WELCOME TO HENRY CHIROPRACTIC

Grimsley,Chiropractic Services, P.C
22780 Three Notch Road, Lexington Park, MD 20653
Phone: 301-737-0662 Fax: 301-737-0675

Full Name:	Date:	Circle: M or F
How did you hear about us?	Date of Birth:	Age:
Address:		
City, State, Zip code:		
Home phone:	Cell:	Work:
Employer:	Occupation:	
Name of Spouse:	Email:	
Emergency Contact:	Relationship:	Phone:

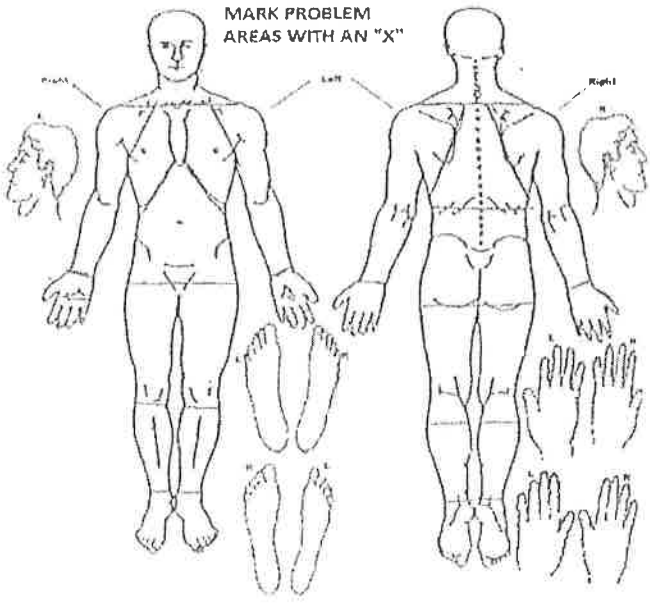
Health Insurance Information

Primary Insurance	**Secondary Insurance**
Insurance Carrier:	Insurance Carrier:
ID#:	ID#:
Group#:	Group#:
Name of Insured:	Name of Insured:
Relationship: ☐Self ☐Spouse ☐Child ☐Other	Relationship:☐Self ☐Spouse ☐Child ☐Other
Insured's DOB:	Insured's DOB:
Insured Employer:	Insured Employer:

I certify that I, and/or my dependent(s) have insurance coverage with & assign directly to GCS, P.C. all insurance benefits, if any, otherwise, payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. GCS, P.C. may use my health care information & may disclose such information to the above named insurance companies & their agents for the purpose of obtaining payment for services & insurance benefits or the benefits payable for related services. A photocopy of the Assignment shall be considered as effective & valid as the original.

Signature _____ Printed Name: _____ Date: _____

YOUR CONDITION



Reason for visit:

Onset Date:

Condition is getting: ☐Worse ☐Better ☐Same

Rate your pain (1=least, 10=severe):

Frequency of the pain:

Pain interferes with:
☐Work ☐Daily Routine ☐Recreation

Pain to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying

Type of Pain: ☐Aching ☐Burning ☐Cramps ☐Dull ☐Numbness ☐Sharp ☐Shooting ☐Stabbing ☐Stiff ☐Swelling ☐Throbbing ☐Tingling ☐Other

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone: H) _____ Phone: W) _____

Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____ **HENRY CHIROPRACTIC & WELNESS CENTER** _____

Address: _____ **22780 THREE NOTCH ROAD** _____

City, State, Zip: **LEXINGTON PARK, MD 20650**

☐ **Please mail records.**
☐ **Please fax records.**

Fax: **301-737-0675** **Phone:** **301-737-0662**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

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 that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

Notice of Privacy Practices
Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record:

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnosis, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning our care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure accuracy and enable you to relate to who, what, when, where, and why others may be allowed to access your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others. Use or disclosure of your health information will follow the more stringent of State or Federal laws.

Understanding Your Health Information Rights:

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health record be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our Responsibilities:

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to changes it practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our website that provides information about our customer service and/or benefits. Other than the reason described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or to report a problem:

For further explanation of this notice you may contact our Privacy Officer at (301) 737-0662. If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual above, or by contacting the Secretary of Health and Human Services, with no fear of retaliation by this office.

Your Health Information Will Be Used For Treatment, Payment, and Health Care Operations:

Treatment---Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those others involved in providing your care such as his/her physician assistant, nurse, or medical assistant. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment---Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

Health Care Operations---The medical staff in this office will use your health information to assess the care provided and the outcome of your care compare to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

(continued over)

Business Associates---Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To protect our health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Notification---Your health care record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or whereabouts.

Communications with Family---Using best judgment, a family member, or a close personal friend, identified by you, may be given information relevant to your care and/or recovery.

Upon Your Death--- Your health information may be disclosed consistent with laws governing estate and post-mortem personal matters. Generally, your health information may be disclosed to your personal representative as designated by you and certified by the State and to Funeral Directors with laws governing mortician services.

Organ Procurement Organization---Your health information may be disclosed consistent governing entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.

Marketing---This office reserves the right to contact you with information about treatment alternatives and other health related benefits that may be appropriate to you.

Appointment Reminders---This office reserves the right to contact you with appointment reminders through an automated system, by our staff, or via U.S. Postal Service.

Phone Contact---This office reserves the right to contact you via the telephone for such things as test result notification. We may leave a generic message on your answering machine, or with the person answering the phone concerning the nature of the call along with a request that you call us for more specific details.

Research---Your information will be disclosed to researchers upon institutional Review Board approval and upon the assurance that established protocol to ensure the privacy of your health information has been obtained.

Food and Drug Administration (FDA)--- This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable products recalls, repairs, or replacements.

Workers Compensation---This office will release information to the extent authorized by law in matters of Workers' Compensation.

Public Health---This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports or birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Correction Facilities---This office will release medical information on incarcerated individuals to Correctional Agents or Institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

Law Enforcement--- (1) Your health information will be disclosed for law enforcement purposes as required under State Law or in response to a valid subpoena. (2) Provisions of Federal Law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more parties, workers, or the general public.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posed where registration occurs. All individuals receiving care will be given a hard copy

Patient's Comments:

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

_____ (Description of Legal Representative's Attorney)

If any of your health goals is to lose weight, please fill out the following:

SURVEY FOR WEIGHT LOSS

An honest inventory on the quest to lose weight. There are no wrong answers.

1. My Primary reason for losing weight is:
   - ☐ I don't like the way I look
   - ☐ I don't like the way I feel
   - ☐ I'm concerned about my health
   - ☐ Other

2. My concern level regarding losing weight is:
   - ☐ I'm concerned I'll fail
   - ☐ With help I can do this
   - ☐ I'm confident that I can do this
   - ☐ Other

3. How long do you feel you'll commit to your weight loss plan:
   - ☐ One week
   - ☐ One month
   - ☐ Permanently
   - ☐ Other

4. I'm losing weight for:
   - ☐ My spouse
   - ☐ My children
   - ☐ Myself
   - ☐ Other

5. My biggest obstacle in losing weight is:
   - ☐ I love food
   - ☐ I eat for comfort
   - ☐ I eat out of boredom
   - ☐ Other

6. What are 3 things that would help me commit to losing the weight I want to lose & sticking with it:

   1. _____

   2. _____

   3. _____

Nutritional Health Questionnaire

DATE _____

General Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email address: _____

Preferred Contact Method: _____

( ) Male ( ) Female DOB: _____

Relationship Status: ( ) S ( ) M ( ) D ( ) W

Occupation: _____ How Long: _____ Satisfied? (1-10) _____

Passions / Interests: _____

_____

What do you hope I can do for you at this time?

_____

_____

_____

What are your health concerns?

_____

_____

_____

For how long have you experienced these conditions?

_____

_____

_____

Medical Information

Primary Physician's Name: _____ Phone #: _____

Please list any Allergies you may have to:

1) Foods: _____

_____

2) Medications: _____

_____

3) Chemicals: _____

_____

4) Environmental: _____

_____

5) Others: _____

List Major Traumas, Surgeries and Hospitalizations you have had:

_____

_____

_____

_____

Have you had prolonged use of any medication in the past? (Antibiotic, Acid Blockers...)

_____

_____

Medications and Supplements:

- Please list ALL prescription medication, nutritional supplements and herbs that you are currently taking.

	Name	Dosage	Frequency	How Long	Reason
Medications					

	Name	Dosage	Frequency	How Long	Reason
Supplements					

FOR WOMEN ONLY:

1) # Of pregnancies: _____Year:_____Trying to Conceive? _____
2) Are you currently pregnant? _____ Are you breastfeeding? _____

Family History

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		

Physical Activity / Life Style

What kind of physical activities do you do? _____
Are you satisfied with your energy level? _____
Do you have any problems/limitations that limit your physical activity? _____
_____

Activity	Type(s)	Days per Week	Duration
Cardio / Aerobic			
Strength training			
Yoga / Stretching			
Others			

What do you do for Relaxation? _____
_____
How many hours of sleep do you get a night / day? _____
Do you sleep well? _____
On a scale of 1 – 10, with 1 being low and 10 being high, how stressful is your:
- Work: _____ - Social/Family Situation: _____
- Current Health Status: _____ - Life in General: _____

What do you believe you can do to make a difference in your current health status?
_____
_____

Nutrition Information

Have you ever had nutritional counseling? _____
Please list any special dietary restrictions / habits you have: _____
_____
_____
What foods do you crave if anything? _____
_____
Please describe any changes you have made to your diet to improve your health: ___
_____
_____
How would you describe your relationship to food? _____
_____
_____
Height: _____ Current Weight: _____ Ideal Weight: _____
Highest Adult Weight: _____
Lowest Adult Weight: _____

Food Frequency: How often do you eat, drink or do the following? Please insert a number and circle day (d) or week (wk.)

Meals per day: _____.
Snacks per day: _____.
Red Meat: _____ d / wk.
Chicken / Turkey: _____ d / wk.

Water (ounces per day): _____.
Prepare meals: _____ d / wk.
Nuts / Seeds: _____ d / wk.
Lentils/Beans: _____ d / wk.
Yogurt/Kefir: _____ d / wk.
Fats and oils: _____ d / wk. What Kinds? _____
Eggs: _____ d / wk.
ALL VEGGIES: _____ d / wk.
Bread: _____ d / wk.
Whole grains: _____ d / wk.
Pasta: _____ d / wk.
Soft Drinks: _____ d /wk., diet OR Regular
Chips/crackers etc.: _____ d / wk.
Fast Food: _____ d / wk.

Deli Meat: _____ d / wk.
Fish: _____ d / wk.
Shellfish: _____ d / wk.
Organ Meat: _____ d / wk.
Soy products: _____ d / wk.
Dairy Milk / Cheese: _____ d / wk.
ALL FRUITS: _____ d / wk.
Coffee: _____ d / wk. Decaf? _____
Herb or other Tea: _____ d / wk.
Frozen Dinners: _____ d / wk.
Candy: _____ d / wk.
Alcoholic Drinks: _____ d / wk.
Eat fast or on the run: _____ d / wk.

Environmental Information

How often do you consume or are exposed to any of the following? Please insert a number and circle day (d) or week (wk.).

Cigarette smoke: _____ d / wk.
Perfumes/hair dyes: _____ d / wk.
Recreational drugs: _____ d / wk.
Mold: _____ d / wk.
Bottled water: _____ d / wk.

Wood Stove: _____ d / wk.
Pesticides: _____ d / wk.
Pet dander: _____ d / wk.
Cleaning Products: _____ d / wk.
Teflon or aluminum pans: _____ d / wk.

Metabolic Assessment Form™

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list your 5 major health concerns in order of importance:

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

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes		No	
Category VIII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	
Category IX				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category X				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3
Category XI				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Metabolic Effect Questionnaire

To find out what kind of fuel burner you are- sugar, muscle, or mixed- answer each question to the best of your ability. Don't stop and think about the details, just check the box next to the answer that fits you best. If none of the answers suits you, then choose the one that is the closest.

- Which of the following meals would give you sustained and lasting energy if it were the only meal you could eat all day?
  - ☐ Cereal (0)
  - ☐ Eggs and Cereal (+1)
  - ☐ Steak and Eggs (+2)
- What best describes your reaction to high-carbohydrate foods such as pasta or potatoes?
  - ☐ They give me short boost in energy, but I can crash later. (+1)
  - ☐ They make me feel tired and lethargic almost immediately after eating them. (+2)
  - ☐ They give me long-lasting energy (-2)
- When it comes to desserts, which do you prefer?
  - ☐ I have no preference. (+1)
  - ☐ Creamy, rich sweets like cheesecake or chocolate mousse (+2)
  - ☐ I like all sweets, but I prefer lighter things like cookies and candy bars (0)
- What best describes your reaction to eating protein such as chicken, steak, or eggs?
  - ☐ They satisfy my hunger and give me energy for many hours. (+4)
  - ☐ They give me about the same energy as carbohydrate-rich foods such as pasta and potatoes. (+1)
  - ☐ They fill me up and often make me feel sluggish and tired OR I do not eat meat (-2)
- Which do you crave the most?
  - ☐ Protein, salt, and coffee (+2)
  - ☐ Sugar; coffee; or cocktails, wine, or beer (-2)
  - ☐ I don't get cravings very often, but when I do, I crave a. and b. (+1)
- What describes your reaction to strong bright lights?
  - ☐ I'm not sensitive to bright lights. (+2)
  - ☐ Light has to be very bright for me to notice. (+1)
  - ☐ I'm sensitive to bright lights and prefer sunglasses when I'm outside. (-2)

- What best describes your tendency toward anxiety or depression?
  - ☐ I tend to become depressed or moody. (+2)
  - ☐ I'm rarely depressed or anxious. (+1)
  - ☐ I tend to become anxious in many situations. (-2)
- What best describes your weight?
  - ☐ I am average weight. (+2)
  - ☐ I am underweight, but can store fat around my waist. (-8)
  - ☐ I am overweight or obese. (+6)
- How do you best describe your appetite?
  - ☐ I live to eat and frequently overeat. (+4)
  - ☐ I use food as fuel, but indulge on occasion. (+2)
  - ☐ I eat to live and sometimes have to remind myself to eat. (-6)
- If you needed to stay focused for a long period of time, which would help?
  - ☐ Nuts like almonds, walnuts, or peanuts. (+2)
  - ☐ Trail mix with a mix of dried fruit and nuts. (+1)
  - ☐ Dried fruit or candy. (-2)
- What best describes your facial skin?
  - ☐ My skin is very healthy and balanced. (+2)
  - ☐ My skin is sometimes oily and I'm prone to acne or breakouts. (+4)
  - ☐ I have sensitive, often dry skin that sometimes looks red and irritated. (0)
- What best describes your digestive system?
  - ☐ I suffer from heartburn or irritable bowel syndrome (IBS). (0)
  - ☐ I am frequently constipated or have irregular bowel movements. (+4)
  - ☐ I have regular bowel movements with no problems. (+2)
- What state best describes your energy levels?
  - ☐ I feel mentally balance, except on rare occasions when I am stressed or don't get enough sleep. (+2)
  - ☐ I feel mentally alert and wired, yet at the same time, physically tired. (-6)
  - ☐ I feel mentally and physically fatigued most of the time. (+4)

- What happens when you skip meals?
  - ☐ I become irritable, shaky, and/or light-headed. (+4)
  - ☐ I can skip 1 meal and feel fine, but I become irritable, shaky, and/or light-headed if I miss 2 or more meals. (+2)
  - ☐ Skipping meals does not bother me. I frequently go more than 4 to 6 hours without eating. (-4)
- What best describes your sleeping habits?
  - ☐ I'm frequently tired, but still have difficulty falling asleep and/or getting up in the morning. (+4)
  - ☐ I have difficulty falling asleep or sleeping soundly, yet still feel wired during the day. (-4)
  - ☐ I fall asleep fine, sleep soundly, and wake feeling refreshed. (+2)
- How do you best describe how old you look?
  - ☐ I look my age. (+1)
  - ☐ I look older than my age. (0)
  - ☐ I look young for my age. (+2)
- When do you perspire?
  - ☐ I rarely perspire even when exercising. (+2)
  - ☐ I only perspire when exercising or am very hot. (+1)
  - ☐ I perspire a lot during exercise and even when I'm not exercising. (0)
- How do you best describe your state of awareness and alertness?
  - ☐ I am acutely aware of my surroundings and the people around me, but can find it difficult to focus on any one task. (-4)
  - ☐ It often takes me a moment to register questions and respond. (+2)
  - ☐ I am aware of my surroundings and responsive to people and their questions. (+1)

KEY:

SUGAR BURNER: 35 or more points
MIXED BURNER: 20-35 points
MUSCLE BURNER: Less than 20 points

Total Points:

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Diet Diary / Exercise Log

Name:_____

Please complete your "Diet Diary / Exercise Log" every day.

1.) Make note of the time you wake up.

2.) List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list everything you eat or drink, including any condiments used (i.e. mayonaise, mustard relish, etc.).

3.) Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.

4.) Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.

5.) Note any periods of relaxation and what kind of relaxation it was.

6.) Note the time you go to sleep.

Day 1	Date:
Wake up:	
Morning Meal Time:	
Snack Time:	
Mid-Day Meal Time:	
Snack Time:	
Evening Meal Time:	
Snack Time:	
Water (ounces)	
Other Drinks (that are not listed with meals or snacks above)	
Activity/Exercise What kind: How long:	
Relaxation type: How long:	
sleep time:	

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Diet Diary / Exercise Log

	Day 2 - Date:	Day 3 - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack		
Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		

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Diet Diary / Exercise Log

	Day 4 - Date:	Day 5 - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		

FLT MISSED APPONTMENT POLICY

Effective January 1, 2012, if your scheduled appointment is not cancelled with at least a 24-hour notice or a message left on our voicemail, your account will be charged a $50.00 fee.

Thank you for your consideration to our other patients who can fill in these missed slots.

I have read and accept the above terms and conditions:

Print name:_____

Signature: _____Date: _____