

**Rejuvenate Wellness Center**  
**6940 South Holly Circle**  
**Centennial, CO 80112**  
**303-850-0880**



**Dear friend,**

**Welcome to Rejuvenate Wellness Center!**

Thank you and congratulations on making the choice to come see us!

You have scheduled an appointment with Dr. Peter M. Petropulos on \_\_\_\_\_,  
 \_\_\_\_\_ (day/date) at \_\_\_\_\_ (time) at our Rejuvenate Wellness Center  
 office.

**Please complete all paperwork prior to arriving at the office and arrive 15 minutes BEFORE your appointment time (which is listed above).**

You have taken an important step and made the choice to turn either your own and/or your family member's health around. We understand that this process will involve some challenging lifestyle changes, and we are here to work together as partners with you to help you reach your optimum health.

Many of our patients have previously consulted with numerous other health practitioners. Your decision to partner with us in a quest to improve your health will result in identifying the cause(s) of your illness, and eliminate the use of "Band-Aid" treatments for your symptoms. Answers to some of the common questions/concerns by our patients are listed below.

#### **What Should I Do Prior to My Visit?**

In this packet, you have received a health questionnaire. Take the time to answer the questions with as much detail as possible. **Please try to assemble any of your medical information that may be helpful (tests, consultations with other physicians, list of current medications and supplements).** If you have had tests, lab studies, surgeries, and/or consultations but don't have the records, please ask the appropriate physicians and/or hospitals to give them to you or have them sent directly to us. Bring the completed questionnaire and any additional information with you to your appointment.

#### **What If I Am on Any Medications or Supplements?**

Please stay on them until we have an opportunity to review your complete history. Most of our patients are able to eventually stop or reduce many of the medications that other doctors have put them on after they have been on our program for awhile. At your initial appointment, you will receive nutritional supplement recommendations. We carry an extensive line of the finest supplements available to physicians anywhere. They are specifically designed to complement the other lifestyle recommendations of our program. Although you may be able to purchase similar products at local health food

stores, the potential quality of these supplements may compromise our treatment and therefore hinder your progress.

### **What Happens at My First Appointment?**

Dr. Petropulos will thoroughly review your medical history and symptom survey that you completed prior to your visit and also review medical records including recent lab results which you will have provided. He will do a complete physical examination, muscle testing for food and environmental intolerances as well as bio-diagnostic testing utilizing the latest in BAX Aura testing. If, after your examination, further laboratory analysis is required, we also have a full range of laboratory services and a wide variety of cutting-edge testing available in-house including blood, saliva, hair, urine, and stool analyses. After reviewing all the information, he will make recommendations for an individualized program of nutritional and lifestyle augmentation. This can also include Chiropractic care, acupuncture and further BAX therapies if you wish.

### **How Long Will it Take Before I Feel Better?**

You should notice your health beginning to improve within a few weeks. Some people notice the difference in only a few days. However, it can take a bit longer, especially if significant psychological trauma is involved or if you are slow in adopting the lifestyle changes we recommend.

### **What Will Be The Cost For My First Visit?**

The time spent with you on the first visit is approximately 1 hour, 45 minutes. An initial appointment is \$415 (which does not include any lab work, testing, or supplements).

### **Follow-Up Appointments**

Follow-up appointments are typically 15 minutes with the doctor and cost \$110. You may be in the room 15 to 30 minutes longer depending on individual therapies (i.e., acupuncture, electrical stimulation, laser treatment, etc.) needed for your treatment; however, no additional cost will be assessed. If you require or desire more than the standard 15-minute appointment with the doctor, the fee will be an additional \$110 per 15 minutes.

### **Will My Insurance Cover The Visit?**

Most insurance companies do not cover the alternative therapies we offer to our patients, so we do not work with insurance companies. We do not typically provide any paperwork (superbills), diagnosis codes, or information for insurance companies.

### **Do We See Patients From Out of State?**

We do have out-of-town and international patients. In these cases, we try to do most of the follow-up via telephone and the Internet; but a personal visit is generally preferred, but not mandatory, for the initial consultation. If you are coming from out of state, we will try to accommodate you so we are able to complete as many tests as possible when you are here and will use your time with us as effectively as possible.

### **What If I Want to Send a Friend or Family Member to See You?**

We would be delighted and deeply honored to work with your loved ones. However, it is vital that this friend or family member is ready to commit to a change in diet, nutrition, and lifestyle in order to meet his/her own health goals.

**What Happens If I Need to Cancel My Appointment?**

Please call us as soon as you know that you need to cancel but no later than **48 hours prior to your appointment time** (except for cancellations due to inclement weather).

**Voice mail messages are acceptable.** Keep in mind that there is a waiting list of patients desiring these appointments. These patients may have their treatments delayed if you do not call in a timely manner. Alternative medicine emphasizes very thorough personalized care; therefore, we do not 'double book' appointments. As a result, our policy is to charge \$415 for initial visits not cancelled with a 48-hour notice; and \$110 will be charged for follow-up appointments not cancelled with a 24-hour notice.

**Driving Directions:**

Rejuvenate Inc is located at **6940 South Holly Circle Suite 201** in the southern Denver suburb of Centennial; the closest major cross streets are Arapahoe and Dry Creek.

Driving directions from I-25 and C-470 are as follows:

**South Denver:** Take I-25 N to Dry Creek Road, head West, then turn right (North) onto S. Holly Street, and then right (East) onto South Holly Circle, when you see a cul-de-sac and a sign for the Centennial Montessori turn right, head East. You will see a sign with our address on the right and a sign for the Joyous Chinese Cultural Center on the left, there is where our parking and entrance will be. We are located on the 2nd floor inside the Joyous Chinese Cultural Center.

**North Denver:** Take I-25 south to Arapahoe Road turn right (West), then turn left onto S. Holly Street (South), and then left onto South Holly Circle (East), when you see a cul-de-sac and a sign for the Centennial Montessori turn left, head East. You will see a sign with our address on the right and a sign for the Joyous Chinese Cultural Center on the left, there is where our parking and entrance will be. We are located on the 2nd floor inside the Joyous Chinese Cultural Center.

**West Denver:** From C-470 exit Quebec (North) to County Line (West), turn right (North) on S. Holly Street turn Right (East) onto South Holly Circle, when you see a cul-de-sac and a sign for the Centennial Montessori turn right, head East. You will see a sign with our address on the right and a sign for the Joyous Chinese Cultural Center on the left, there is where our parking and entrance will be. We are located on the 2nd floor inside the Joyous Chinese Cultural Center.

On behalf of Dr. Petropulos and Rejuvenate Wellness Center staff, we sincerely welcome you and look forward to helping you regain and maintain optimal health for many years to come.

We hope this information has answered your questions; however, if you still have questions, please feel free to call our office. We are open on Tuesdays and Thursdays, from 8am to 1pm and 3pm to 7pm; Fridays, 8am to 1pm and 3pm to 5pm; Saturdays from 8am to 2pm.

*An aerial map showing I-25 and E-470 in relation to our office is attached.*



**REQUIRED INFORMATION for your Case History File—PLEASE PRINT**

Name: \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Want to Receive our Newsletter? Yes / No

Phone: H \_\_\_\_\_ C \_\_\_\_\_ W \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status: M S W D Civil Union

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/Partner's Name \_\_\_\_\_ Occupation \_\_\_\_\_

No. of Children \_\_\_\_\_ Names, in birth order \_\_\_\_\_

Person responsible for this account \_\_\_\_\_

Referred by \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

List medications (over-the-counter and prescription) you are currently taking with dosage and frequency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to medications:

\_\_\_\_\_  
\_\_\_\_\_

List any surgeries with dates:

\_\_\_\_\_  
\_\_\_\_\_

List supplements, vitamins or herbs you are currently taking with dosage and frequency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had a personal injury or accident? [ Yes  Past year  Past 5 years  Over 5 years]  
If you answered 'yes,' describe:

\_\_\_\_\_  
\_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list any doctors who have treated these conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For each of your previously stated 5 major health concerns, Please indicate the following if they apply:

Major Health Concern 1:

**Onset:** What caused it and when did it begin?

**Provoke:** What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

**Palliative:** What makes it better – ice, over-the-counter medications, massage, position, etc.?

**Quality:** Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

**Radiation:** Does the pain (or symptoms) travel from one area to another?

**Timing:** Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

**Severity:**

**\*At its worst** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

**\*At its best** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

Major Health Concern 2:

**Onset:** What caused it and when did it begin?

**Provoke:** What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

**Palliative:** What makes it better – ice, over-the-counter medications, massage, position, etc.?

**Quality:** Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

**Radiation:** Does the pain (or symptoms) travel from one area to another?

**Timing:** Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

**Severity:**

**\*At its worst** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

**\*At its best** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

Major Health Concern 3:

**Onset:** What caused it and when did it begin?

**Provoke:** What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

**Palliative:** What makes it better – ice, over-the-counter medications, massage, position, etc.?

**Quality:** Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

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**Radiation:** Does the pain (or symptoms) travel from one area to another?

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**Timing:** Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

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**Severity:**

**\*At its worst** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

**\*At its best** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

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Major Health Concern 4:

**Onset:** What caused it and when did it begin?

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**Provoke:** What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

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**Palliative:** What makes it better – ice, over-the-counter medications, massage, position, etc.?

---

**Quality:** Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

---

**Radiation:** Does the pain (or symptoms) travel from one area to another?

---

**Timing:** Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

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**Severity:**

**\*At its worst** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

**\*At its best** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

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Major Health Concern 5:

**Onset:** What caused it and when did it begin?

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**Provoke:** What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

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**Palliative:** What makes it better – ice, over-the-counter medications, massage, position, etc.?

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**Quality:** Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

---

**Radiation:** Does the pain (or symptoms) travel from one area to another?

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**Timing:** Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

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**Severity:**

**\*At its worst** – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

## PART I

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## PART II

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

<b>Category I</b>				<b>Category VI (continued)</b>					
Feeling that bowels do not empty completely	0	1	2	3	Excessive passage of gas	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3	Nausea and/or vomiting	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Diarrhea	0	1	2	3	Frequent urination	0	1	2	3
Constipation	0	1	2	3	Increased thirst and appetite	0	1	2	3
Hard, dry, or small stool	0	1	2	3	Difficulty losing weight	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3	<b>Category VII</b>				
Pass large amount of foul-smelling gas	0	1	2	3	Greasy or high-fat foods cause distress	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Use laxatives frequently	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
<b>Category II</b>					Unexplained itchy skin	0	1	2	3
Increasing frequency of food reactions	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Unpredictable food reactions	0	1	2	3	Stool color alternates from clay colored to normal brown	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3	Reddened skin, especially palms	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3	Have you had your gallbladder removed?	Yes	No		
<b>Category III</b>					<b>Category VIII</b>				
Intolerance to smells	0	1	2	3	Acne and unhealthy skin	0	1	2	3
Intolerance to jewelry	0	1	2	3	Excessive hair loss	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3	Overall sense of bloating	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3	Bodily swelling for no reason	0	1	2	3
Constant skin outbreaks	0	1	2	3	Hormone imbalances	0	1	2	3
<b>Category IV</b>					Weight gain	0	1	2	3
Excessive belching, burping, or bloating	0	1	2	3	Poor bowel function	0	1	2	3
Gas immediately following a meal	0	1	2	3	Excessively foul-smelling sweat	0	1	2	3
Offensive breath	0	1	2	3	<b>Category IX</b>				
Difficult bowel movement	0	1	2	3	Crave sweets during the day	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Irritable if meals are missed	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3	Depend on coffee to keep going/get started	0	1	2	3
<b>Category V</b>					Get light-headed if meals are missed	0	1	2	3
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3	Eating relieves fatigue	0	1	2	3
Use antacids	0	1	2	3	Feel shaky, jittery, or have tremors	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3	Agitated, easily upset, nervous	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Poor memory/forgetful	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3	Blurred vision	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3	<b>Category X</b>				
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3	Fatigue after meals	0	1	2	3
<b>Category VI</b>					Crave sweets during the day	0	1	2	3
Roughage and fiber cause constipation	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3	Must have sweets after meals	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	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

<b>Category XI</b>			
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
<b>Category XII</b>			
Cannot fall asleep	0	1	2 3
Perspire easily	0	1	2 3
Under 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
<b>Category XIII</b>			
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
<b>Category XIV</b>			
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
<b>Category XV</b>			
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
Night sweats	0	1	2 3
Difficulty gaining weight	0	1	2 3
<b>Category XVI</b>			
Diminished sex drive	0	1	2 3
Menstrual disorders or lack of menstruation	0	1	2 3
Increased ability to eat sugars without symptoms	0	1	2 3

<b>Category XVII</b>			
Increased sex drive	0	1	2 3
Tolerance to sugars reduced	0	1	2 3
“Splitting” - type headaches	0	1	2 3
<b>Category XVIII (Males Only)</b>			
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
<b>Category XIX (Males Only)</b>			
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
<b>Category XX (Menstruating Females Only)</b>			
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
<b>Category XXI (Menopausal Females Only)</b>			
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? \_\_\_\_\_

List the three worst foods you eat during the average week: \_\_\_\_\_

List the three healthiest foods you eat during the average 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? \_\_\_\_\_

**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:

# Health Questionnaire (NTAF)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

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

## SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

## SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

## SECTION C

### SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

### SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

## SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3

- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

## SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

## SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

## SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

## Medication History\*

Please check any of the following medications you have been or are currently taking.

### Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine,  Ipratropium,  Scopolamine,  Tiotropium

### Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine,  Hexamethonium,  Nicotine (high doses),  Trimethaphan

### Acetylcholinesterase Reactivators

Pralidoxime

### Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium,  Cisatracurium,  Doxacurium,  Metocurine,  Mivacurium,  Pancuronium,  Rocuronium,  Succinylcholine,  Tubocurarine,  Vecuronium,  Hemicholinium

### Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax<sup>®</sup>,  Lexotanil,  Lexotan<sup>®</sup>,  Librium,  Klonopin<sup>®</sup>,  Valium<sup>®</sup>,  ProSom<sup>®</sup>,  Rohypnol,  Dalmane,  Ativan,  Loramet<sup>®</sup>,  Sedoxil,  Dormicum,  Megalodon,  Serax<sup>®</sup>,  Restoril,  Halcion

### Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien CR<sup>®</sup>,  Sonata<sup>®</sup>,  Lunesta<sup>®</sup>,  Imovane

### Cholinesterase Inhibitors (irreversible)

Echotiophate,  Isoflurophate,  Organophosphate Insecticides,  Organophosphate-containing nerve agents

### Cholinesterase Inhibitors (reversible)

Donepezil,  Galatamine,  Rivastigmine,  Tacrine,  THC,  Edrophonium,  Neostigmine,  Physostigmine,  Pyridostigmine,  Carbamate Insecticides

### Dopamine Reuptake Inhibitors

Wellbutrin XL<sup>®</sup> (Bupropion)

### Dopamine Receptor Agonists

Mirapex<sup>®</sup>,  Sifrol<sup>®</sup>,  Requip<sup>®</sup>

### D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine<sup>®</sup>,  Prolixin<sup>®</sup>,  Trilafon<sup>®</sup>,  Compazine<sup>®</sup>,  Mellaril<sup>®</sup>,  Stelazine<sup>®</sup>,  Vesprin<sup>®</sup>,  Nozinan<sup>®</sup>,  Depixel<sup>®</sup>,  Navane<sup>®</sup>,  Fluanxol<sup>®</sup>,  Clopixol<sup>®</sup>,  Acuphase<sup>®</sup>,  Haldol<sup>®</sup>,  Orap<sup>®</sup>,  Clozaril<sup>®</sup>,  Zyprexa<sup>®</sup>,  Zydys<sup>®</sup>,  Seroquel XR<sup>®</sup>,  Geodon<sup>®</sup>,  Solian<sup>®</sup>,  Invega<sup>®</sup>,  Abilify<sup>®</sup>

### GABA Antagonist Competitive binder

Flumazenil

### Monoamine<sup>b</sup> Oxidase Inhibitors (MAOI)

Marplan<sup>®</sup>,  Aurorix<sup>®</sup>,  Manerix<sup>®</sup>,  Moclodura,  Nardil,  Adeline<sup>®</sup>,  Eldepryl<sup>®</sup>,  Azilect<sup>®</sup>,  Marsilid<sup>®</sup>,  Iprozid<sup>®</sup>,  Ipronid<sup>®</sup>,  Rivivol,  Popilniazida<sup>®</sup>,  Zyvox<sup>®</sup>,  Zyvoxid<sup>®</sup>

### Noradrenergic<sup>c</sup> and Specific Serotonergic<sup>c</sup> Antidepressants (NaSSaa)

Remeron<sup>®</sup>,  Zispin<sup>®</sup>,  Avanza<sup>®</sup>,  Norset<sup>®</sup>,  Remergil<sup>®</sup>,  Axit<sup>®</sup>

### Selective Serotonin Reuptake Inhibitors

Paxil<sup>®</sup>,  Zoloft<sup>®</sup>,  Prozac<sup>®</sup>,  Celexa<sup>®</sup>,  Lexapro<sup>®</sup>,  Luvox<sup>®</sup>,  Cipramil<sup>®</sup>,  Emocal<sup>®</sup>,  Seropram<sup>®</sup>,  Cipralax<sup>®</sup>,  Esteria<sup>®</sup>,  Fontex<sup>®</sup>,  Dapoxetine<sup>®</sup>,  Seromex<sup>®</sup>,  Seronil<sup>®</sup>,  Sarafem<sup>®</sup>,  Fluctin<sup>®</sup>,  Faverin<sup>®</sup>,  Seroxat,  Aropax<sup>®</sup>,  Deroxat<sup>®</sup>,  Rextin<sup>®</sup>,  Paroxat<sup>®</sup>,  Lustral<sup>®</sup>,  Serlain<sup>®</sup>

### Selective Serotonin Reuptake Enhancers

Stablon<sup>®</sup>,  Coaxil,  Tatinol<sup>®</sup>

### Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor<sup>®</sup>,  Pristiq<sup>®</sup>,  Meridia,  Serzone<sup>®</sup>,  Dalcipran<sup>®</sup>,  Despiramin,  Duloxetine

### Tricyclic Antidepressants (TCAs)

Elavil<sup>®</sup>,  Endep<sup>®</sup>,  Tryptanol,  Trepiline<sup>®</sup>,  Asendin<sup>®</sup>,  Asendis<sup>®</sup>,  Defanyl<sup>®</sup>,  Demolox<sup>®</sup>,  Moxadil<sup>®</sup>,  Anafranil<sup>®</sup>,  Norpramin<sup>®</sup>,  Pertofrane<sup>®</sup>,  Prothiaden<sup>®</sup>,  Adapin<sup>®</sup>,  Sinequan<sup>®</sup>,  Tofranil<sup>®</sup>,  Janamine<sup>®</sup>,  Gamamil<sup>®</sup>,  Aventyl<sup>®</sup>,  Pamelor<sup>®</sup>,  Opipramol<sup>®</sup>,  Vivactil<sup>®</sup>,  Rhotrimine<sup>®</sup>,  Surmontil<sup>®</sup>

\*Please refer to prescribing physician for nutritional interactions with any medications you may be taking.

<sup>12</sup>Percent of the time \_\_\_\_\_

\*At its best – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

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**++Dr. Findings++**

**Complaint:**

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**Onset:**

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**Provoke:**

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**Palliative:**

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**Quality:**

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**Radiation:**

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**Timing:**

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**Severity:**

\*At its worst – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

\*At its best – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) \_\_\_\_\_

Percent of the time \_\_\_\_\_

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**Healthcare: Therapies: Past (P) and/or Current (C) and date**

\_\_\_\_ Chiropractic \_\_\_\_\_  
\_\_\_\_ Chiro for pets \_\_\_\_\_  
\_\_\_\_ Acupuncture \_\_\_\_\_  
\_\_\_\_ Therapeutic Massage \_\_\_\_\_

\_\_\_\_ Naturopathic \_\_\_\_\_  
\_\_\_\_ Oriental Medicine \_\_\_\_\_  
\_\_\_\_ Nutritional Consult \_\_\_\_\_  
\_\_\_\_ Medical Treatment \_\_\_\_\_

\_\_\_\_ Specialist \_\_\_\_\_  
\_\_\_\_ Natural Healer \_\_\_\_\_  
\_\_\_\_ Spiritual Healer \_\_\_\_\_  
\_\_\_\_ Energy Work \_\_\_\_\_

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**Diagnostic or Routine Exams:** Check all that apply and list date

<input type="checkbox"/> X-Rays _____	<input type="checkbox"/> Upper/Lower GI _____	<input type="checkbox"/> Dental Exam _____
<input type="checkbox"/> MRI _____	<input type="checkbox"/> DEXA Scan _____	<input type="checkbox"/> Colonoscopy _____
<input type="checkbox"/> CAT Scan _____	<input type="checkbox"/> Breast Exam _____	<input type="checkbox"/> Other _____ Date _____
<input type="checkbox"/> Blood Draw _____	<input type="checkbox"/> Prostate Exam _____	<input type="checkbox"/> Other _____ Date _____
<input type="checkbox"/> Ultrasound _____	<input type="checkbox"/> Eye Exam _____	<input type="checkbox"/> Other _____ Date _____

**Medical History:** Current = C Past = P (greater than 6 months) include dates if possible

**Childhood:** List Dates/Ages

<input type="checkbox"/> Chronic Strep Throat _____ Illnesses _____	<input type="checkbox"/> Chronic Ear infections _____ Allergies _____ Injuries _____	<input type="checkbox"/> Traumatic events _____ Other _____
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**Significant Illnesses:** List Dates

<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Hepatitis A / B / C _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Low blood pressure _____	<input type="checkbox"/> Thyroid disease _____
<input type="checkbox"/> Depression _____	<input type="checkbox"/> Lung disease _____	<input type="checkbox"/> Vascular disease _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Neurological _____	<input type="checkbox"/> Other _____

**Illness/Injuries/Surgeries/Hospitalizations:** List Dates

<input type="checkbox"/> Broken bones _____	<input type="checkbox"/> Burns _____	<input type="checkbox"/> Car accidents _____
<input type="checkbox"/> Concussion _____	<input type="checkbox"/> Fallen down/upstairs _____	<input type="checkbox"/> Fallen from any height _____
<input type="checkbox"/> Fallen on ice _____	<input type="checkbox"/> Feeling un-coordinated _____	<input type="checkbox"/> Fevers _____
<input type="checkbox"/> Flu/colds _____	<input type="checkbox"/> Frequent accidents _____	<input type="checkbox"/> Frequent Illness _____
<input type="checkbox"/> Frequent Infections _____	<input type="checkbox"/> Head trauma _____	<input type="checkbox"/> Hospitalizations _____
<input type="checkbox"/> Infected wounds _____	<input type="checkbox"/> Loss of consciousness _____	<input type="checkbox"/> Psychological Hosp _____
<input type="checkbox"/> Recreational Injuries _____	<input type="checkbox"/> Serious cuts _____	<input type="checkbox"/> Serious Depression _____
<input type="checkbox"/> Significant trauma _____	<input type="checkbox"/> Surgeries _____	<input type="checkbox"/> Transfusions _____
<input type="checkbox"/> Transplants _____	<input type="checkbox"/> Tripping/Stumbling _____	<input type="checkbox"/> Wounds slow to heal _____

**Appliances or Aides:**

<input type="checkbox"/> Glasses/Prisms _____	<input type="checkbox"/> Contacts _____	<input type="checkbox"/> Orthotics _____
<input type="checkbox"/> Joint replacement _____	<input type="checkbox"/> Prosthetics _____	<input type="checkbox"/> Implants of any kind _____
<input type="checkbox"/> Braces _____	<input type="checkbox"/> Splints _____	<input type="checkbox"/> Pace Maker _____
<input type="checkbox"/> Hearing Aids _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

**Skin and Hair: List Dates**

<input type="checkbox"/> Rashes _____	<input type="checkbox"/> Eczema _____	<input type="checkbox"/> Hair/skin texture change _____
<input type="checkbox"/> Ulcerations _____	<input type="checkbox"/> Pimples _____	<input type="checkbox"/> Purpura _____
<input type="checkbox"/> Hives _____	<input type="checkbox"/> Dandruff _____	<input type="checkbox"/> Itching _____
<input type="checkbox"/> Loss of hair _____	<input type="checkbox"/> New moles/growth _____	<input type="checkbox"/> Other _____

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**General: List times of day or any correlating factors**

<input type="checkbox"/> Poor appetite _____	<input type="checkbox"/> Heavy appetite _____	<input type="checkbox"/> Change in appetite _____
<input type="checkbox"/> Weight gain _____	<input type="checkbox"/> Weight loss _____	<input type="checkbox"/> Cravings salt/sweet/fats _____
<input type="checkbox"/> Poor sleep _____	<input type="checkbox"/> Can't fall asleep easily _____	<input type="checkbox"/> Wake feeling rested _____
<input type="checkbox"/> Decreased sleep _____	<input type="checkbox"/> Heavy sleep _____	<input type="checkbox"/> Insomnia _____
<input type="checkbox"/> Apnea/Narcolepsy _____	<input type="checkbox"/> Night sweats _____	<input type="checkbox"/> Hours of sleep/night _____
<input type="checkbox"/> Day napping _____	<input type="checkbox"/> Strong thirst hot/cold _____	<input type="checkbox"/> Cold hands/feet _____
<input type="checkbox"/> Sudden energy drop _____	<input type="checkbox"/> Sudden temp changes _____	<input type="checkbox"/> Fatigue _____
<input type="checkbox"/> Chills _____	<input type="checkbox"/> Poor circulation _____	<input type="checkbox"/> Localized weakness _____
<input type="checkbox"/> Tremors _____	<input type="checkbox"/> Bowel/bladder changes _____	<input type="checkbox"/> Peculiar tastes/smells _____
<input type="checkbox"/> Night pain _____	<input type="checkbox"/> Radiating pain _____	<input type="checkbox"/> Numbness/tingling _____
<input type="checkbox"/> Pins and needles _____	<input type="checkbox"/> Sweats easily _____	<input type="checkbox"/> Excessive sweating _____
<input type="checkbox"/> Body odor change _____	<input type="checkbox"/> Stress _____	<input type="checkbox"/> Bleed/bruise easily (where?) _____
		<input type="checkbox"/> Sudden awakening at night _____

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**Head, Eyes, Ears Nose and Throat: List any noticeable correlation and frequency**

<input type="checkbox"/> Dizziness _____	<input type="checkbox"/> Migraines _____	<input type="checkbox"/> Auras, Sounds, Smells _____
<input type="checkbox"/> Headaches _____	<input type="checkbox"/> Vision problems _____	<input type="checkbox"/> Near/Far sighted _____
<input type="checkbox"/> Blurry vision _____	<input type="checkbox"/> Night Blindness _____	<input type="checkbox"/> Eye strain/pain _____
<input type="checkbox"/> Color blindness _____	<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Glaucoma _____
<input type="checkbox"/> Spots in eyes _____	<input type="checkbox"/> Ringing in ears _____	<input type="checkbox"/> Poor hearing _____
<input type="checkbox"/> Earaches _____	<input type="checkbox"/> Ear Pain _____	<input type="checkbox"/> Ear discharge _____
<input type="checkbox"/> Heavy ear wax _____	<input type="checkbox"/> Nose bleeds _____	<input type="checkbox"/> Sinus problems _____
<input type="checkbox"/> Mucus _____	<input type="checkbox"/> Dry throat/mouth _____	<input type="checkbox"/> Copious saliva (lots) _____
<input type="checkbox"/> Mouth/tongue sores _____	<input type="checkbox"/> Sore throats _____	<input type="checkbox"/> Other _____

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**Musculoskeletal: List location and type of pain, i.e. sharp, dull, radiating, traveling, etc... Use image on last page of this document to depict specific areas of complaint.**

<input type="checkbox"/> Neck Pain _____	<input type="checkbox"/> Muscle Pain _____	<input type="checkbox"/> Back Pain _____
<input type="checkbox"/> Joint Pain _____	<input type="checkbox"/> Other muscle or joint problems? _____	<input type="checkbox"/> Intractable night pain _____
<input type="checkbox"/> Scar tissue adhesions _____		

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**Are you wearing:**

<input type="checkbox"/> Heel Lifts _____	<input type="checkbox"/> Sole Lifts _____	<input type="checkbox"/> Inner Soles _____
<input type="checkbox"/> Arch Supports _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

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**Dental:** <sup>15</sup> List Dates

\_\_\_ Teeth problems \_\_\_\_\_  
\_\_\_ Bridges \_\_\_\_\_  
\_\_\_ Tooth pain \_\_\_\_\_  
\_\_\_ Molars \_\_\_\_\_  
\_\_\_ Jaw clicks \_\_\_\_\_  
\_\_\_ Implants \_\_\_\_\_  
\_\_\_ Periodontal Tx \_\_\_\_\_  
\_\_\_ Dry mouth \_\_\_\_\_

\_\_\_ Cavities \_\_\_\_\_  
\_\_\_ Fillings/amalgams \_\_\_\_\_  
\_\_\_ Head pain \_\_\_\_\_  
\_\_\_ Extractions \_\_\_\_\_  
\_\_\_ Grinding teeth \_\_\_\_\_  
\_\_\_ Dentures \_\_\_\_\_  
\_\_\_ Sealants \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_

\_\_\_ Braces \_\_\_\_\_  
\_\_\_ Crowns gold/porcelain \_\_\_\_\_  
\_\_\_ Jaw pain \_\_\_\_\_  
\_\_\_ Surgeries \_\_\_\_\_  
\_\_\_ Facial pain \_\_\_\_\_  
\_\_\_ Swollen/bleeding gums \_\_\_\_\_  
\_\_\_ Fluoride Tx \_\_\_\_\_  
\_\_\_ Root Canals \_\_\_\_\_

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**Neurologic:** List Dates

\_\_\_ Balance problems \_\_\_\_\_  
\_\_\_ Vomiting \_\_\_\_\_  
\_\_\_ Loss of strength \_\_\_\_\_  
\_\_\_ Stumbling/tripping \_\_\_\_\_  
\_\_\_ Loss of hand grip \_\_\_\_\_

\_\_\_ Vertigo \_\_\_\_\_  
\_\_\_ Sudden blurry vision \_\_\_\_\_  
\_\_\_ Weakness limb/body \_\_\_\_\_  
\_\_\_ "Running into walls or things" \_\_\_\_\_  
\_\_\_ Loss of fine motor skills \_\_\_\_\_

\_\_\_ Nausea \_\_\_\_\_  
\_\_\_ Loss of consciousness \_\_\_\_\_  
\_\_\_ Feel un-coordinated \_\_\_\_\_  
\_\_\_ Frequently dropping things \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_

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**Cardio Vascular:** List Dates and/or Times

\_\_\_ High blood pressure \_\_\_\_\_  
\_\_\_ Low blood pressure \_\_\_\_\_  
\_\_\_ Chest Pain \_\_\_\_\_  
\_\_\_ Irregular heartbeat \_\_\_\_\_  
\_\_\_ Heaviness in chest \_\_\_\_\_

\_\_\_ Dizziness \_\_\_\_\_  
\_\_\_ Fainting \_\_\_\_\_  
\_\_\_ Cold hands/feet \_\_\_\_\_  
\_\_\_ Hand/feet swelling \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_

\_\_\_ Blood Clots \_\_\_\_\_  
\_\_\_ Phlebitis \_\_\_\_\_  
\_\_\_ Difficulty breathing \_\_\_\_\_  
\_\_\_ Rapid pulse \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_

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**Respiratory and Lungs:** List Dates

\_\_\_ Persistent Cough \_\_\_\_\_  
\_\_\_ Asthma \_\_\_\_\_  
\_\_\_ COPD \_\_\_\_\_  
\_\_\_ Asthma \_\_\_\_\_

\_\_\_ Coughing Blood \_\_\_\_\_  
\_\_\_ Production of phlegm \_\_\_\_\_  
\_\_\_ Phlegm Color \_\_\_\_\_  
\_\_\_ Bronchitis \_\_\_\_\_

\_\_\_ Difficulty breathing while lying down \_\_\_\_\_  
\_\_\_ Tight chest \_\_\_\_\_  
\_\_\_ Pneumonia \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_

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**Genito-Urinary:**

\_\_\_ Pain w/urination \_\_\_\_\_  
\_\_\_ Kidney Stones \_\_\_\_\_  
\_\_\_ Venereal Disease/STD \_\_\_\_\_  
\_\_\_ Blood in urine \_\_\_\_\_  
\_\_\_ Impotency \_\_\_\_\_

\_\_\_ Loss of bladder function \_\_\_\_\_  
\_\_\_ Frequent Urination \_\_\_\_\_  
\_\_\_ Odor \_\_\_\_\_  
\_\_\_ Color \_\_\_\_\_  
\_\_\_ Prostate problems \_\_\_\_\_

\_\_\_ Wake to urinate \_\_\_\_\_  
\_\_\_ Time \_\_\_\_\_  
\_\_\_ Times Per Night \_\_\_\_\_  
\_\_\_ Urgency to urinate \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_

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**Gastrointestinal:**

<input type="checkbox"/> Nausea _____	<input type="checkbox"/> Gas/bloating _____	<input type="checkbox"/> Bad breath _____
<input type="checkbox"/> Constipation _____	<input type="checkbox"/> Diarrhea _____	<input type="checkbox"/> Pain or cramps _____
<input type="checkbox"/> Vomiting _____	<input type="checkbox"/> Belching _____	<input type="checkbox"/> Rectal pain _____
<input type="checkbox"/> Bloody stools bright/dark red _____	<input type="checkbox"/> Hemorrhoids _____	<input type="checkbox"/> Sensitive abdomen _____
<input type="checkbox"/> Laxative use: ___ x/wk; type _____	<input type="checkbox"/> Bowel Changes _____	

**Bowel movements:**

<input type="checkbox"/> Frequency/day/wk _____	<input type="checkbox"/> Color _____	<input type="checkbox"/> Odor (foul) _____
<input type="checkbox"/> Form (loose, compact) _____	<input type="checkbox"/> Texture (smooth, segmented) _____	<input type="checkbox"/> Other _____

**Gynecology and pregnancy:**

<input type="checkbox"/> Age of 1 <sup>st</sup> menses _____	<input type="checkbox"/> Vaginal Sores _____	<input type="checkbox"/> Vaginal discharge _____
<input type="checkbox"/> Irregular Periods _____	<input type="checkbox"/> Last Menses _____	<input type="checkbox"/> Birth Control type _____
<input type="checkbox"/> Number of pregnancies _____	<input type="checkbox"/> Number of births _____	<input type="checkbox"/> Live Births: _____
<input type="checkbox"/> Premature births _____	<input type="checkbox"/> Miscarriages; What month? _____	<input type="checkbox"/> C-section: _____
<input type="checkbox"/> PMS _____	<input type="checkbox"/> Mood Changes _____	<input type="checkbox"/> Vaginal: _____
<input type="checkbox"/> Cramps _____	<input type="checkbox"/> Bloating _____	<input type="checkbox"/> Breast Lumps (tender) _____
<input type="checkbox"/> Vomiting _____	<input type="checkbox"/> Menopause _____	<input type="checkbox"/> Body Changes _____
<input type="checkbox"/> Last Breast Exam _____	<input type="checkbox"/> Last Ob/GYN Appt _____	<input type="checkbox"/> Last PAP _____

**YOUR birth and infancy:**

<input type="checkbox"/> Born by; (vaginal, c-section) _____	<input type="checkbox"/> Breast or Bottle Fed _____	<input type="checkbox"/> Immunized? _____
<input type="checkbox"/> Premature _____	<input type="checkbox"/> How long _____	<input type="checkbox"/> Fully/Partially _____
<input type="checkbox"/> Colic _____	<input type="checkbox"/> Good/Bad sleep habits _____	<input type="checkbox"/> Reactions? _____
<input type="checkbox"/> NICU _____	<input type="checkbox"/> Surgeries after birth _____	<input type="checkbox"/> Stress/Trauma to your mother _____

while in utero? \_\_\_\_\_

**Neuropsychological:**

<input type="checkbox"/> Seizures _____	<input type="checkbox"/> Depression _____	<input type="checkbox"/> Anxiety _____
<input type="checkbox"/> Poor memory _____	<input type="checkbox"/> Foggy thinking _____	<input type="checkbox"/> Bad Temper _____
<input type="checkbox"/> Concussions _____	<input type="checkbox"/> Easily stressed _____	<input type="checkbox"/> Considered/attempted suicide _____
<input type="checkbox"/> Treated for emotional concerns _____	<input type="checkbox"/> Antidepressant medications _____	<input type="checkbox"/> Other neurological or psych concerns _____

**Do you find any dysfunction or concern in the following areas?**

<input type="checkbox"/> Relationship with Family _____	<input type="checkbox"/> Relationships with friends _____	<input type="checkbox"/> Social Skills _____
<input type="checkbox"/> Career _____	<input type="checkbox"/> Work _____	<input type="checkbox"/> Leisure Time _____
<input type="checkbox"/> Hobbies _____	<input type="checkbox"/> Past time activities _____	<input type="checkbox"/> Intimate relationships _____
<input type="checkbox"/> Sex _____	<input type="checkbox"/> Religious Life _____	<input type="checkbox"/> Spiritual Path _____
<input type="checkbox"/> Childhood Religious teachings _____	<input type="checkbox"/> Past relationships _____	<input type="checkbox"/> Childhood _____
<input type="checkbox"/> School _____		

**Habits: List type and quantities where valid**

Exercise x's/week _____	Seek conflict _____	Un-protected sex _____
Sports _____	Walks _____	Regular Religious activity _____
Regular Spiritual activity _____	Seatbelts _____	Helmets/Protective gear _____
Road Rage _____	Consume Alcohol _____	Crave sugar/salt/fats _____
Smoke/chew tobacco _____	Recreational drugs use _____	Other _____
Un-necessary risk taking _____	Caffeine/pills/coffee/tea/drinks _____	Participate in community events _____

**Nutritional: List typical ounces/servings per week and type**

Drink soda oz/wk _____	Fruit juices oz/wk _____
Gatorade/hydration drinks oz/wk _____	Coffee/black tea _____
Caffeine _____	Chocolate _____
Alcohol _____	Health drinks _____
Nutritional Shakes _____	Health bars _____
Protein powders _____	Cravings salt/sweet/fats _____
Meat _____	Protein _____
Milk, oz/wk _____	Dairy, Type _____
Veg, serving/day _____	Fruits, serving/day _____
Food Allergies _____	Chew Gum with Aspartame or Nutra-sweet? _____

**Environmental Stressors: Do you have or use (How often?)**

Scented Laundry Detergent _____	Scented Dryer Sheets _____
Perfumes or Colognes _____	Scented Lotions _____
Scented Candles or Plug-ins _____	Pool _____
Hot Tub _____	Memory Foam Bedding (Mattress, Pillow, etc) _____

Is your home or office near a major thoroughfare? \_\_\_\_\_  
 Any "New Construction" at home or work - Paint, Carpet, Tile, Flooring, etc. \_\_\_\_\_  
 Is there or has there been any water damage or flooding at home or work? \_\_\_\_\_  
 Does your bedroom contain plants, books or any dry cleaned items? \_\_\_\_\_  
 Are there any bedrooms or living areas in your home located above the garage? \_\_\_\_\_  
 In the last year have you purchased a new car, appliance or furniture? \_\_\_\_\_  
 Do you have a water filter? If so, when was the last time the filter was changed? \_\_\_\_\_  
 Do you use flea or tick medicine (or collar) on your pets? \_\_\_\_\_  
 Do you or a yard service use herbicidal products like Round Up? \_\_\_\_\_  
 Do you use any service that sprays for pests around your house? \_\_\_\_\_

**Current Immunizations: Have you received any of the following? (recently or regularly)**

Shingles: _____ Date _____ Frequency _____	HPV: _____ Date _____ Frequency _____
Pneumonia: _____ Date _____ Frequency _____	Influenza: _____ Date _____ Frequency _____
Covid 19: _____ Date _____ Booster? _____	Which one? _____
Other: _____	

**Family History: Medical, Psychological, Social**

<b>Concern</b>	<b>Maternal</b>	<b>Paternal</b>	<b>Relationship</b>	<b>Concern</b>	<b>Maternal</b>	<b>Paternal</b>	<b>Relationship</b>
<input type="checkbox"/> Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Neuromuscular Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> ALS	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> OCD	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Back/Spine Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Bi-Polar	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Rigid Upbringing	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Rigid Religious Beliefs	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Dementia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Family Violence	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> GI Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Suicide (or attempted)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Thyroid Problems/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Tremors	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Low Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Mental Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Mental Illness(other)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Multiple-sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Neglect	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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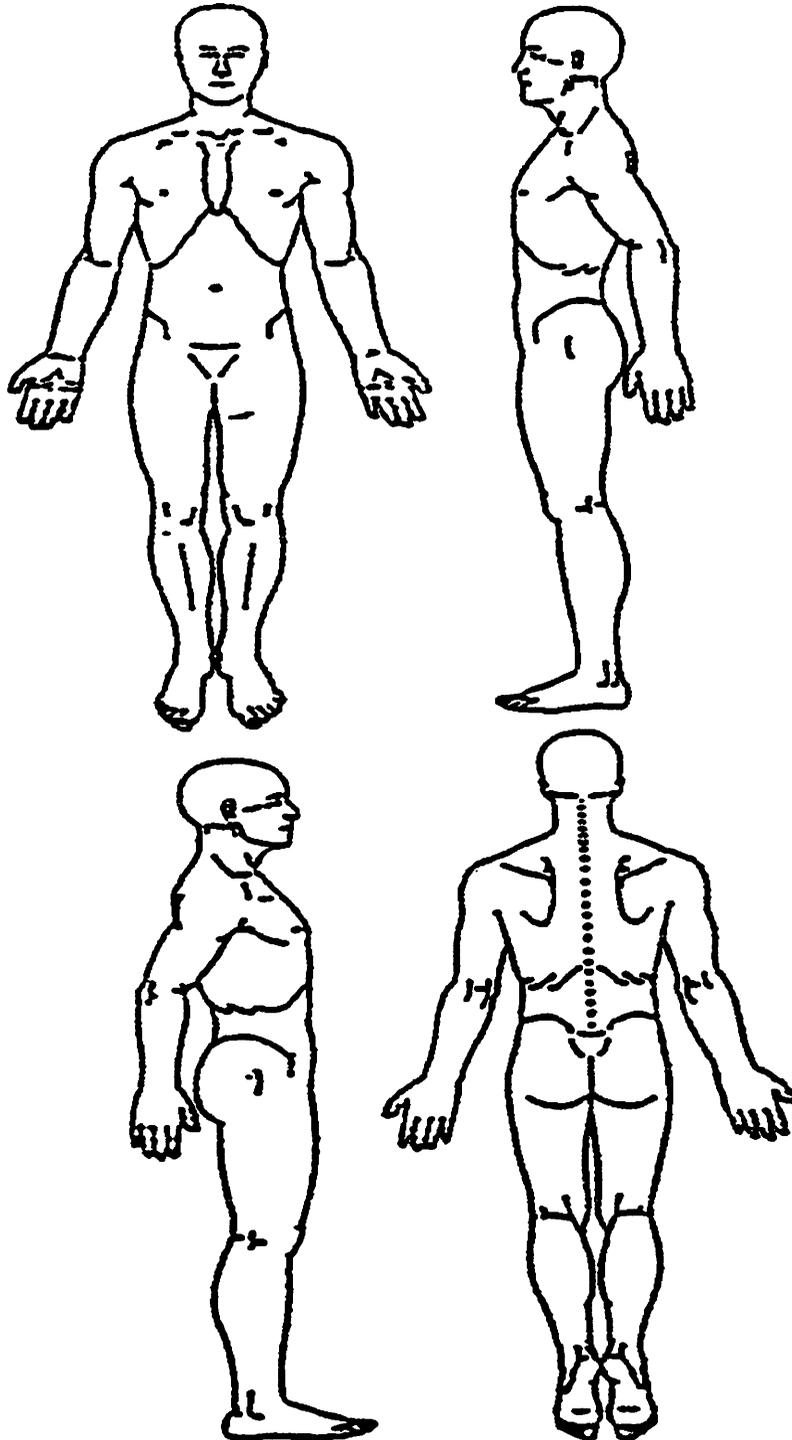


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I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that, if I suspend or terminate my care and treatment, any fees for professional services rendered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

Patient (or Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please specify any symptom locations below using initials indicated:**



<p>XX – Sharp Pain  OO – Dull Ache  TT – Throbbing Pain  CT – Constant  DP – Deep  RR – Radiating  SU – Superficial  BU – Burning  NU – Numbness  TI – Tingling  WE – Weakness</p>
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# The Rejuvenate Wellness Center



**Your Daily Food Intake Record:** Track your daily eating patterns for one full week, including the approximate amounts of each food. Bring this intake record with your first new patient appointment.

**Name:** \_\_\_\_\_

**Patient #:** \_\_\_\_\_

**Day 1 –**

**Breakfast (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-MORNING SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Bowel Movements (# and Consistency)  
 \_\_\_\_\_

**Lunch (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-DAY SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Hours of Sleep: \_\_\_\_\_

**Dinner (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**NIGHTTIME SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Quality of Sleep: \_\_\_\_\_

..... Check # Glasses Water  
 Consumed Each Day

**Day 2 –**

**Breakfast (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-MORNING SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Bowel Movements (# and Consistency)  
 \_\_\_\_\_

**Lunch (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-DAY SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Hours of Sleep: \_\_\_\_\_

**Dinner (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**NIGHTTIME SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Quality of Sleep: \_\_\_\_\_

..... Check # Glasses Water  
 Consumed Each Day

**Day 3 –**

**Breakfast (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-MORNING SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Bowel Movements (# and Consistency)  
 \_\_\_\_\_

**Lunch (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-DAY SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Hours of Sleep: \_\_\_\_\_

**Dinner (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**NIGHTTIME SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Quality of Sleep: \_\_\_\_\_

..... Check # Glasses Water  
 Consumed Each Day

**Day 4 –**

**Breakfast (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-MORNING SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Bowel Movements (# and Consistency) \_\_\_\_\_

**Lunch (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-DAY SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Hours of Sleep: \_\_\_\_\_

**Dinner (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**NIGHTTIME SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Quality of Sleep: \_\_\_\_\_

.....  
 Check # Glasses Water  
 Consumed Each Day

**Day 5 –**

**Breakfast (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-MORNING SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Bowel Movements (# and Consistency) \_\_\_\_\_

**Lunch (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-DAY SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Hours of Sleep: \_\_\_\_\_

**Dinner (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**NIGHTTIME SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Quality of Sleep: \_\_\_\_\_

.....  
 Check # Glasses Water  
 Consumed Each Day

**Day 6 –**

**Breakfast (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-MORNING SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Bowel Movements (# and Consistency) \_\_\_\_\_

**Lunch (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-DAY SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Hours of Sleep: \_\_\_\_\_

**Dinner (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**NIGHTTIME SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Quality of Sleep: \_\_\_\_\_

.....  
 Check # Glasses Water  
 Consumed Each Day

**Day 7 –**

**Breakfast (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-MORNING SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Bowel Movements (# and Consistency) \_\_\_\_\_

**Lunch (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**MID-DAY SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Hours of Sleep: \_\_\_\_\_

**Dinner (Time: \_\_\_\_\_)**  
 Meat & Dairy \_\_\_\_\_  
 Vegetable/Fruit \_\_\_\_\_  
 Bread/Cereal/Grain \_\_\_\_\_  
 Fats/Butter \_\_\_\_\_  
 Candy/Junk Food \_\_\_\_\_  
 Water Intake (fl. Oz.) \_\_\_\_\_  
 Other Drinks \_\_\_\_\_  
**NIGHTTIME SNACK (TIME: \_\_\_\_\_)**  
 Snack \_\_\_\_\_  
 Quality of Sleep: \_\_\_\_\_

.....  
 Check # Glasses Water  
 Consumed Each Day

**NOTES:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The Rejuvenate Wellness  
Center  
6940 S. Holly Cir. #201  
Centennial, CO 80112  
303-850-0880  
www.rejuvenatewellnessecenter.com



## PATIENT - DOCTOR AGREEMENTS

The purpose of these agreements is to allow us to more completely serve you and to get the best results in the shortest amount of time. Our experience is that those patients who adhere to the following agreements, get the best results.

### PAYMENT OF BILLS-

Whatever arrangements you make with our office, we expect you to honor. If you can't fulfill your arrangement in this area, please let our financial manager know immediately so new arrangements can be made. Accounts past due will be charged a handling fee. Failure to communicate after three billings in the form of payment or explanation will result in immediate legal action.

### FIRST APPOINTMENT ARRIVAL-

In order to honor your time and the time of our other patients, please arrive **15 minutes prior** to your initial appointment with all of your New Patient forms completed preceding your arrival. This will allow the office staff to assemble your patient chart and permit Dr. Petropulos to review all of your health history information prior to the start of your appointment time. We feel that this is extremely important, so strict adherence to this expectation is required.

### CANCELLING OR CHANGING APPOINTMENTS-

We have set up a specific course of treatment for you. A certain amount of treatments are required in a set amount of time to get the results we both desire. Thus, if you need to change the time of your appointment, attempt to come in another time the same day. If you are unable to keep your appointment within the same day, we require 24 hour notice, otherwise you will be charged for the time reserved.

### WAIT TIME-

Due to the inability to predict patient needs, appointments may take longer than anticipated. Waiting can be expected. Please feel free to call our office prior to your appointment to see how the doctor is running. Every attempt to predict wait time will be made at the time of your call. Please feel free to communicate any frustrations concerning this directly to the doctor.

### PERFUMES, LOTIONS AND COLOGNES-

For the comfort of our office staff and patients, please refrain from wearing any perfume, cologne, or strongly scented lotions when visiting our office. Many of those with whom you will be in contact suffer from allergies to the above referenced items. Your cooperation in this is greatly appreciated!

### DIETS AND FOOD SUPPLEMENTS-

Both should be followed or taken as requested by your doctor. Please communicate any inability to do such, so that the doctor can compensate for any nutritional inadequacy. You are expected to pay for vitamins at the time of purchase.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# HIPAA Notice of Privacy Practices

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THE LIFE CENTER  
Dr. Peter M. Petropulos  
7200 E. Dry Creek Road,  
Bldg. A #101  
Englewood, Co. 80112

## **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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your protected health information. "Protected health information" is information about you, including demographics information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **1. Uses and Disclosures of Protected Health Information**

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by Law.**

**You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclose indicated in the authorization.**

**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_