctor, family member etc.)

Address: _____

Fax: _____

For the purpose of: _____

(Specify)

Signed: _____ Date: _____

_____ Patient _____ Spouse _____ Parent _____ Guardian