CYNTHIA PRESTON
NATUROPATHIC DOCTOR

Adult New Patient Intake

Practice policies for Patients

Congratulations on taking the first step towards your journey of Health. Dr. Preston's goal is to provide you with the highest level of personalized care. She is committed to helping you on your path to health and healing.

It is important to read all the enclosed information carefully. You may mail or fax completed forms prior to your appointment. This will allow Dr. Preston to help solve your problems more efficiently and enhance the quality of your care. Alternatively, you may bring the forms in with you to your first appointment.

Appointment Scheduling

Due to the overwhelming requests for consultations, there is a 24 business hour cancellation policy. We encourage patient responsibility with their appointment schedule. Scheduling reminder calls are a courtesy and are NOT meant to replace your management of our appointment schedule. Please don't depend on the reminder calls as your only means of arriving at your appointment. The charge for Late Canceled Appointments and NO show appointments are **charged $100 per appointment and $25 for IV'S or Shots.** This means that we will charge you $100. 24 business hours advance notice is required and cancellation for a next day appointment left on voicemail after business hours will be charged as a late cancellation. If you are canceling a Monday appointment you are required to call on Friday. You may cancel your appointment by calling Beachside Naturopathic Clinic at 562-794-9027. If calling after hours, please leave a message.

I have read & agree to the 24-Business Hour Cancellation policy: PATIENT INITIALS____Date_____

Phone and Email Policy

For your safety all questions or emails to Dr. Preston will be charged. Should you have **one brief question regarding clarification of treatment from previous visit,** the message must be left with staff. Dr. Preston will return answers to emails either personally or to staff during those clinic hours when she is not actively providing direct patient care. Any other questions must be scheduled with Dr. Preston as a phone/email or office consult, unless you are a concierge patient. Considerable effort is made to respond to phone messages within 24 hours of their receipt; however, with a busy schedule and the only doctor on staff, telephone time is limited. It is preferable and safe that the evaluation and treatment of medical questions or recommendations be conducted during a scheduled office visit with Dr. Preston where you can receive adequate care and attention. We appreciate your understanding and consideration in this regard. Our phone and email policy is below:

- **1-10 minute phone call - $75**
- **Emails –$75 per email.**
- **Concierge patients – NO CHARGE**

I have read & agree to the Phone and Email policy: PATIENT INITIALS _____ Date_____

Insurance and Payment Information

Cynthia Preston, ND, **does not accept insurance or** Medicare and we cannot assure you that services (office visits, phone consultations or lab tests) will be reimbursed. You will be provided with diagnosis and procedure codes to assist you with possible insurance reimbursement. You can request a bill of services rendered that you can submit to your insurance provider who may reimburse you for some or the entire fee at their discretion.

REFILL FEE POLICY – For ALL patients receiving compounding hormones- There is an $80 administrative fee for refills every 3 months. This DOES NOT INCLUDE COST OF HORMONES or VISITS. Fee is waived for Hormone Concierge members.

Payment for the office visit or phone appointment is expected at time of service and can be in the form of check, cash or credit card payments. All credit card payments will be processed the same day of the visit or phone call.
You will receive an invoice receipt and superbill with the medical codes at the completion of your visit.
Dr. Preston does not accept insurance or Medicare. If you are using a health savings account, all supplements and visits can be used towards this. Please save your superbill for tax filing purposes.

NO REFUNDS ON SERVICES RENDERED, SUPPLEMENTS, AND/OR MEDICATIONS

Please be prepared to pay for your visit in full. Please ask about discounts for paying upfront for refill services.

I have read & agree to the Insurance & Payment policy (if applicable):
PATIENT INITIALS _____ Date_____

LAB TESTS

After your initial or follow–up consultations, lab tests and/or diagnostic tests may be ordered.
Testing recommendations and cost(s) per test will be reviewed at time of visit. Fees for such tests are billed directly by the lab to the patient, meaning that payment must always be sent with test kits at time of administration. In many cases, the lab will work directly with the patient's insurance care provider. We cannot guarantee that your labs will always be covered and will not reimburse your fees for any reason. We are also not responsible for insurance denials or balances due. With specialty testing kits there is a $**45 – 95** dollar fee depending on each test for shipping and processing of the test kits. This must be paid at time of visit when kit is given.
All specialty lab tests take up to 3 weeks to be finalized and sent to the office. Your appointment will be scheduled at 3 weeks for this reason.

Dr. Preston does provide phlebotomy services at Cynthia Preston, ND. This is a convenient service we offer for patients that includes a **$30 draw fee.** Specialty Kits do not include interpretation and processing fees of **$30 -55 .**

I have read & agree to the Lab Tests policy: PATIENT INITIALS _____Date_____

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Patient Contact Information

Name of Patient _____ Date of First Visit _
Name of Parent(s)/Guardian(s) (if applicable)_____ _____
Relationship to patient _____
Address_____
City _____ State _____ Zip Code _____
Telephone # (cell) _____
(home) _____
(work) _____
Email address_____
Age _____ Date of Birth _____ Gender: Female ___Male
Married _____ Separated _____ Divorced____ Widowed ____ Single _____ Partnership
Live with: Spouse _____ Partner____ Parents ____ Children_ Friends ____ Alone _____
Occupation _____ Hours per week _____ Retired
Employer _____
(Work address) _____
How did you hear about our clinic?_____

Next of Kin or other to reach in an emergency
_____
Relationship _____ Phone_____

Address_____

I authorize employees or agents of Cynergetics to leave a detailed message for me on a voice message device associated with the phone number listed below regarding my:

Laboratory reports ___Yes (initials) _____No (initials)
Protected Health Information ___Yes (initials) _____No (initials)

If you answered yes, please list number to call:

Consent to Treat

I understand that the treatment provided is determined by the professional discretion of my naturopathic doctor. Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children or those with multiple medications. It is very important that you inform Dr. Preston immediately of any disease process that you are suffering from or if you are taking any medications. If you are pregnant or you are breast-feeding, please inform me as well. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I will immediately notify the doctor if I become aware that I am pregnant.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to temporary aggravation of pre-existing symptoms, allergic reactions to herbs or supplements, bruising and bleeding from injection therapies.

I will immediately inform the doctor if I experience any gastrointestinal upset, allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur.

I have read, or have had read to me, the above information and I consent to receiving naturopathic medical care from the above mentioned naturopathic doctor I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment. Signing below means I consent to treatment

I have read & agree to the Consent to Treat policy: PATIENT INITIALS _____Date_____

Notice of Privacy Practices

This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPAA). Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. To correctional institutions or law enforcement officials, if you are an inmate

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care.
3. You have the right to inspect and obtain a copy of the health information that, but not including psychotherapy notes.

I have also read and understand the attached NOTICE OF PRIVACY PRACTICES**,** which discusses my rights under the Health Insurance Portability and Accountability Act of 1996.

I have read the attached (to clipboard), have a right to a copy & agree to the Notice of Privacy Practices policy:

REPRESENTATIVE or PATIENT INITIALS _____Date_____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice including deputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties' consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to. sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2). and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

PATIENT SIGNATURE X

(Or patient Representative) **(Indicate relationship if signing for patient)**

OFFICE SIGNATURE X

Article 5: Revocation: This agreement may be revoked by written notice delivered to the hearth care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.
Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example emergency treatment) patient should initial here_____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE X
(Or patient Representative) **(Indicate relationship if signing for patient)**

OFFICE SIGNATURE X

Consent Regarding E-mail Use or Disclosure of Health Information

Cynthia Preston, ND provides patients with the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail however, has a number of risks:

1. Risks:
    a. 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 copy information
2. It is the policy of Cynthia Preston, ND 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. We cannot guarantee 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 with the following conditions:
    a. All e-mails to or from patients concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Cynergetics staff, insurance coordinators and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
    b. Cynthia Preston, ND 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.
    c. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmittable or communicable diseases such as syphilis, gonorrhea and the like; behavioral health, mental health; or alcohol and drug abuse.
    d. Cynthia Preston, ND cannot guarantee that electronic communications will be private. Dr. Preston, ND is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct and is not liable for breaches of confidentiality caused by the patient.

I understand that my consent to the use of e-mail may be withdrawn at any time be e-mail or written communication to Cynthia Preston, ND. I have read this form carefully and understand the risks and responsibility associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

I have read & agree to the Consent Regarding E-mail Use or Disclosure of Health Information policy:

PATIENT INITIALS_____ Date_____

Release of Records

REQUESTING PARTY: Today's Date_____

Printed Legal Name _____ Date of Birth_____

I, the undersigned, hereby authorize:

Name of Agency or doctor _____

Address_____

City, State, Zip_____

Phone_____ Fax_____

TO RELEASE MY INFORMATION TO:

Dr. Cynthia Preston, ND
16601 Pacific Coast Highway
Sunset Beach, CA 90742
Tel: (562) 794-9027
Fax: (949)528-2526

Information to be released:

_____ALL MEDICAL RECORDS
_____OTHER_____

Initial next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information	Yes_____	No_____
Mental Health Information	Yes_____	No_____
AIDS/HIV Testing & Results	Yes_____	No_____
Sexually Transmitted Diseases Testing & Results	Yes_____	No_____
Communicable Diseases	Yes _____	No_____
Genetic Testing	Yes_____	No_____

and is limited to the time period from _____ to_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise specified, this authorization will automatically expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. A copy of this authorization shall be as valid as the original.

SIGNATURES: _____

Requesting Party_____ Date_____

For_____ Relationship_____

Nutritional Assessment Questionnaire 1.5

Name: Date:

Birth Date: Gender:

Please list your five major health concerns in order of importance:

1.

2.

3.

4.

5.

PART I

Read the following questions and circle the number that best applies:

0 = Do not consume or use	**2 = Consume or use weekly**
1 = Consume or use 2 to 3 times monthly	**3 = Consume or use daily**

DIET

1. 0 1 2 3 Alcohol
2. 0 1 2 3 Artificial Sweeteners
3. 0 1 2 3 Candy, Desserts, Refined Sugar
4. 0 1 2 3 Carbonated beverages
5. 0 1 2 3 Chewing Tobacco
6. 0 1 2 3 Cigarettes
7. 0 1 2 3 Cigars/Pipes
8. 0 1 2 3 Caffeinated Beverages
9. 0 1 2 3 Fast Foods
10. 0 1 2 3 Fried Foods
11. 0 1 2 3 Luncheon Meats
12. 0 1 2 3 Margarine
13. 0 1 2 3 Milk Products
14. 0 1 Radiation exposure (0=no,1=yes)
15. 0 1 2 3 Refined flour/baked goods
16. 0 1 2 3 Vitamins and minerals
17. 0 1 2 3 Water- Distilled
18. 0 1 2 3 Water- Tap
19. 0 1 2 3 Water- Well
20. 0 1 2 3 Diet often for weight control

LIFESTYLE

21. 0 1 2 3 Exercise per week (0= 2 or more times a week, 1= 1 time a week, 2= 1 or 2 times a month, 3= never, less than once a month)
22. 0 1 2 3 Changed Jobs (0= over 12 months ago, 1= within last 12 months, 2= within last 6 months, 3= within last 2 months)
23. 01 2 3 Divorced (0= never, over 2 years ago, 1= within last 2 years, 2= within last year, 3= within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0= never, 1= occasionally, 2= usually, 3= always)

MEDICATIONS- **Indicate any medications you're currently taking or have taken in the last month (0= no, 1= yes):**

25. 0 1 Antacids
26. 0 1 Anti-Anxiety medications
27. 0 1 Antibiotics
28. 0 1 Anticonvulsants
29. 0 1 Antidepressants
30. 0 1 Antifungals
31. 0 1 Aspirin/Ibuprofen
32. 0 1 Asthma Inhalers
33. 0 1 Beta blockers
34. 0 1 Birth control pills/ implant contraceptives
35. 0 1 Chemotherapy
36. 0 1 Cholesterol lowering medications
37. 0 1 Cortisone/steroids
38. 0 1 Diabetic medications/insulin
39. 0 1 Diuretics
40. 0 1 Estrogen or Progesterone (natural)
41. 0 1 Estrogen or Progesterone (pharmaceutical, prescription)
42. 0 1 Heart Medications
43. 0 1 High blood pressure medications
44. 0 1 Laxatives
45. 0 1 Recreational Drugs
46. 0 1 Relaxants/Sleeping pills
47. 0 1 Testosterone (natural or prescription)
48. 0 1 Thyroid medication
49. 0 1 Acetaminophen (Tylenol)
50. 0 1 Ulcer medications
51. 0 1 Sildenafil citrate (Viagra)

PART II

0= No, symptom does not occur	**2= Moderate symptom, occurs occasionally (weekly)**
1= Yes, minor or mild symptoms, rarely occurs (monthly)	**3= Severe symptom, occurs frequently (daily)**

SECTION I- Upper Gastrointestinal System

52. 0 1 2 3 Belching or gas within one hour after eating
53. 0 1 2 3 Heartburn or acid reflux
54. 01 2 3 Bloating within one hour after eating
55. 0 1 Vegan Diet (no dairy, meat, fish or eggs) (0=no, 1=yes)
56. 01 2 3 Bad Breath (halitosis)
57. 01 2 3 Loss of taste for meat
58. 01 2 3 Sweat has a strong odor
59. 01 2 3 Stomach upset by taking vitamins
60. 01 2 3 Sense of excess fullness after meals
61. 01 2 3 Feel like skipping breakfast
62. 01 2 3 Feel better if you don't eat
63. 01 2 3 Sleepy after meals
64. 01 2 3 Fingernails chip, peel or break easily
65. 01 2 3 Anemia unresponsive to iron
66. 01 2 3 Stomach pains or cramps
67. 01 2 3 Diarrhea, chronic
68. 01 2 3 Diarrhea shortly after meals
69. 01 2 3 Black or tarry colored stools
70. 01 2 3 Undigested food in stool

SECTION II- Liver and Gallbladder

71. 0 1 2 3 Pain between shoulder blades
72. 01 2 3 Stomach upset by greasy foods
73. 01 2 3 Greasy or shiny stools
74. 0 1 2 3 Nausea
75. 0 1 2 3 Sea, car, airplane or motion sickness
76. 0 1 History of motion sickness (0=no, 1=yes)
77. 0 1 2 3 Light or clay colored stools
78. 0 1 2 3 Dry skin, itchy feet or skin peels on feet
79. 0 1 2 3 Headache over eyes
80. 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
81. 0 1 Gallbladder removed (0=no, 1=yes)
82. 0 1 2 3 Bitter taste in mouth, especially after meals
83. 0 1 Become sick if you were to drink wine (0=no, 1=yes)
84. 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
85. 0 1 Easily hungover if you were to drink wine (0=no, 1=yes)
86. 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2=<14, 3=>14)
87. 0 1 Recovering alcoholic (0=no, 1=yes)
88. 0 1 History of drug or alcohol abuse (0=no, 1=yes)
89. 0 1 History of hepatitis (0=no, 1=yes)
90. 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
91. 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
92. 0 1 2 3 Sensitive to tobacco smoke
93. 0 1 2 3 Exposure to diesel fumes
94. 0 1 2 3 Pain under right side of rib cage
95. 0 1 2 3 Hemorrhoids or varicose veins
96. 0 1 2 3 Nutrasweet (aspartame) consumption
97. 0 1 2 3 Sensitive to Nutrasweet (aspartame)
98. 0 1 2 3 Chronic fatigue or Fibromyalgia

SECTION III- Small Intestine

99. 0 1 2 3 Food Allergies
100. 0 1 2 3 Abdominal bloating1 to 2 hours after eating
101. 0 1 Specific foods make you tired or bloated (0=no,1=yes)
102. 0 1 2 3 Pulse speeds after eating
103. 0 1 2 3 Airborne allergies
104. 0 1 2 3 Experience hives
105. 0 1 2 3 Sinus congestion, "stuffy head"
106. 0 1 2 3 Crave bread of noodles
107. 0 1 2 3 Alternating constipation and diarrhea
108. 0 1 2 3 Crohn's disease (0=no, 1=yes in the past, 2=currently mild condition, 3=severe)
109. 0 1 2 3 Wheat or grain sensitivity
110. 0 1 2 3 Dairy sensitivity
111. 0 1 Are there foods you could not give up (0=no,1=yes)
112. 0 1 2 3 Asthma, sinus infections, stuffy nose
113. 0 1 2 3 Bizarre vivid dreams, nightmares
114. 0 1 2 3 Use over-the-counter pain medications
115. 0 1 2 3 Feel spacey or unreal

SECTION IV- Large Intestine

116. 0 1 2 3 Anus Itches
117. 0 1 2 3 Coated tongue
118. 0 1 2 3 Feel worse in moldy or musty place
119. 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1=<1 month, 2=<3 months, 3=>3 months)
120. 0 1 2 3 Fungus or yeast infections
121. 0 1 2 3 Ring worm, “jock itch”, “athletes foot”, nail fungus
122. 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
123. 0 1 2 3 Stool hard or difficult to pass
124. 0 1 History of parasites (0=no, 1=yes)
125. 0 1 2 3 Less than one bowel movement per day
126. 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
127. 0 1 2 3 Stools are not well formed (loose)
128. 0 1 2 3 Irritable bowel or mucus colitis
129. 0 1 2 3 Blood in stool
130. 0 1 2 3 Mucus in stool
131. 0 1 2 3 Excessive foul smelling lower bowel gas
132. 0 1 2 3 Bad breath or strong body odors
133. 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
134. 0 1 2 3 Cramping in lower abdominal region
135. 0 1 2 3 Dark circles under eyes

SECTION V- Mineral Needs

136. 0 1 History of carpal tunnel syndrome (0=no,1=yes)
137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
138. 0 1 History of stress fracture (0=no, 1=yes)
139. 0 1 2 3 Bone loss (reduced density on bone scan)
140. 0 1 Are you shorter than you used to be? (0=no,1=yes)
141. 0 1 2 3 Calf, foot or toe cramps at rest
142. 0 1 2 3 Cold Sores, fever blisters or herpes lesions
143. 0 1 2 3 Frequent fevers
144. 0 1 2 3 Frequent skin rashes and/or hives
145. 0 1 Herniated disc (0=no, 1=yes)
146. 0 1 2 3 Excessively flexible joints, “double jointed”
147. 0 1 2 3 Joints pop or click
148. 0 1 2 3 Pain or swelling in joints
149. 0 1 2 3 Bursitis or tendonitis
150. 0 1 History of bone spurs (0=no, 1=yes)
151. 0 1 2 3 Morning stiffness
152. 0 1 2 3 Nausea with vomiting
153. 0 1 2 3 Crave chocolate
154. 0 1 2 3 Feet have a strong odor
155. 0 1 2 3 History of anemia
156. 0 1 2 3 Whites of eyes (sclera) blue tinted
157. 0 1 2 3 Hoarseness
158. 0 1 2 3 Difficulty swallowing
159. 0 1 2 3 Lump in throat
160. 0 1 2 3 Dry mouth, eyes and/or nose
161. 0 1 2 3 Gag easily
162. 0 1 2 3 White spots on fingernails
163. 0 1 2 3 Cuts heal slowly and/or scar easily
164. 0 1 2 3 Decreased sense of taste or smell

SECTION VI- Essential Fatty Acids

165. 0 1 Experience pain relief with aspirin
166. 0 1 2 3 Crave fatty or greasy foods
167. 0 1 2 3 Low- or reduced- fat diet (0= never, 1=years ago, 2=within past year, 3=currently)
168. 0 1 2 3 Tension headaches at base of skull
169. 0 1 2 3 Headaches when out in the hot sun
170. 0 1 2 3 Sunburn easily or suffering from poisoning
171. 0 1 2 3 Muscles easily fatigued
172. 0 1 2 3 Dry flaky skin or dandruff

SECTION VII- Sugar Handling

173. 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
174. 0 1 2 3 Crave sweets
175. 0 1 2 3 Binge or uncontrolled eating
176. 0 1 2 3 Excessive appetite
177. 0 1 2 3 Crave coffee or sugar in the afternoon
178. 0 1 2 3 Sleepy in the afternoon
179. 0 1 2 3 Fatigue that is relieved by eating
180. 0 1 2 3 Headache if meals are skipped or delayed
181. 0 1 2 3 Irritable before meals
182. 0 1 2 3 Shaky if meals delayed
183. 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
184. 0 1 2 3 Frequent thirst
185. 0 1 2 3 Frequent urination

SECTION VIII- Vitamin Need

186. 0 1 2 3 Muscles become easily fatigued
187. 0 1 2 3 Feel exhausted or sore after moderate exercise
188. 0 1 2 3 Vulnerable to insect bites
189. 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
190. 0 1 2 3 Enlarged heart or congestive heart failure
191. 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
192. 0 1 2 3 Ringing in the ears (Tinnitus)
193. 0 1 2 3 Numbness, tingling or itching in the hands and feet
194. 0 1 2 3 Depressed
195. 0 1 2 3 Fear of impending doom
196. 0 1 2 3 Worrier, apprehensive, anxious
197. 0 1 2 3 Nervous or agitated
198. 0 1 2 3 Feelings of insecurity
199. 0 1 2 3 Heart races
200. 0 1 2 3 Can hear heartbeat on pillow at night
201. 0 1 2 3 Whole body or limb jerk as falling asleep
202. 0 1 2 3 Night sweats
203. 0 1 2 3 Restless leg syndrome
204. 0 1 2 3 Cracks at corner of mouth (Cheilosis)
205. 0 1 2 3 Fragile skin, easily chaffed, as in shaving
206. 0 1 2 3 Polyps or warts
207. 0 1 2 3 MSG sensitivity
208. 0 1 2 3 Wake up without remembering dreams
209. 0 1 2 3 Small bumps on back of arms
210. 0 1 2 3 Strong light at night irritated eyes
211. 0 1 2 3 Nose bleeds and/or tend to bruise easily
212. 0 1 2 3 Bleeding gums especially when brushing teeth

SECTION IX- Adrenal

213. 0 1 2 3 Tend to be a “night person”
214. 0 1 2 3 Difficulty falling asleep
215. 0 1 2 3 Slow starter in the morning
216. 0 1 2 3 Tend to be keyed up, trouble calming down
217. 0 1 2 3 Blood pressure above 120/80
218. 0 1 2 3 Headache after exercising
219. 0 1 2 3 Feeling wired or jittery after drinking coffee
220. 0 1 2 3 Clench or grind teeth
221. 0 1 2 3 Calm on the outside, troubled on the inside
222. 0 1 2 3 Chronic low back pain, worse with fatigue
223. 0 1 2 3 Become dizzy when standing up immediately
224. 0 1 2 3 Difficulty maintaining manipulative correction
225. 0 1 2 3 Pain after manipulative correction
226. 0 1 2 3 Arthritic tendencies
227. 0 1 2 3 Crave salty foods
228. 0 1 2 3 Salt foods before tasting
229. 0 1 2 3 Perspire easily
230. 0 1 2 3 Chronic fatigue, or get drowsy often
231. 0 1 2 3 Afternoon yawning
232. 0 1 2 3 Afternoon headache
233. 0 1 2 3 Asthma, wheezing or difficulty breathing
234. 0 1 2 3 Pain on the medial or inner side of the knee
235. 0 1 2 3 Tendency to sprain ankles or “shin splints”
236. 0 1 2 3 Tendency to need sunglasses
237. 0 1 2 3 Allergies and/or hives
238. 0 1 2 3 Weakness, dizziness

SECTION X- Pituitary

239. 0 1 Height over 6’6” (0=no, 1=yes)
240. 0 1 Early sexual development (before age 10) (0=no,1=yes)
241. 0 1 2 3 Increased libido
242. 0 1 2 3 Splitting type headache
243. 0 1 2 3 Memory failing
244. 0 1 Tolerate sugar, feel fine when eating sugar (0=no,1=yes)
245. 0 1 Height under 4’10” (0=no, 1=yes)
246. 0 1 2 3 Decreased libido
247. 0 1 2 3 Excessive thirst
248. 0 1 2 3 Weight gain around hips or waist
249. 0 1 2 3 Menstrual disorders
250. 0 1 Delayed sexual development (after age 13) (0=no,1=yes)
251. 0 1 2 3 Tendency to ulcers or colitis

SECTION XI- Thyroid

252. 0 1 2 3 Sensitive/allergic to iodine
253. 0 1 2 3 Difficulty gaining weight, even with large appetite
254. 0 1 2 3 Nervous, emotional, can't work under pressure
255. 0 1 2 3 Inward trembling
256. 0 1 2 3 Flush easily
257. 0 1 2 3 Fast pulse at rest
258. 0 1 2 3 Intolerance to high temperatures
259. 0 1 2 3 Difficulty losing weight
260. 0 1 2 3 Mentally sluggish, reduced initiative
261. 0 1 2 3 Easily fatigued, sleepy during the day
262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
263. 0 1 2 3 Constipation, chronic
264. 0 1 2 3 Excessive hair loss and/or coarse hair
265. 0 1 2 3 Morning headaches, wearing off during the day
266. 0 1 2 3 Loss of lateral ⅓ of eyebrow
267. 0 1 2 3 Seasonal sadness

SECTION XII- Men Only

268. 0 1 2 3 Prostate Problems
269. 0 1 2 3 Difficulty with urination, dribbling
270. 0 1 2 3 Difficult to start and stop urine stream
271. 0 1 2 3 Pain or burning with urination
272. 0 1 2 3 Waking to urinate at night
273. 0 1 2 3 Interruption of stream during urination
274. 0 1 2 3 Pain on inside of legs or heels
275. 0 1 2 3 Feeling of incomplete bowel evacuation
276. 0 1 2 3 Decreased sexual function

SECTION XIII- Women Only

277. 0 1 2 3 Depression during periods
278. 0 1 2 3 Mood swings associated with periods (PMS)
279. 0 1 2 3 Crave chocolate around periods
280. 0 1 2 3 Breast tenderness associated with cycle
281. 0 1 2 3 Excessive menstrual flow
282. 0 1 2 3 Scanty blood flow during periods
283. 0 1 2 3 Occasional skipped periods
284. 0 1 2 3 Variations in menstrual cycles
285. 0 1 2 3 Endometriosis
286. 0 1 2 3 Uterine fibroids
287. 0 1 2 3 Breast fibroids, benign masses
288. 0 1 2 3 Painful intercourse (dysparenia)
289. 0 1 2 3 Vaginal Discharge
290. 0 1 2 3 Vaginal dryness
291. 0 1 2 3 Vaginal itchiness
292. 0 1 2 3 Gain weight around hips, thighs and buttocks
293. 0 1 2 3 Excess facial or body hair
294. 0 1 2 3 Hot flashes
295. 0 1 2 3 Night sweats (in menopausal females)
296. 0 1 2 3 Thinning skin

SECTION XIV- Cardiovascular

297. 0 1 2 3 Aware of heavy and/or irregular breathing
298. 0 1 2 3 Discomfort at high altitudes
299. 0 1 2 3 "Air hunger" or sigh frequently
300. 0 1 2 3 Compelled to open windows in a closed room
301. 0 1 2 3 Shortness of breath with moderate exertion
302. 0 1 2 3 Ankles swell, especially at the end of the day
303. 0 1 2 3 Cough at night
304. 0 1 2 3 Blush or face turns red for no reason
305. 0 1 2 3 Dull pain or tightness in chest and/or radiate
306. 0 1 2 3 Muscle cramps with exertion

SECTION XV- Kidney and Bladder

307. 0 1 2 3 Pain in mid-back region
308. 0 1 2 3 Puffy around the eyes, dark circles under eyes
309. 0 1 History of kidney stones (0=no, 1=yes)
310. 0 1 2 3 Cloudy, bloody or darkened urine
311. 0 1 2 3 Urine has a strong odor

SECTION XVI- Immune System

312. 0 1 2 3 Runny or drippy nose
313. 0 1 2 3 Catch colds at the beginning of winter
314. 0 1 2 3 Mucus producing cough
315. 0 1 2 3 Frequent cold or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
317. 0 1 2 3 Never get sick (0= sick only 1 or 2 times in the last 2 years, 1= not sick in the last 2 years, 2=not sick in the last 4 years, 3= not sick in the last 7 years)
318. 0 1 2 3 Acne (adult)
319. 0 1 2 3 Itchy skin (Dermatitis)
320. 0 1 2 3 Cystys, boils, rashes
321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0=no, 1=yes in the past, 2= currently mild condition, 3= severe)

Do you have any known contagious diseases at this time? Y N If yes, what?_____

Current Medications
Please list any **prescription** or **over-the-counter medications** you are taking, with dosages.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list any **vitamins** or other **supplements** you are taking, with dosages.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Allergies - Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____