The UltraWellness Center

YOUR KEY TO LIFELONG HEALTH AND VITALITY

Pediatric Patient Information

55 Pittsfield Road, Suite 9
Lenox Commons
Lenox, MA 01240

Phone (413) 637-9991
Fax (413) 637-9995

www.ultrawellnesscenter.com
office@ultrawellnesscenter.com

U2000-031617

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PATIENT CHECKLIST

DID YOU REMEMBER TO?

- ☐ Read all of the practice documents
- ☐ Obtain your child's medical records and/or test results from previously seen physicians and have them sent to The UltraWellness Center at 55 Pittsfield Road, Suite 9, Lenox Commons, Lenox MA 01240, arriving at least 7 days prior to your appointment date.
- ☐ Provide your preferred shipping/mailing address; if listing a P.O. Box please indicate a street address for receiving packages, UPS or FEDEX.
- ☐ Provide us with your pharmacy name, address, phone and FAX number.

FILL OUT AND/OR SIGN THE FOLLOWING FORMS

- ☐ Patient Pledge
- ☐ Important Patient Information
- ☐ Medicare Private Contract (to be signed upon arrival)
- ☐ Authorization for Release of Medical Information
- ☐ Informed Consent Regarding Email or the Internet Use Of Protected Personal Information
- ☐ Research Consent Form
- ☐ Health Questionnaire
- ☐ 3-Day Diet Diary
- ☐ MSQ - Medical Symptom/Toxicity Questionnaire

Thank you

The UltraWellness Center

YOUR KEY TO LIFELONG HEALTH AND VITALITY

Dear Patient,
Welcome to The UltraWellness Center. We look forward to meeting you.

WHAT TO EXPECT AT THE ULTRAWELLNESS CENTER

Please arrive 20 minutes before your appointment time

ADMINISTRATION OFFICE—*Check In*
(10 minutes)
Welcome to The UltraWellness Center
Update personal forms and sign consent forms
Vital signs & picture for medical chart
Registration for Healthy Living Supplement Store

MD CONSULTATION:
Mark Hyman (60 minutes)
MD; Elizabeth Boham, MD, RD; Todd R. LePine, MD; Edward Levitan, MD *(80 minute appointment)*
Medical Assessment & Initial Treatment Plan

LABS/TESTING: *Lab Technician*
(30 minute appointment)
Review of lab orders, test descriptions and test prices
Lab testing (if not returning the next morning for lab tests)

NUTRITIONIST CONSULTATION:
Margaret Ward, MS, RD, CDN; Lisa Fischer, MS, RDN, LDN; Deborah Phillips, MS, LDN; Kathie Swift, MS, RD; Eileen Connor Bote, RD, *(50 minute appointment)*
Nutrition Assessment & Initial Nutrition Plan

NURSE WRAP UP AND REVIEW
(30 minute appointment)
Review of MD's treatment plan
Review of medications prescribed-if needed
How to obtain prescribed nutritional supplements
Exit plan and information reviewed and discussed

RECEPTION OFFICE—*Check Out*
(20 minutes)
Schedule follow-up appointments
Obtain superbill to send to your insurance company for possible reimbursement

PRACTICE POLICIES FOR PATIENTS

Our goal at The UltraWellness Center is to provide you with the highest level of personalized care. We are committed to helping you achieve optimal health.

It is important to read all the enclosed information carefully and mail or fax all attached forms to our office at least 7 days prior to your appointment. This will allow us to help solve your problems more efficiently and enhance the quality of your care. If your patient packet is late, it may take up to 30 minutes of your appointment time to review your records.

The UltraWellness Center is a fragrance-free building due to the chemical sensitivities of our patients and staff.

WEBSITE

Information about The UltraWellness Center and all relevant patient forms are available through our website, www.ultrawellnesscenter.com.

MEDICAL RECORDS

Medical records can only be released with your authorization. You are responsible for obtaining previous medical records from other physicians or health care providers. A medical records release form is included for your use. Please contact your physician or other health care provider to obtain these records. Your records should be express mailed to The UltraWellness Center, 55 Pittsfield Road, Suite 9, Lenox Commons, Lenox, MA 01240.

CONSULTATIONS

Your initial visit will include an 60-80 minute medical consultation with your physician and a 50-minute nutrition consultation. Nutritional therapy and laboratory/diagnostic testing are integral components of your treatment plan. Test results are used to design your personal health care program as well as uncover the root causes of your medical condition. Nutritional supplements are often recommended and we will help you select and find the highest quality products. Our clinical team includes a nurse practitioner who will see patients on an alternating basis with your physician.

INITIAL VISITS

When coming from out of town, you may need to stay overnight after your consultation to have your blood drawn the next morning. Many of the tests require a 10-hour fast. You can, and should drink water during this fast.

Costs of all testing will be reviewed with you by our staff after your medical consultation before labs are drawn. You will receive all final lab results and be guided through their interpretation at your follow-up visits.

INITIAL CONSULTATION FEES

- Initial MD consultation (80-minutes): $2,000; (60-minutes) $2,500 with Dr. Hyman
- Initial Nutrition Consultation (50-minutes): $250

FOLLOW-UP CONSULTATION FEES

- MD (Dr. Hyman) Office Visit or Phone Follow-up (50-minutes): $500
- MD (Dr. Hyman) Office Visit or Phone Follow-up (25-minutes): $300
- MD Office Visit or Phone Follow-up (25-minutes): $275
- MD Office Visit or Phone Follow-up (50-minutes): $500
- MD Office Visit or Phone Follow-up (15-minutes): $200
- Nutrition 1st Follow-up Visit or Phone (50-minutes): $240
- Nutrition Office Visit or Phone Follow-up (50-minutes): $200
- Nutrition Office Visit or Phone Follow-up (25-minutes): $100
- Physician Assistant Visit or Phone Follow-up (50-minutes): $375
- Physician Assistant Visit or Phone Follow-up (25-minutes): $190

PRACTICE POLICIES FOR PATIENTS

PAYMENT OPTIONS

Our office accepts cash, checks or credit cards (Mastercard, Visa, Discover) for services rendered. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations (medical and nutritional) as well as laboratory testing will be itemized and reviewed with you. Payment is due on the day of service.

Follow-up phone consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account.

INSURANCE INFORMATION

The UltraWellness Center does not accept insurance and we cannot assist you with claim resolution. In addition, we are not Medicare providers. You will be provided with a billing summary which you can submit to your insurance carrier.

PHONE CALLS, MESSAGES & FAXES

1. Our office hours are Monday – Thursday 8 am to 4:30 pm EST and Friday from 8 am to 3 pm EST.
2. To reach The UltraWellness Center, please call (413) 637-9991.
3. Our fax number is (413) 637-9995.
4. If you call after hours, our office staff will return your call on the next business day.
5. If you have a medical emergency, call 911 or go directly to the nearest emergency room.
6. When leaving a message, please be brief and include the following information:
    a. Full name, spell your last name, and date of birth
    b. Reason for call
    c. Best time to be called back
    d. Phone number(s)
    e. Email address (if desired)

PRESCRIPTION REFILL REQUEST

It may take up to 72 hours to process a prescription refill. Please plan ahead to avoid any interruptions in your medications. Prescription refills can be faxed to our office by your pharmacy. Our fax number is 413-637-9995.

PRACTICE POLICIES FOR PATIENTS

CONFIRMATION AND CANCELLATION OF APPOINTMENTS

Due to the overwhelming requests for consultations, there is a 7 day cancellation policy for your first Initial appointment. Your appointment must be cancelled at least 7 days prior to your scheduled consultation or you will be charged for the visit. There is a 72-hour cancellation policy for all follow-up appointments. You may cancel your appointment by calling the office. If calling after hours, dial 0 and please leave a message.

PAYMENT OPTIONS

Our office accepts cash, checks or credit cards (MasterCard, Visa, Discover) for services rendered. When you schedule the initial visit, we request a credit card be put on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations (medical and nutritional), as well as laboratory testing will be itemized and reviewed with you. Payment is due on the day of service.

Follow-up phone consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account.

INSURANCE INFORMATION

(This section does not apply to Medicare; Medicare recipients please see Medicare information below.)

The UltraWellness Center does not participate with any insurance carrier. We do not submit medical claims on your behalf and we cannot assist you with claim resolution. All services are strictly on a self-pay basis; however we will provide you with a detailed billing summary that you may submit to your insurance carrier for reimbursement. Please note that there may be procedures and laboratory tests that are non-covered due to your individual policy/plan type. Should you have any questions regarding your medical coverage, please call the telephone number on the back of your insurance card.

MEDICARE INFORMATION

The UltraWellness Center providers *do not participate* in the Medicare program. If you are a Medicare Part B beneficiary and wish to become a patient of the Center, you are required to accept the terms and conditions set forth in a Private Contract between you and your UltraWellness Center provider. This Private Contract provides that absolutely no Medicare payment will be made to you or to the Center for the services provided, even if such services are covered by Medicare. Under the Private Contract, you acknowledge that you accept full responsibility for the payment of charges for all services rendered by The UltraWellness Center; such payments are due in full at the time of service. The Center will not require you to sign the Private Contract if you are experiencing an emergency or urgent issue.

PHONE CALLS, MESSAGES & FAXES

- If you have a medical emergency, call 911 or go directly to the nearest emergency room.
- Our office hours are Monday – Thursday 8 am to 4:30 pm EST and Friday from 8 am to 3 pm EST.
- To reach The UltraWellness Center, please call (413) 637-9991.
- Our fax number is (413) 637-9995.
- If you call after hours, our office staff will return your call on the next business day.
- When leaving a message, please be brief and include the following information:
    1. Full name, spell your last name, and date of birth
    2. Reason for call
    3. Best time to be called back
    4. Phone number(s)
    5. Email address (if desired)

PRACTICE POLICIES FOR PATIENTS

PRESCRIPTION REFILL REQUESTS

It may take up to 5 business days to process a prescription refill. Please plan ahead to avoid any interruptions in your medications. Prescription refills can be faxed to our office by your pharmacy. Our fax number is 413-637-9995.

PLACES TO STAY IN THE BERKSHIRES

There are a number of nearby inns, resorts and hotels that our patients have enjoyed. In addition, please see www.berkshires.org. for a comprehensive listing of Berkshire accommodations:

- Cranwell Resort, Lenox: (413) 637-1364
- Hampton Inn and Suites, Lenox: (413) 499-1111
- Red Lion Inn, Stockbridge: (413) 298-5545
- Canyon Ranch, Lenox: (413) 637-4100
- Blantyre, Lenox: (413) 637-3556
- Wheatleigh, Lenox: (413) 637-0610

LOCAL RECOMMENDED RESTAURANTS

- Jaes Asian Bistro, Lenox: (413) 637-9777
- Haven, Lenox: 413-637-8998
- Alta, Lenox: (413) 637-0003
- Bistro Zinc, Lenox: (413) 637-8800
- Bizen, Great Barrington: (413) 528-4343
- Allium, Great Barrington: (413) 528-2118

Wishing you the best of health and happiness,
Mark Hyman, MD & The Staff at The UltraWellness Center

DIRECTIONS TO THE ULTRAWELLNESS CENTER

FROM THE MASSACHUSETTS TURNPIKE

Get off at Exit 2 – Lee/Pittsfield/Lenox (Berkshires).
Go through the toll booth and bear right onto Route 20W.
Go through the town of Lee, bearing right around the park and remain on Route 20, into Lenox.
Pass Cranwell Resort on the right.
Continue straight on Route 7 North/Pittsfield Road.
At your 4th set of lights, take a left into Lenox Commons.
The UltraWellness Center is the white building, last on the left hand side at the end of the parking lot, Suite 9.

The UltraWellness Center
55 Pittsfield Road, Suite 9
Lenox Commons
Lenox, MA 01240
(413) 637-9991

FREQUENTLY ASKED QUESTIONS

What is your website address? And how can I order the supplements I need?

Information about The UltraWellness Center can be found at www.ultrawellnesscenter.com. The website also provides an online store for your child's nutritional and supplement needs. Our team has researched the highest quality products available that meet independently verified standards of effectiveness, quality and purity. To access the store your user name is your email address and your password is "health".

We encourage you to log on to our site to learn more about our services, resources, blogs and links to recommended sites such as www.ultrawellness.com and www.ultrametabolism.com. The site contains a library of articles on health and disease that can be a useful resource. We will sign you up for Dr. Hyman's free weekly educational email newsletter and video blog. If you do not wish to receive this, please click on the link to unsubscribe at the bottom of the email.

Do you think you can help me with my child's health problem?

Our physicians use an innovative systems approach to assessing and treating your child's health care concerns. Perhaps you have experienced your child being examined by your doctor, having blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that "all your tests are normal". Yet, both you and your doctor know that your child is sick. Unfortunately, this experience is all too common.

Most physicians were trained to look only in specific places for the answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found in these places. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies and metabolic imbalances. New gene testing can uncover underlying genetic predispositions that can be modified through diet, lifestyle, supplements or medications.

Dr. Hyman has pioneered the use of such testing to help his patients prevent illness and recover from many chronic and difficult to treat conditions. Our physicians are highly skilled in evaluating, assessing and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, memory problems, Parkinson's disease and other chronic, complex conditions. We also focus on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

Can all the tests my child needs be done at The UltraWellness Center?

Most of the testing can be performed at The UltraWellness Center. Some testing can be done through conventional laboratories and others are only available through specialty laboratories. During your child's medical consultation, your physician will determine which tests are needed and then our nurses/medical office assistants will review testing recommendations, instructions (ex. fasting or non-fasting, etc.) and costs. Some testing can be performed at home with test kits to collect urine, saliva or stool. Others may require your child to go to a local laboratory to have blood drawn. In all cases, we will assist you in coordinating initial and follow-up testing.

Occasionally, we may recommend certain tests that are not performed at our facility (i.e. heart scans, cardiac stress tests, bone density, sleep studies, etc.) In those instances, we can provide you with an order that you can take to a facility near your home or we can schedule an appointment to have them done near our office.

FREQUENTLY ASKED QUESTIONS

Will my child see other practitioners at The UltraWellness Center?

Nutritional therapy is a vital component of your treatment plan. Following your initial medical consultation, you will meet with one of our nutritionists, Margaret Ward, MS, RD, CDN; Lisa Fischer, MS, RDN, LDN; Deborah Phillips, MS, LDN; Kathie Swift, MS, RD; Eileen Connor Bote, RD. They will provide recommendations based on your health concerns and tailor your diet based on medical evaluation and test results. You will follow-up with your nutritionist in person, by phone or email consultations.

Do you take insurance?

The UltraWellness Center does not accept insurance; we do not file insurance claims on your behalf, nor do we assist with claim resolution. However, we will provide a detailed receipt of services performed for you to submit to your insurance carriers. We expect payment in full by check, cash or credit card due at the time services are provided.

Can a claim be submitted to Medicare?

No, The UltraWellness Center providers *do not participate* in the Medicare program. If you are a Medicare Part B beneficiary and wish to become a patient of the Center, you are required to accept the terms and conditions set forth in a Private Contract between you and your UltraWellness Center provider. This Private Contract provides that absolutely no Medicare payment will be made to you or to the Center for the services provided, even if such services are covered by Medicare. Under the Private Contract, you acknowledge that you accept full responsibility for the payment of charges for all services rendered by the UltraWellness Center; such payments are due in full at the time of service. The Center will not require you to sign the Private Contract if you are experiencing an emergency or urgent issue.

What credit cards do you accept?

We accept the following credit cards: MasterCard, Visa and Discover. It is important to maintain an active credit card on file with our office for billing of follow-up consultations, laboratory testing, and other services.

If you plan to pay with a debit card we require a second method of payment on file as some debit cards have a daily payment limit.

Are Dr. Hyman, Dr. Boham, Dr. LePine, and Dr. Romm primary care physicians?

The physicians are trained as primary care physicians but they do not provide acute care services. We will work with you closely as consultants and coaches in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. They can confer with your child's primary care doctor if required.

Does my child have to see the physician in person for my medical consultation?

Yes, their medical licenses require that they meet with a patient in order to provide an initial medical consultation. Follow-up appointments can be arranged by phone or in the office.

Whom do I contact?

Our phone number is: (413) 637-9991.
All questions and concerns can be communicated via email to:

Administration: Practice Manager, (manager@ultrawellnesscenter.com) **Lab Results:** Phlebotomist, (lab@ultrawellnesscenter.com)
Patient Concerns and Questions: (413) 637-9991 Ext. 0
Prescription Refills: (413) 637-9991 Ext. 184
Medical Records: Office (office@ultrawellnesscenter.com

Where are you located?

The UltraWellness Center is located in beautiful Lenox, Massachusetts. Albany International Airport (Albany, NY) is approximately 50 minutes and Bradley International Airport (Hartford, CT) is approximately 75 minutes from our office.

The UltraWellness Center

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Pediatric Consent Forms

55 Pittsfield Road, Suite 9
Lenox Commons
Lenox, MA 01240

Phone (413) 637-9991
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www.ultrawellnesscenter.com
office@ultrawellnesscenter.com

U2100-050814

PATIENT PLEDGE

Your health and healing depend on our commitment to doing the best we can and your commitment to:

- ***Primary Care Physician***
  You will need a PCP (Primary Care Physician) while working with The UltraWellness Center. We cannot see you here without a PCP on record. The UltraWellness Center does not handle medical or mental health emergencies. Your PCP will only be contacted by the UWC clinical staff if a situation arises that requires the attention of your local provider.
- ***The UWC Approach***
  We strongly recommend that you fully commit to The UltraWellness Center medical approach in order to succeed. Working with multiple centers or physicians, other than your primary care physician, may create contradiction, confusion and frustration – ultimately delaying your progress.
- ***A Partnership and a Process***
  Some chronic illnesses can take weeks, months or even longer to improve. If you don't see immediate results, don't give up. At The UltraWellness Center, healing is based on a partnership and a process. It takes time, patience and persistence to find and treat the root causes of your illness. You will have to work hard, and so will we.
- ***Prescribed Changes***
  Your commitment to comply with prescribed dietary changes, supplements, and medications, as well as other treatment recommendations, is the key to healing. If you don't follow the plan with reasonable consistency, your progress will likely be stalled.
- ***Nutritionist Appointments***
  Our medical nutritionists are your support system for making the necessary lifestyle changes. If you maintain regular ongoing appointments with your UltraWellness Center nutritionists, you'll benefit from guidance for overcoming challenges, ideas for implementing those changes and helpful resources.
- ***Patient / Physician Commitment***
  Establishing and maintaining a good working relationship with your physician here at the center, is a key element in your success. Once treatment is initiated with your physician, it is important that you remain in that physician's care and stay in regular communication with your clinical team.
- ***Ongoing Support***
  Functional medicine is a different approach from the existing health care model. Chronic illness can contribute to challenges with focus, cognition, energy and mood. Some of the changes that we ask of you may feel overwhelming at times. We urge every patient to find support at home. Family or friends may provide support, but that is not always adequate. It is the obligation of your UWC team to identify difficulty you might be having with behaviors that are interfering with your stated goals and to recommend additional outside services. These services include a range of behavioral and mental health therapies. Refusal to make appropriate use of recommended treatment will result in termination of UWC services.

I have read and agree to the statements above.

Please Print Your Name _____ Date _____

Patient Signature _____

IMPORTANT PATIENT INFORMATION

APPOINTMENTS

- There is a 7 day cancellation policy for your first Initial appointment.
- There is a 72-hour cancellation policy for all follow-up appointments.
- As a courtesy, we call to confirm the appointment prior to your scheduled time; ultimately it is your responsibility to keep the scheduled appointment or reschedule.

LAB TESTS

- After your initial and follow-up consultations, lab tests and/or diagnostic tests may be ordered.
- Testing recommendations and cost(s) per test will be reviewed.
- Lab tests are performed "fasting", which means nothing except water 10 hours before your visit.
- Some lab tests take up to 6 weeks to be finalized. The results will be mailed or emailed to you when they are finalized. If your follow-up appointment was not booked at the time of your initial visit, then you should contact the office to schedule a follow-up appointment.

BILLING/INSURANCE

- Payment for the office visit, phone consultation or lab tests is expected at time of service. We accept cash, check or credit cards. All credit card payments will be processed the same day of the visit or phone call.
- If test kits are sent to you, you will be charged the day the kit is mailed.
- The UltraWellness Center does not participate with any insurance carrier. We do not submit medical claims on your behalf and we cannot assist you with claim resolution. All services are strictly on a self-pay basis; however we will provide you with a detailed billing summary that you may submit to your insurance carrier for possible reimbursement. Please note that there may be procedures and laboratory tests that are non-covered due to your individual policy/plan type. Should you have any questions regarding your medical coverage, please call the telephone number on the back of your insurance card.
- The UltraWellness Center providers do not participate in the Medicare program. If you are a Medicare Part B beneficiary and wish to become a patient of the Center, you are required to accept the terms and conditions set forth in a Private Contract between you and your UltraWellness Center provider. This Private Contract provides that absolutely no Medicare payment will be made to you or to the Center for the services provided, even if such services are covered by Medicare. Under the Private Contract, you acknowledge that you accept full responsibility for the payment of charges for all services rendered by the UltraWellness Center; such payments are due in full at the time of service. The Center will not require you to sign the Private Contract if you are experiencing an emergency or urgent issue.

PRIMARY CARE PHYSICIAN

- Please note that our physicians are not your primary care physicians. We require that you have a primary care physician at home.

Patient Signature _____ Date _____

MEDICARE PRIVATE CONTRACT

(In compliance with 42 U.S.C. §1395a; 42 C.F.R. § 405, subpart D)

This contract is entered into by and between _____ (hereinafter called "physician"), whose principal medical office is located at **55 Pittsfield Road, Suite 9, Lenox MA 01240** and_____(hereinafter called "beneficiary"), who resides at _____, and shall become effective on this ___ day of _____, 20_____, and shall expire on the _____ day of _____, 20_____ (the "opt out period"), unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

PHYSICIAN OBLIGATIONS

The physician acknowledges that [he or she] [is or is not] excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician acknowledges that [he or she] must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare & Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that [he or she] must enter into a contract for each opt-out period.

BENEFICIARY OBLIGATIONS

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.

The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

[Optional provision, not required by Medicare to be included in the affidavit]: I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

(To be signed upon arrival.)

Name of physician (printed)

Signature | Date

55 Pitsfield Road, Suite 9, Lenox, MA 01240 | **413-637-9991**

Principle office address | Telephone number

National Provider Identifier

Name of beneficiary (or his/her legal representative)

Signature | Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

You should use this form to submit to your Physician's office to release records to The UltraWellness Center.

Name of Facility or Person: _____

Address: _____

Telephone Number: ( ) _____ – _____ Fax Number: ( ) _____ – _____

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to The UltraWellness Center all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: ○ Yes ○ No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: ○ Yes ○ No

Genetic Testing: ○ Yes ○ No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release The UltraWellness Center, its employees, agents, managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

_____ _____

Please Print Your Name DOB

_____ _____

Patient Signature Date

PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM

Information Released: _____ Date: _____

Medical Records Technician Name: _____

Signature: _____

Please send records to: The UltraWellness Center 55 Pittsfield Rd, Suite 9, Lenox MA 01240 • Fax (413) 637-9995

INFORMED CONSENT REGARDING EMAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
   b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.
2. It is the policy of The UltraWellness Center that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. The UltraWellness Center will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail or internet communication.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
   a. All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, such as The UltraWellness Center physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. The UltraWellness Center may forward e-mail messages within the practice as necessary for diagnosis and treatment. The UltraWellness Center will not, however, forward the email outside the practice without the consent of the patient as required by law.
   c. The UltraWellness Center will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
   d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
   e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
   f. The UltraWellness Center cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication but The UltraWellness Center is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
   g. If consent is given for the use of e-mail, it is the responsibility of the patient's to inform The UltraWellness Center of any types of information you do not want to be sent by e-mail.
   h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from The UltraWellness Center to protect confidentiality. The UltraWellness Center is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to The UltraWellness Center.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name: _____ Date: _____

Signature: _____

RESEARCH CONSENT AGREEMENT

Patient's Name: _____

Patient's Address: _____

_____

THE STUDIES

You are being asked to provide your consent for The UltraWellness Center to use information from your medical records in research studies the goal of which is to improve the practices of the functional medicine approach. No personal identifying information will be used in the study. The Principal Investigator of these research studies is Mark Hyman, M.D.

If you consent to the use of your medical records in these research studies, your personal information will be kept confidential to the extent permitted by law and will not be released without your written permission except as described in this paragraph. In all study forms, you will be identified only by a randomly selected patient number. Your name will not be reported in any publication; only the data obtained as a result of the use of your medical records in these studies will be made public.

Your decision as to whether or not to consent to the use of your medical records is completely voluntary (of your free will). If you decide not to consent to the use of your medical records it will not affect the care you receive.

If you decide to consent to the use of your medical records in connection with these studies, you may withdraw consent at any time without affecting the care you receive. You should contact the Principal Investigator and let him know about your decision if you decide to withdraw consent.

AGREEMENT TO PARTICIPATE

I have read the description of the research studies and general conditions. Anything I did not understand was explained to me by: _____ , any questions I had were answered by: _____ . I hereby give my consent to The UltraWellness Center to use my medical records as described herein in connection with the research studies described herein. I will receive a copy of this Consent Form.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Print Name of Person Name of Person Obtaining Consent

The UltraWellness Center

YOUR KEY TO LIFELONG HEALTH AND VITALITY

Pediatric Health Questionnaires

55 Pittsfield Road, Suite 9
Lenox Commons
Lenox, MA 01240

Phone (413) 637-9991
Fax (413) 637-9995

www.ultrawellnesscenter.com
office@ultrawellnesscenter.com

U2200-050814

The UltraWellness Center

YOUR KEY TO LIFELONG HEALTH AND VITALITY

GENERAL INFORMATION

Name	*First Middle*		*Last*	
Preferred Name				
Date of Birth				
Age				
Gender	☐ Male	☐ Female		
Genetic Background	☐ African	☐ European	☐ Native American	☐ Mediterranean
	☐ Asian	☐ Ashkenazi	☐ Middle Eastern	☐ _____
Highest Education Level	☐ High School	☐ Under-Graduate	☐ Post-Graduate	
Job Title				
Nature of Business				
Primary Address	*Number, Street*			*Apt. #*
	City		*State*	*Zip*
Alternate Address	*Number, Street*			*Apt. #*
	City		*State*	*Zip*
Home Phone 1				
Home Phone 2				
Work Phone				
Cell Phone				
Fax				
E-mail				
Emergency Contact 1	*Name*		*Phone Number*	
Relationship			*Cell Number*	
	Address		*Work Number*	
	City		*State*	*Zip*
Emergency Contact 2	*Name*		*Phone Number*	
Relationship			*Cell Number*	
	Address		*Work Number*	
	City		*State*	*Zip*

Primary Care Physician *Name* *Phone*

Fax

Referred by ☐ Book ☐ Website ☐ Media ☐ Friend or Family Member
☐ Other _____

PHARMACY INFORMATION

Primary Pharmacy *Name* *Phone*

Address

City *State* *Zip*

E-mail ***Fax****

** It is extremely important that you list the pharmacy's fax number*

Compounding/ Supplement Pharmacy *Name* *Phone*

Address

City *State* *Zip*

E-mail ***Fax****

** It is extremely important that you list the pharmacy's fax number*

CREDIT CARD INFORMATION

Patient _____ Date _____

DOB _____

Preferred Method of Payment *(please circle one)*: Cash / Check / Credit Card / Debit Card

If paying by credit card, we accept VISA, MasterCard and Discover

**Note: If Discover is your primary card, please provide another card (i.e., MasterCard or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover.*

PRIMARY CARD

Name on Card _____

Card Type ○ Visa ○ MasterCard ○ Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

SECONDARY CARD

Name on Card _____

Card Type ○ Visa ○ MasterCard ○ Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

Pediatric Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS CONCERNS

What do you hope to achieve in your visit with us? _____

_____

If you had a magic wand and could help your child in three ways, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt your child was well? _____

_____

Did something trigger your child's change in health? _____

_____

Is there anything that makes your child feel worse? _____

_____

Is there anything that makes your child feel better? _____

_____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Success: Good	Success: Fair
Example: Difficulty Maintaining Attention		X		*Elimination Diet*	X		

MEDICAL HISTORY

☑ = *Past Condition* ☑ = *Ongoing Condition*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

GASTROINTESTINAL

☐ ☐ Irritable Bowel Syndrome _____
☐ ☐ Inflammatory Bowel Disease _____
☐ ☐ Crohn's _____
☐ ☐ Ulcerative Colitis _____
☐ ☐ Gastritis or Peptic Ulcer Disease _____
☐ ☐ GERD (reflux) _____
☐ ☐ Celiac Disease _____
☐ ☐ Other _____

CARDIOVASCULAR

☐ ☐ Heart Disease _____
☐ ☐ Elevated Cholesterol _____
☐ ☐ Hypertension (high blood pressure) _____
☐ ☐ Rheumatic Fever _____
☐ ☐ Mitral Valve Prolapse _____
☐ ☐ Other _____

METABOLIC/ENDOCRINE

☐ ☐ Type 1 Diabetes _____
☐ ☐ Type 2 Diabetes _____
☐ ☐ Hypoglycemia _____
☐ ☐ Metabolic Syndrome _____
(Insulin Resistance or Pre-Diabetes)
☐ ☐ Hypothyroidism *(low thyroid)* _____
☐ ☐ Hyperthyroidism *(overactive thyroid)* _____
☐ ☐ Endocrine Problems _____
☐ ☐ Polycystic Ovarian Syndrome *(PCOS)* _____
☐ ☐ Weight Gain _____
☐ ☐ Weight Loss _____
☐ ☐ Frequent Weight Fluctuations _____
☐ ☐ Bulimia _____
☐ ☐ Anorexia _____
☐ ☐ Binge Eating Disorder _____
☐ ☐ Night Eating Syndrome _____
☐ ☐ Eating Disorder *(non-specific)* _____
☐ ☐ Other _____

CANCER

☐ ☐ _____

GENITAL AND URINARY SYSTEMS

☐ ☐ Kidney Stones _____
☐ ☐ Urinary Tract Infections _____
☐ ☐ Yeast Infections _____
☐ ☐ Other _____

MUSCULOSKELETAL/PAIN

☐ ☐ Arthritis _____
☐ ☐ Fibromyalgia _____
☐ ☐ Chronic Pain _____
☐ ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

☐ ☐ Chronic Fatigue Syndrome _____
☐ ☐ Autoimmune Disease _____
☐ ☐ Rheumatoid Arthritis _____
☐ ☐ Lupus SLE _____
☐ ☐ Immune Deficiency Disease _____
☐ ☐ Severe Infectious Disease _____
☐ ☐ Poor Immune Function _____
(frequent infections)
☐ ☐ Food Allergies _____
☐ ☐ Environmental Allergies _____
☐ ☐ Multiple Chemical Sensitivities _____
☐ ☐ Latex Allergy _____
☐ ☐ Other _____

RESPIRATORY DISEASES

☐ ☐ Frequent Ear Infections _____
☐ ☐ Frequent Upper Respiratory Infections _____
☐ ☐ Asthma _____
☐ ☐ Chronic Sinusitis _____
☐ ☐ Bronchitis _____
☐ ☐ Sleep Apnea _____
☐ ☐ Other _____

SKIN DISEASES

☐ ☐ Eczema _____
☐ ☐ Psoriasis _____
☐ ☐ Acne _____
☐ ☐ Other _____

MEDICAL HISTORY (CONTINUED)

☑ = *Past Condition* ☑ = *Ongoing Condition*

NEUROLOGIC/MOOD

☐ ☐ Depression _____
☐ ☐ Anxiety _____
☐ ☐ Bipolar Disorder _____
☐ ☐ Schizophrenia _____
☐ ☐ Headaches _____
☐ ☐ Migraines _____
☐ ☐ ADD/ADHD _____
☐ ☐ Sensory Integrative Disorder _____
☐ ☐ Autism _____
☐ ☐ Mild Cognitive Impairment _____
☐ ☐ Multiple Sclerosis _____
☐ ☐ ALS _____
☐ ☐ Seizures _____
☐ ☐ Other Neurological Problems _____

PREVIOUS EVALUATIONS

Check box if yes and provide date

☐ Full Physical Exam _____
☐ Psychological Evaluations _____
☐ Wechsler Preschool & Primary Scale of Intelligence _____
☐ Speech and Language Evaluations _____
☐ Genetic Evaluation _____
☐ Neurological Evaluations _____
☐ Gastroenterology Evaluations _____
☐ Celiac/Gluten testing _____
☐ Allergy Evaluation _____
☐ Nutritional Evaluation _____
☐ Auditory Evaluation _____
☐ Vision Evaluation _____
☐ Osteopathic _____
☐ Acupuncture _____
☐ Physical Therapy _____
☐ Occupational Therapy _____
☐ Sensory Integration Therapy _____
☐ Language Classes _____
☐ Sign Language _____
☐ Homeopathic _____
☐ Naturopathic _____
☐ Craniosacral _____
☐ Chiropractic _____
☐ MRI _____
☐ CT Scan _____
☐ Upper Endoscopy _____
☐ Upper GI Series _____
☐ Ultrasound _____

INJURIES

Check box if yes and provide date

☐ Back injury _____
☐ Neck Injury _____
☐ Head Injury _____
☐ Broken Bones _____
☐ Other _____

SURGERIES

Check box if yes and provide date

☐ Appendectomy _____
☐ Circumcision _____
☐ Hernia _____
☐ Tonsils _____
☐ Adenoids _____
☐ Dental Surgery _____
☐ Tubes in Ears _____
☐ Other _____

BLOOD TYPE: ○ A ○ B ○ AB ○ 0 ○ Rh+ ○ unknown

HOSPITALIZATIONS ☐ None

Date	Reason

MEDICAL HISTORY (CONTINUED)

IMMUNIZATIONS

Is your child up to date with immunizations? ○ Yes ○ No

Do you feel immunizations have had an impact on your child's health? ○ Yes ○ No
If relevant, attach a copy of your child's immunization record or see addendum.

PSYCHOSOCIAL

Has your child experienced any major life changes that may have impacted his/her health? ○ Yes ○ No

Have your child ever experienced any major losses? ○ Yes ○ No

STRESS/COPING

Have you ever sought counseling for your child? ○ Yes ○ No

Is your child or family currently in therapy? ○ Yes ○ No Describe:_____

Does you child have a favorite toy or object? ○ Yes ○ No

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: _____

Has your child ever been abused, a victim of a crime, or experienced a significant trauma? ○ Yes ○ No

SLEEP/REST

Average number of hours your child sleeps per night: ○ >12 ○ 10-12 ○ 8-10 ○ < 8

Does your child have trouble falling asleep? ○ Yes ○ No

Does your child feel rested upon awakening? ○ Yes ○ No

Does your child snore? ○ Yes ○ No

ROLES/RELATIONSHIP

List Family Members:

Family Member and Relationship	Age	Gender

Who are the main people who care for your child?

Their Employment/Occupation: _____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

GYNECOLOGIC HISTORY (*for females only*)

MENSTRUAL HISTORY

Age at first period:_____ Menses Frequency:_____ Length:_____ Pain: ○ Yes ○ No Clotting: ○ Yes ○ No

Has your period ever skipped?_____ For how long?_____

Last Menstrual Period:_____

Does your child use contraception? ○ Yes ○ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?_____

GI HISTORY

Has your child traveled to foreign countries? ○ Yes ○ No Where? _____

Wilderness Camping? ○ Yes ○ No Where? _____

Ever had severe: ○ Gastroenteritis ○ Diarrhea

DENTAL HISTORY

☐ Silver Mercury Fillings How many? _____

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ○ Yes ○ No

PATIENT BIRTH HISTORY

MOTHER'S PAST PREGNANCIES

Number of: Pregnancies: _____ Live births: _____ Miscarriages: _____

MOTHER'S PREGNANCY

Check box if yes and provide description if applicable

☐ Difficulty getting pregnant (more than 6 months) ___
☐ Infertility drugs used Specify: _____
☐ In vitro fertilization _____
☐ Drink alcohol _____
☐ Drink coffee _____
☐ Smoke tobacco _____
☐ Take Progesterone _____
☐ Take prenatal vitamins _____
☐ Take antibiotics ☐ During Labor? _____
☐ Take other drugs Specify: _____
☐ Excessive vomiting, nausea (more than 3 weeks) ___
☐ Have a viral infection _____
☐ Have a yeast infection _____
☐ Have amalgam fillings put in teeth _____
☐ Have amalgam fillings removed from teeth _____
☐ Number of fillings in teeth when pregnant? _____
☐ Have bleeding (which months?) _____
☐ Have birth problems _____

☐ Group B strep infection _____
☐ Have c-section because of _____
☐ Use induction for labor (such as Pitocin) _____
☐ Have anesthesia -what was used? _____
☐ Use oxygen during labor _____
☐ Have an x-ray _____
☐ Have Rhogam, if so how many shots _____
How many when pregnant? _____
☐ Gestational Diabetes _____
☐ High blood pressure (pre-eclampsia) _____
☐ High blood pressure/toxemia _____
☐ Have chemical exposure _____
☐ Father have chemical exposure _____
☐ Move to a newly built house _____
☐ House painted indoors _____
☐ House painted outdoors _____
☐ House exterminated for insects _____

PREGNANCY

Total weight gain during pregnancy: _____lb Total weight loss during pregnancy: _____ lb

Please describe diet during pregnancy: _____

_____

_____

Please describe labor: _____

_____

_____

PATIENT BIRTH HISTORY (CONTINUED)

PERINATAL

Pregnancy duration: *X following the week of gestation.*

○ 24 ○ 25 ○ 26 ○ 27 ○ 28 ○ 29 ○ 30 ○ 31 ○ 32 ○ 33 ○ 34 ○ 35
○ 36 ○ 37 ○ 38 ○ 39 ○ 40 (full term) ○ 41 ○ 42 ○ 43 ○ 44 Weeks

Very active before birth? ○ Yes ○ No

Hospital/Birthing Center? ○ Yes ○ No

Needed Newborn Special Care? ○ Yes ○ No

Appeared healthy? ○ Yes ○ No

Easily consoled during first month? ○ Yes ○ No

Antibiotics first month? ○ Yes ○ No

Experienced no complications first month of life? ○ Yes ○ No

BIRTH WEIGHT AND APGAR

Weight at birth: _____ lbs Apgar score at one minute: _____ Apgar score at 5 mins: _____

EARLY CHILDHOOD ILLNESSES

Number of earaches in the first two years: _____

Number of other infections in the first two years: _____

Number of times you had antibiotics in the first two years of life: _____

Number of courses of prophylactic antibiotics in first 2 years of life: _____

First antibiotic at _____ months.

First illness at _____ months.

DESCRIPTION OF DEVELOPMENTAL PROBLEMS

If your child has developmental problems, at what age did they occur?

○ 0-1months ○ 2-6 months ○ 6-15 months ○ 16-24 months ○ After 24 months

Is this impression shared among parents and others caring for the child? ○ Yes ○ No

Does this impression, as to the timing of onset, differ among parents and others caring for the child? ○ Yes ○ No

Is the impression, as to the timing of onset, weak? ○ Yes ○ No

Or is the impression strong? ○ Yes ○ No

DEVELOPMENTAL HISTORY

Please indicate the approximate age in months for the following milestones: (example: walking 14 months):

Sitting up _____ months ○ Never
Crawl _____ months ○ Never
Pulled to stand _____ months ○ Never
Potty trained _____ months ○ Never
Walked alone _____ months ○ Never

Dry at night _____ months ○ Never
First words (“mama, dada” etc.) _____ months ○ Never
Spoke clearly _____ months ○ Never
Lost language _____ months ○ Never
Lost eye contact _____ months ○ Never

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS *Last 10 years*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have medications or supplements ever caused your child unusual side effects or problems? ○ Yes ○ No
Describe: _____

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ○ Yes ○ No

Has your child had prolonged or regular use of Tylenol? ○ Yes ○ No

Has your child had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ○ Yes ○ No

Frequent antibiotics > 3 times/year ○ Yes ○ No

Long term antibiotics ○ Yes ○ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ○ Yes ○ No

Use of oral contraceptives ○ Yes ○ No

FAMILY HISTORY

Check Family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

NUTRITION HISTORY

Has your child ever had a nutrition consultation? ○ Yes ○ No

Have you made any changes in your child's diet because of health problems? ○ Yes ○ No Describe _____

Does your child follow a special diet or nutritional program? ○ Yes ○ No

Check all that apply:

☐ Yeast Free ☐ Feingold ☐ Weight Management ☐ Diabetic ☐ Dairy Free ☐ Wheat Free ☐ Ketogenic

☐ Specific Carbohydrate ☐ Gluten Free/Casein Free ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Low Oxalate

☐ Food Allergy (*Ex. Peanuts, Eggs, etc.*): _____

Height (feet/inches)_____ Current Weight _____

Longest Weight Fluctuations ○ Yes ○ No

Does your child avoid any particular foods? ○ Yes ○ No If yes, types and reason: _____

_____

If your child could eat only a few foods daily, what would they be? _____

_____

Who does the shopping in your household? _____

Who does the cooking in your household? _____

How many meals does your child eat out per week? ○ 0-1 ○ 1-3 ○ 3-5 ○ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Poor snack choices
☐ Sensory issues with food
☐ Picky eater
☐ Limited variety of foods <5/day
☐ Prefers cold food
☐ Prefers hot food
☐ Every meal is a struggle
☐ Most family meals together
☐ Use food as a bribe or reward
☐ Erratic mealtimes
☐ Most meals eaten at the table
☐ High juice intake
☐ Low fruit/vegetable intake
☐ High sugar/sweet intake
☐ Drinks soda or diet soda
☐ Cow's Milk 1 2 3+
☐ Caffeine intake
☐ TV or videos with meals
☐ Challenges with food served outside the home (Ex. childcare, friend's home)

BREASTFED HISTORY

Breastfed? ○ Yes ○ No How long? _____ Problems latching on? ○ Yes ○ No

Sucking quality? ○ Very Good ○ Good ○ Poor Exclusively breastfed for _____ months

BOTTLE FED HISTORY

Bottle fed? ○ Yes ○ No Type of formula: ○ Soy ○ Cow's Milk ○ Low Allergy

Introduction of cow's milk at _____ months. Introduction of solid foods at _____ months.

First foods introduced at _____ months. Introduction of wheat or other grain at _____ months.

Choke/Gas/Vomit on milk? ○ Yes ○ No Refused to chew solids? ○ Yes ○ No

List mother's known food allergies or sensitivities: _____

Please describe any other eating concerns that you have regarding your child: _____

_____

ACTIVITY

List type and amount of activity daily.

Type	Amount Daily

How much time does your child spend watching tv? _____

How much time does your child spend on the computer or playing video games? _____

ENVIRONMENTAL HISTORY

☑ = *Past Condition* ☑ = *Ongoing Condition*

Please check appropriate box

EXPOSURES

☐ ☐ Mold in bathroom
☐ ☐ Damp cellar
☐ ☐ Pest extermination - Inside
☐ ☐ Pest extermination - Outside
☐ ☐ Forced hot air heat
☐ ☐ Had water in basement
☐ ☐ Mold visible on exterior of house
☐ ☐ Heavily wooded or damp surroundings
☐ ☐ Mold in cellar, crawl space, or basement
☐ ☐ Moldy, musty school/daycare
☐ ☐ Tobacco smoke
☐ ☐ Well water
☐ ☐ Carpet in bedroom
☐ ☐ Carpet in most parts of house
☐ ☐ Feather or down bedding

SOME THINGS ABOUT YOUR PARENTS

When were your parents married: _____ If separated, when: _____

If divorced, when: _____ If remarried, when: _____

Custody arrangements: _____

MOTHER - PERSONAL

Age at your birth _____

Education _____

Ethnicity _____

Blood type _____

FATHER - PERSONAL

Age at your birth _____

Education _____

Ethnicity _____

Blood type _____

SYMPTOM REVIEW (CONTINUED)

Please check all current symptoms occurring or present in the past 6 months.

- ☐ Canker sores in mouth
- ☐ Gums bleed
- ☐ Teeth grinding
- ☐ Tooth cavities
- ☐ Tooth with amalgam fillings
- ☐ Mouth thrush (yeast infection)
- ☐ Sore throat
- ☐ Fecal belching
- ☐ Burping
- ☐ Nausea
- ☐ Reflux
- ☐ Spitting up
- ☐ Vomiting
- ☐ Abdominal bloating
- ☐ Lower abdominal bloating
- ☐ Colic
- ☐ Abdomen distended
- ☐ Abdominal pain
- ☐ Intestinal parasites
- ☐ Pinworms
- ☐ Crampy pain with pooping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Farting - regular
- ☐ Farting - stinky
- ☐ Anal fissures
- ☐ Red ring around anus
- ☐ Stools bulky
- ☐ Stools light color
- ☐ Stools very stinky
- ☐ Stools with blood
- ☐ Stools with mucous
- ☐ Stools with undigested food
- ☐ Flatulence
- ☐ Stool odor foul
- ☐ Stool odor yeasty
- ☐ Stools pale
- ☐ Stools slimy
- ☐ Stools watery

EATING

- ☐ Poor appetite
- ☐ Thirst
- ☐ Extreme water drinking
- ☐ Bingeing
- ☐ Bread craving
- ☐ Craving for carbohydrates
- ☐ Craving for juice
- ☐ Craving for salt
- ☐ Diet soda craving
- ☐ Pica (eating non-edibles)
- ☐ Abnormal food cravings
- ☐ Carbohydrate intolerance
- ☐ Starch/disaccharide intol.
- ☐ Sugar intolerance
- ☐ Salicylate intolerance
- ☐ Oxalate intolerance
- ☐ Phenolics intolerance
- ☐ MSG intolerance
- ☐ Food coloring intolerance
- ☐ Gluten Intolerance
- ☐ Casein intolerance
- ☐ Specific food(s) intolerance
- ☐ Lactose intolerance
- ☐ Behavior worse with food
- ☐ Behavior better when fasting

BEHAVIOR

- ☐ Behavior purposeless
- ☐ Unusual play
- ☐ Uses adults hand for activity
- ☐ Aloof, indifferent, remote
- ☐ Doesn't do for self
- ☐ Extremely cautious
- ☐ Hides skill/knowledge
- ☐ Lacks initiative
- ☐ Lost in thought, unreachable
- ☐ No purpose to play
- ☐ Poor focus, attention
- ☐ Sits long time staring
- ☐ Uninterested in live pet
- ☐ Watches television long time
- ☐ Won't attempt/can't do
- ☐ Poor sharing
- ☐ Rejects help
- ☐ Curious/gets into things
- ☐ Erratic
- ☐ Unable to predict actions
- ☐ Destructive
- ☐ Hyperactive
- ☐ Constant movement
- ☐ Melt downs
- ☐ Tantrums
- ☐ Self mutilation
- ☐ Runs away
- ☐ Jumps when pleased
- ☐ Whirls self like a top
- ☐ Climbs to high places
- ☐ Insists on what wanted
- ☐ Tries to control others
- ☐ Head banging
- ☐ Falls, gets hurt running climbing
- ☐ Does opposite/asked
- ☐ Teases others
- ☐ Silly
- ☐ Shrieks
- ☐ Holds hands in strange pose
- ☐ Spends time w/ pointless task
- ☐ Stares at own hands
- ☐ Toe walking
- ☐ Arched back with bright lights
- ☐ Imitates others
- ☐ Finger flicking
- ☐ Flaps hands
- ☐ Licking
- ☐ Likes spinning objects
- ☐ Likes to flick finger in eye
- ☐ Likes to spin things
- ☐ Rhythmic rocking
- ☐ Slapping books
- ☐ Tooth tapping
- ☐ Visual stims
- ☐ Wiggle finger front of face
- ☐ Wiggle finger side of face
- ☐ Bites or chews fingers
- ☐ Bites wrist or back of hands
- ☐ Chews on things

MOOD

- ☐ Apathy
- ☐ Blank look
- ☐ Depression
- ☐ Detached
- ☐ Disinterested
- ☐ Eye contact poor
- ☐ Isolates
- ☐ Negative
- ☐ Fright without cause
- ☐ Always frightened
- ☐ Anguish
- ☐ Discontented
- ☐ Does not want to be touched
- ☐ Inconsolable crying
- ☐ Irritable
- ☐ Looks like in pain
- ☐ Moaning, groaning
- ☐ Phobias
- ☐ Restless
- ☐ Severe mood swings
- ☐ Unhappy
- ☐ Agitated
- ☐ Anxious

SENSORY

- ☐ Bothered by certain sounds
- ☐ Covers ears with sounds
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Hearing acute

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

STRENGTHS
- ☐ Especially attractive
- ☐ Accepts new clothes
- ☐ Cuddly
- ☐ Physically coordinated
- ☐ Happy
- ☐ Pleasant/easy to care for
- ☐ Sensitive/affectionate
- ☐ Wants to be liked
- ☐ Responsible
- ☐ Draws accurate pictures
- ☐ Sensitive to peoples feelings
- ☐ OK if parents leave
- ☐ Answers parent
- ☐ Follows instructions
- ☐ Pronounces words well
- ☐ Unusual memory
- ☐ Perfect musical pitch
- ☐ Good with math
- ☐ Good with computer
- ☐ Good with fine work
- ☐ Good throwing and catching
- ☐ Good climbing
- ☐ Strong desire to do things
- ☐ Swimming
- ☐ Bold, free of fear
- ☐ Likes to be held
- ☐ Likes to be swaddled

SLEEP
- ☐ Sleeps in own bed
- ☐ Sleeps with parent(s)
- ☐ Awakens screaming/crying
- ☐ Awakes at night
- ☐ Difficulty falling asleep
- ☐ Early waking
- ☐ Insomnia
- ☐ Sleeps less than normal
- ☐ Daytime sleepiness
- ☐ Jerks during sleep
- ☐ Nightmares
- ☐ Sleeps more than normal

PHYSICAL
- ☐ Looks sick
- ☐ Glazed look
- ☐ Overweight
- ☐ Underweight
- ☐ Pupils unusually large
- ☐ Unusual long eye lashes
- ☐ Pupils unusually small
- ☐ Dark circles under eyes
- ☐ Red lips
- ☐ Red fingers
- ☐ Red toes
- ☐ Webbed toes
- ☐ Red ears
- ☐ Double jointed
- ☐ High arched palate
- ☐ Lymph nodes enlarged neck
- ☐ Head warm
- ☐ Head sweats
- ☐ Night sweats
- ☐ Abnormal fatigue
- ☐ Failure to thrive
- ☐ Cold all over
- ☐ Cold hands and feet
- ☐ Cold intolerance
- ☐ Hands/feet - very sweaty
- ☐ Head very hot/sweaty
- ☐ Night sweats
- ☐ Perspiration - odd odor

SKIN
- ☐ Paleness, severe
- ☐ Fungus / fingernails
- ☐ Fungus / toenails
- ☐ Dandruff
- ☐ Chicken skin
- ☐ Oily skin
- ☐ Patchy dullness
- ☐ Seborrhea on face
- ☐ Thick calluses
- ☐ Athletes foot
- ☐ Feet - stinky
- ☐ Diaper rash
- ☐ Odd body odor
- ☐ Strong body odor
- ☐ Acne
- ☐ Dark circle under eyes
- ☐ Ears get red
- ☐ Eczema
- ☐ Flushing
- ☐ Red face
- ☐ Sensitive to insect bites
- ☐ Stretch marks
- ☐ Blotchy skin
- ☐ Bugs love to bite you
- ☐ Cradle cap
- ☐ Dry Hair
- ☐ Dry Scalp
- ☐ Hair Unmanageable
- ☐ Bites nails
- ☐ Nails brittle
- ☐ Nails frayed
- ☐ Nails pitted
- ☐ Nails soft
- ☐ Skin pale
- ☐ Dark birth mark(s)
- ☐ Easy bruising
- ☐ Inability to tan
- ☐ Light birth mark(s)
- ☐ Ragged cuticles
- ☐ Thickening finger nails
- ☐ Thickening toenails
- ☐ Vitiligo
- ☐ White spots or lines in nails
- ☐ Dry skin in general
- ☐ Feet cracking
- ☐ Feet peeling
- ☐ Hands cracking
- ☐ Hands peeling
- ☐ Lower legs dry
- ☐ Skin lackluster
- ☐ Itchy skin in general
- ☐ Itchy scalp
- ☐ Itchy ear canals
- ☐ Itchy eyes
- ☐ Itchy nose
- ☐ Itchy roof of mouth
- ☐ Itchy arms
- ☐ Itchy hands
- ☐ Itchy legs
- ☐ Itchy feet
- ☐ Itchy anus
- ☐ Itchy penis
- ☐ Itchy vagina

DIGESTIVE
- ☐ Breath bad
- ☐ Increased salivation
- ☐ Drooling
- ☐ Cracking lip corners
- ☐ Cold sores on lips, face
- ☐ Geographic tongue (map-like)
- ☐ Sore tongue
- ☐ Tongue coated

SYMPTOM REVIEW (CONTINUED)

Please check all current symptoms occurring or present in the past 6 months.

- ☐ Hearing loss
- ☐ Likes certain sounds
- ☐ Sensitive to loud noise
- ☐ Sounds seem painful
- ☐ Tinnitus
- ☐ Acute sense of smell
- ☐ Examines by smell
- ☐ Intensely aware of odors
- ☐ Blinking
- ☐ Bothered by bright lights
- ☐ Distorted vision
- ☐ Conjunctivitis
- ☐ Eye crusting
- ☐ Eye problem
- ☐ Lid margin redness
- ☐ Examines by sight
- ☐ Fails to blink at bright light
- ☐ Likes fans
- ☐ Likes flickering lights
- ☐ Looks out of corner of eye
- ☐ Poor vision
- ☐ Puts eye to bright light or sun
- ☐ Strabismus (crossed eye)
- ☐ Fearful of harmless object
- ☐ Fearful of unusual events
- ☐ Unaware of danger
- ☐ Unaware of peoples feelings
- ☐ Unaware of self as person
- ☐ Upset if things change
- ☐ Upset of things aren't right
- ☐ Adopts complicated rituals
- ☐ Car, truck, train obsession
- ☐ Collects particular things
- ☐ Draws only certain things
- ☐ Fixated on one topic
- ☐ Lines objects precisely
- ☐ Repeats old phrases
- ☐ Repetitive play/objects
- ☐ Finger tip squeezing
- ☐ Hates wearing shoes
- ☐ Insensitive to pain
- ☐ Likes head burrowed
- ☐ Likes head pressed hard
- ☐ Likes head rubbed
- ☐ Likes head under blanket
- ☐ Likes to be held upside down
- ☐ Likes to be swung in the air
- ☐ Very insensitive to pain
- ☐ Very sensitive to pain

NEUROMUSCULAR

- ☐ Clumsiness
- ☐ Coordination
- ☐ Fine motor poor
- ☐ Gross motor poor
- ☐ Holds bizarre posture
- ☐ Hyperactivity
- ☐ Physically awkward
- ☐ Rocking
- ☐ Stiffens body when held
- ☐ Calf cramps
- ☐ Foot cramps
- ☐ Muscle pain
- ☐ Muscle tone tense
- ☐ Muscle twitches
- ☐ Fist clenching
- ☐ Jaw clenching
- ☐ Poor muscle tone/limp
- ☐ Tics
- ☐ Muscle tone low trunk
- ☐ Muscle weakness, atrophy
- ☐ Muscle tone low all over
- ☐ Tremors
- ☐ Cognitive delays
- ☐ Memory poor
- ☐ Poor attention, focus
- ☐ Slow and sluggish
- ☐ Expressive language delay

SPEECH

- ☐ Never spoke
- ☐ Occas. words when excited
- ☐ Expressive language poor
- ☐ No answers simple questions
- ☐ Points to objects/can't name
- ☐ Speech apraxia
- ☐ Does not ask questions
- ☐ Babbling
- ☐ Asks using "you" not "I"
- ☐ Answers by repeating question
- ☐ Receptive language poor
- ☐ Says "I"
- ☐ Says "no"
- ☐ Says "yes"
- ☐ Lost language @ 12-24 months
- ☐ Lost language after 24 months
- ☐ Scripting
- ☐ Stuttering
- ☐ Talks to self
- ☐ Poor auditory processing
- ☐ Unusual sound of cry
- ☐ Uses one word for another
- ☐ Rigid behaviors
- ☐ Poor confidence
- ☐ Timid
- ☐ Corrects imperfections
- ☐ Tidy

RESPIRATORY

- ☐ Pneumonia
- ☐ Bad odor in nose
- ☐ Breath holding
- ☐ Bronchitis
- ☐ Congestion chg. season
- ☐ Congestion in the fall
- ☐ Congestion in the spring
- ☐ Congestion in the summer
- ☐ Congestion in the winter
- ☐ Cough
- ☐ Post nasal drip
- ☐ Runny nose
- ☐ Sighing
- ☐ Sinus fullness
- ☐ Wheezing
- ☐ Yawning

REPRODUCTIVE

- ☐ Girls: Early first period
- ☐ Boys: Large testicles
- ☐ Early breast development
- ☐ Early pubic hair
- ☐ Girls: vaginal odor

URINARY

- ☐ Frequent urination
- ☐ Bed wetting after age 4
- ☐ Odd urinary odor
- ☐ Urinary hesitancy
- ☐ Urinary tract infections
- ☐ Urinary urgency
- ☐ Dry at night
- ☐ Seizures - focal
- ☐ Seizures - generalized
- ☐ Seizures - grand mal
- ☐ Seizures - petit mal
- ☐ Unusual fast heart beat
- ☐ Heart murmur
- ☐ Headaches
- ☐ Joint pains
- ☐ Leg pains
- ☐ Muscle pains

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your child's health, how willing is the patient in:

Significantly modifying diet - ○5 ○4 ○3 ○2 ○1

Taking several nutritional supplements each day - ○5 ○4 ○3 ○2 ○1

Keeping a record of everything eaten each day - ○5 ○4 ○3 ○2 ○1

Modifying lifestyle (e.g.,work demands, sleep habits) - ○5 ○4 ○3 ○2 ○1

Practicing a relaxation technique - ○5 ○4 ○3 ○2 ○1

Engaging in regular exercise - ○5 ○4 ○3 ○2 ○1

Have periodic lab tests to assess progress - ○5 ○4 ○3 ○2 ○1

Comments_____

_____

_____

Rate on a scale of: 5 (very confident) to 1 (not confident at all)

How confident are you of your ability to organize and follow through on the above health related activities? - ○5 ○4 ○3 ○2 ○1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities**?** _____

_____

_____

Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? - ○5 ○4 ○3 ○2 ○1

Comments_____

_____

_____

Rate on a scale of: 5 (very frequent contact) to 1 (very infrequent contact)

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your childs health program? - ○5 ○4 ○3 ○2 ○1

Comments_____

_____

_____

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY — DAY 1

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

_____

Daily Bowel Movements: _____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

DIET DIARY — DAY 2

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

_____

Daily Bowel Movements:_____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

DIET DIARY — DAY 3

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

_____

Daily Bowel Movements:_____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

DIET DIARY — DAY 3 *Continued*

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

OTHER COMMENTS / QUESTIONS / CONCERNS:

MSQ – MEDICAL SYMPTOM / TOXICITY QUESTIONNAIRE

Name: _____ Date: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps track your child's progress over time. Rate each of the following symptoms based upon your child's health profile for the past 30 days. If you are completing this after your child's first time, then record your child's symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT
___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total _____

EARS
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total _____

EMOTIONS
___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression

Total _____

ENERGY/ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total _____

EYES
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)

Total _____

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total _____

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total _____

JOINTS/MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Total _____

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total _____

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total _____

MOUTH/THROAT
___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total _____

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total _____

SKIN
___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total _____

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total _____

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total _____

GRAND TOTAL _____

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100