INTEGRATED HEALTHCARE OF GEORGIA

John C. Thomas, DC, DPSc, DAAIM, CNS, CFMP

Improving Lives through Neurological & Nutritional Therapies

Welcome to Our Wellness and Pain Relief Center

Thank you for choosing our office and allowing us to help you in this time of need. We help sick people get healthy and healthy people stay that way. Our purpose is to help as many people as possible and it is an honor each time we are asked to improve a person's health and we take our role as your healthcare provider very seriously. Our patients' confidence in us drives our commitment to provide the highest quality care possible to them and their families.

We have helped many types of patients with many different symptoms and levels of health. We help our patients to find answers to their health problems and if you are accepted as a patient, we hope to do the same for you. The process of identifying the exact, correct underlying CAUSE of your problems requires a great deal of information and testing.

That process begins with filling out our New Patient Application. **Please take your time and fill this form out completely and thoughtfully**. The doctor will meet with you to discuss your condition and do an examination. Based on what the doctor learns, special tests may be ordered like x-rays, MRI's, or advanced metabolic tests. If directed by the doctor your visit may end with some therapy to help provide you some temporary relief. The doctor will review the information learned from the consultation, examination and prior testing to determine if you are accepted into our office. Everything will be explained to you on at your visit.

We do not accept all cases. If we feel we can help you, we will explain your treatment options. If we feel we cannot, we will help you find someone who can. Again, we look forward to serving you. If you have any questions, please do not hesitate to ask.

IMPORTANT!

Please have the New Patient Application Form completed <u>BEFORE</u> your initial visit. If possible, please submit all paperwork and previous lab testing (past 6-12 months) prior to your initial visit. This allows the doctor to familiarize themselves with your case and do any needed research before your visit. Please submit via:

1) Fax: (678) 456-9125
2) Email: info@ihcog.com
3) Mail (if there is sufficient time):

Integrated Healthcare of Georgia
11800 Northfall Lane, Ste 1403, Alpharetta, Georgia 30009

Confiming Your Appointment

We will call you to confirm your appointment one business day prior to the appointment. If we fail to reach you, please leave a message at (678) 456-9122 or email us confirming the appointment at **info@ihcog.com.** Your initial visit will take about an hour. Please arrive a little early, as our schedule often won't allow us to start an appointment late.

If you would like your appointment to be moved to an earlier date, let us know and we will call you if there is an opening.

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Before Receiving Consultation or Treatment In Our Office
Please Review These Principles Outlined Below

1. Dr. John C. Thomas' goal is to provide you with adjunctive and supportive care for your health condition. We do not claim to treat or cure any disease or medical diagnosis.

2. Our office offers some services that are not covered by insurance. These services are considered experimental and may not be billed to your insurance. Dr. John C. Thomas will review all services that are considered covered services and those that are not.

3. Nutritional support may be offered for your case. Nutritional supplements are not FDA regulated and have not been proven to cure or treat any disease or illness. If Dr. John C. Thomas recommends supplementation in your case you may use the products we have in our office or you may purchase your supplementation elsewhere.

4. Our services are not a replacement for your medical treatment. We choose to work alongside your medical provider as this serves you in the most effective manner possible.

5. Dr. John C. Thomas will never give advice on the use of your medications. Medications must be managed by your medical doctor. You must work with a medical doctor for the management of any medications you take now or in the future.

6. I completely understand that there are no guarantees of help, correction, relief, or cure, written, spoken, or implied. I understand that this clinic does NOT treat any disease or any medical diagnosis.

7. I am making a sane and conscious decision to seek advice as per the above understood terms for either myself and/or my dependents. In doing so, I agree to the above terms and acknowledge this with my signature below.

Patient Signature: ____ Date: ____________________

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New Patient Application

Today's Date: ______________________

Please Print Clearly. Please complete ALL information on this form.

PERSONAL INFORMATION

First Name:__________________________ **Middle Initial:** ________ **Last Name:** ____

Called (Nick) Name:_____________________________ **Age:** __________ **Birth Date:**_________________ **Gender:** ☐ **M** ☐ **F**

Home Address: ____ **City:** ______________________________

State:______ **Zip:**_________ **Email:**___________________________________ **May we send you our online newsletters?** ☐ Y ☐ N

Home Phone:__________________________ **Cell Phone:**_________________________ **Work Phone:** ________________________

Employer:____________________________________ **Occupation:** ________________________________

Marital Status: ☐ S ☐ M ☐ W ☐ D **# of Children:** _____________ **Spouse's Name:** ____________________________________

Emergency Contact:____**Phone:**____

Primary Physician:____ **Phone :**_______________________________________

How did you hear about us? ☐ Internet ☐ Insurance Plan ☐ Doctor ☐ Drove By ☐ Advertisement in ____________________
☐ Family __________________________ ☐ Friend __________________________ ☐ Co-Worker _________________________

HEALTH HISTORY

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

Health Concern Description	Approx. Date Began	Complications or Comments	Full Recovery?

List any major illnesses, injuries, and/or surgeries with approximate dates:

Illness, Injury, Surgery Description	Approx. Date Began	Complications or Comments	Full Recovery?

Any Doctor Visits within: ☐ 12 Months; For:____☐ *I deny any doctor visits*

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PRESENT COMPLAINTS

List the main health complaints you have in order of their importance:

1. Description of your <u>MAIN or WORST</u> health problem: ____

____

When did your complaint begin?______________________ **The condition is:** ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? ____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Complaint feels <u>better with</u>: ☐ Activity ☐ Bending ☐ Cold / Heat ☐ Massage ☐ Movement ☐ OTC Meds ☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

Complaint feels <u>worse with</u>: ☐ Standing ☐ Sitting ☐ Cold / Heat ☐ Lifting ☐ Movement ☐ Pushing ☐ Pulling ☐ Rest ☐ Stretching ☐ Lying ☐ Twisting ☐ Walking ☐ Bending

Does your complaint interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ No Other:_________________

What activities do you enjoy, but do poorly or not at all due to your complaint? ______________________________

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other ______________ ☐ Treatment: ______________________________

What have you done to control your symptoms:____

Have you had a similar complaint in the past? ☐ No ☐Yes (How many times?) ______________________________

What are your expectations/goals from care in our office?____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

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2. Description of your <u>SECOND WORST</u> health problem: ____

____

When did your complaint begin?______________________ **The condition is:** ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? ____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Complaint feels <u>better with</u>: ☐ Activity ☐ Bending ☐ Cold / Heat ☐ Massage ☐ Movement ☐ OTC Meds ☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

Complaint feels <u>worse with</u>: ☐ Standing ☐ Sitting ☐ Cold / Heat ☐ Lifting ☐ Movement ☐ Pushing ☐ Pulling ☐ Rest ☐ Stretching ☐ Lying ☐ Twisting ☐ Walking ☐ Bending

Does your complaint interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ No Other:_________________

What activities do you enjoy, but do poorly or not at all due to your complaint? ______________________________

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other ______________ ☐ Treatment: ______________________________

What have you done to control your symptoms:____

Have you had a similar complaint in the past? ☐ No ☐Yes (How many times?) ______________________________

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

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3. Description of your THIRD WORST health problem: ____

____

When did your complaint begin?______________________ **The condition is:** ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? ____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Complaint feels better with: ☐ Activity ☐ Bending ☐ Cold / Heat ☐ Massage ☐ Movement ☐ OTC Meds ☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

Complaint feels worse with: ☐ Standing ☐ Sitting ☐ Cold / Heat ☐ Lifting ☐ Movement ☐ Pushing ☐ Pulling ☐ Rest ☐ Stretching ☐ Lying ☐ Twisting ☐ Walking ☐ Bending

Does your complaint interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ No Other:________________

What activities do you enjoy, but do poorly or not at all due to your complaint? ______________________________

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other ______________ ☐ Treatment: ______________________________

What have you done to control your symptoms:____

Have you had a similar complaint in the past? ☐ No ☐Yes (How many times?) ______________________________

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ **Current** ____ **Avg**

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4. Description of your FOURTH WORST health problem: ____

____

When did your complaint begin?______________________ **The condition is:** ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? ____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Complaint feels better with: ☐ Activity ☐ Bending ☐ Cold / Heat ☐ Massage ☐ Movement ☐ OTC Meds ☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

Complaint feels worse with: ☐ Standing ☐ Sitting ☐ Cold / Heat ☐ Lifting ☐ Movement ☐ Pushing ☐ Pulling ☐ Rest ☐ Stretching ☐ Lying ☐ Twisting ☐ Walking ☐ Bending

Does your complaint interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ No Other:________________

What activities do you enjoy, but do poorly or not at all due to your complaint? ______________________________

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other ______________ ☐ Treatment: ______________________________

What have you done to control your symptoms:____

Have you had a similar complaint in the past? ☐ No ☐Yes (How many times?) ______________________________

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ **Current** ____ **Avg**

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GENERAL HEALTH QUESTIONS (*Please answer the following questions?)*

What is your present weight? _______ What is your ideal weight? _______ Are you currently: ☐ Gaining Weight ☐ Losing Weight

Are you losing weight without trying? ☐ No ☐Yes Do you have problems with recurring headaches? ☐ No ☐Yes

Do you experience pain or stiffness? ☐ Neck ☐Upper back ☐ Low back ☐ Shoulders ☐ Hips ☐ Other ____________________

Are you experiencing unusual fatigue and loss of energy? ☐ No ☐Yes What time(s) of day are you most tired? _______________

Do you have trouble getting to sleep? ☐ No ☐Yes Do you feel groggy and not rested in the morning? ☐ No ☐Yes

Do you wake in the night and have trouble getting back to sleep? ☐ No ☐Yes How many times do you wake up in the night? _____

What time do you usually go to sleep? ________ Number of hours of sleep per night? ______

Does your pain wake you up at night? ☐ No ☐Yes Do you have irritability or mood swings? ☐ No ☐Yes

Do you get: ☐ Depression ☐ Worry ☐ Lack of Concentration ☐ Memory Problems ☐ Anxiety ☐ Panic Attacks ☐ Other

Do you have or experience? ☐ digestive gas ☐ bloating ☐ constipation ☐ diarrhea ☐ reflux ☐ heartburn

Have you had a change in bowel or bladder habits? ☐ No ☐ Yes

Number of bowel movements: ☐ More than 1/day ☐ 1/day ☐ Every 2 days ☐ 3/week ☐ 2/ week ☐ 1/ week ☐ Other _______

Do you have allergy or sinus problems? ☐ No ☐Yes List any food / substances you are sensitive or allergic to: _________________

____

Have you had a sore that does not heal? ☐ No ☐Yes Do you have a nagging cough or hoarseness? ☐ No ☐Yes

STRESS or MAJOR LIFE CHANGES: (divorce, losses, trauma, job, relocation, major life problems, etc.)

____

____

Blood Sugar Levels (if checked)

The HIGHEST your blood sugar gets: WITH medication ______________ WITHOUT medication _______________

The LOWEST your blood sugar gets: WITH medication ______________ WITHOUT medication _______________

FAMILY HISTORY

Father: Age:_____ or Age at Death:_____ Cause of Death:____________________ Significant Illness:________________________

Mother: Age:_____ or Age at Death:_____ Cause of Death:____________________ Significant Illness:________________________

Are there any diseases or conditions common among your family members? ☐ No ☐ Yes, which relative and what type of condition?

☐ Cancer ☐ Diabetes ☐ Heart ☐ Other ____

Any household pets or other animals you or family members are in close contact with? ________________________________

Do pets have health conditions of any kind? ☐ No ☐ Yes What kind? ______________________________ How many? _________

WOMEN ONLY

OB/GYN ☐ I have never been pregnant ☐ I have been pregnant ☐ I am currently pregnant ☐ I am NOT pregnant

Menstrual: Age of onset_____ Last menses ____/____/____ My menses are Regular / Irregular ☐ I am in menopause

Do you experience cramping? ☐ No ☐ Slight ☐ Moderate ☐ Severe **Do you have PMS symptoms?** ☐ No ☐ Yes

Is so, what? ☐ Bloating ☐ Cravings ☐ Back Pain ☐ Irritable ☐ Moody ☐ Other ____

Birth Control Pill Information: Have you ever used Hormonal-type Birth Control? (Pills, Patch, Injection, Implant, IUD) ☐No ☐Yes

Are you currently on Birth Control? ☐ No ☐ Yes Total years on Birth Control? _______ Stopped _____ years ago

I was originally on Birth Control for: ☐ Birth Control ☐ PMS / Irregular Cycle / Other Problem (Fibroids, Endometriosis, etc.)

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HEALTH HISTORY

(*Please check the correct box for each item below. Check at least one box for each sign or symptom listed*)

Childhood Illness: ☐ *I deny any childhood illnesses*

☐ ADD ☐ Bed Wetting ☐ Diabetes ☐ Food Allergies ☐ Measles ☐ Seizure Disorder
☐ Allergies ☐ Hay fever ☐ Cerebral Palsy ☐ Ear Infections ☐ Headaches ☐ Mumps
☐ Sickle Cell ☐ Asthma ☐ Chicken Pox ☐ Fetal Drug Exposure ☐ Hepatitis ☐ Rash
☐ Spina Bifida ☐ Eczema ☐ Depression ☐ HIV ☐ Scoliosis ☐ Other

Adult Illness: ☐ *I deny any adult illnesses*

☐ Alzheimer's ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Suicide Attempts ☐ Seizure Disorder
☐ CRPS(RSD) ☐ CVA(stroke) ☐ Kidney Dx. ☐ Depression ☐ Hypertension ☐ Multiple Sclerosis ☐ Epstein Bar
☐ Emphysema ☐ Eye Problem ☐ Fibromyalgia ☐ HIV ☐ Hepatitis ☐ Diabetes (insulin / non-insulin)
☐ Heart Dx ☐ Liver Disease ☐ Lunge Disease ☐ Chron's/Colits ☐ Shingles ☐ Lupus (Discoid / Systemic)
☐ Parkinson's ☐ Pleurisy ☐ Pneumonia ☐ Psychiatric ☐ Scoliosis ☐ Influenza Pneumonia
☐ STD's ☐ Ear Infection ☐ Thyroid ☐ Vertigo ☐ Chicken Pox ☐ Similar to current complaints
☐ Other____

Any Injuries: ☐ *I deny any injuries*

☐ Broken Bones ☐ Head Injury ☐ Industrial Accident ☐ Soft Tissue Injury
☐ Back Injury ☐ Disc Injury ☐ Joint Injury ☐ Motor Vehicle Accident
☐ Severe Fall ☐ Disability ☐ Severe Laceration ____________________

Any Surgeries: ☐ *I deny any surgeries*

☐ Angioplasty ☐ Appendectomy ☐ Caesarean Section ☐ Cardiac Catheterization
☐ Carpal Tunnel ☐ Coronary Bypass ☐ Cosmetic ☐ Hernia Repair
☐ Dental Surgery ☐ Gallbladder ☐ Hemorroidectomy ☐ Joint Reconstruction
☐ Hysterectomy ☐ D & C ☐ Laminectomy ☐ Joint Replacement
☐ Mastectomy ☐ Pacemaker ☐ Rotator Cuff ☐ Spinal Fusion
☐ Tonsillectomy ☐ Other:____

SOCIAL HISTORY

Educational Level (highest you attained): ☐ Grade School ☐ High School-Graduate ☐ High School-No Degree ☐ High School-GED
☐ College-Graduate ☐ College-No Degree ☐ College-Postgraduate

Exercise: ☐ None ☐ Occasional ☐ Regular ☐ Frequent / Heavy What kind:____________________

Substance Usage: Alcohol: ☐ None ☐ Rarely ☐ Occasionally ☐ Heavy ☐Recovering Alcoholic/How long?_________
Types? ____________________ # ____ how many per: ☐ Day ☐ Week ☐ Month

Recreational Drugs: ☐ None ☐ Past ☐ Type Used: ____________________ How Often? ______________

Tobacco: ☐ None ☐ Cigarettes, packs per day:__________ ☐ Chews, pouches per week:__________
☐ Dip, cans per week:__________ ☐ Previously smoked:______ years, and quit ______ years ago

Caffeine: ☐ None ☐ Sodas (☐ regular ☐ diet) ______ glasses per: ☐ Day ☐ Week ☐ Month
☐ Coffee ____ cups per: ☐ Day ☐ Week ☐ Month (☐ Sugar ☐ milk ☐ non-dairy creamer)
☐ Tea (☐ sweet ☐ unsweet) ______ glasses per: ☐ Day ☐ Week ☐ Month
☐ Energy Drinks ______ per: ☐ Day ☐ Week ☐ Month

Sweets: ☐ None ☐ Chocolate / Candy _____ times per: ☐ Day ☐ Week ☐ Month

Milk / Dairy: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month

Wheat Products: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month (include bread, bagels, pasta, etc.)

Other Grains: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month (rice, oats, corn, quinoa, etc.)

How Much Water Do You Drink (8 oz. glasses / day): ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10-12 ☐ 13-15 ☐ 16+

Hobbies You Enjoy: ____

____

Hobbies / Activities that are limited or prevented by your current health condition? ____________________

____

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DIET (*Please fill out your diet for the 3 day, - food and beverage. Please be as detailed as possible.. Identify brands and how it was made. PLEASE BE HONEST.)*

DAY 1

BREAKFAST (Time eaten: _______) ______________________________

____

LUNCH (Time eaten: ______) ______________________________

____

DINNER (Time eaten: ______) ______________________________

____

SNACK (Time eaten: ______) ______________________________

____

SNACK (Time eaten: ______) ______________________________

____

DAY 2

BREAKFAST (Time eaten: _______) ______________________________

____

LUNCH (Time eaten: ______) ______________________________

____

DINNER (Time eaten: ______) ______________________________

____

SNACK (Time eaten: ______) ______________________________

____

SNACK (Time eaten: ______) ______________________________

____

DAY 3

BREAKFAST (Time eaten: _______) ______________________________

____

LUNCH (Time eaten: ______) ______________________________

____

DINNER (Time eaten: ______) ______________________________

____

SNACK (Time eaten: ______) ______________________________

____

SNACK (Time eaten: ______) ______________________________

____

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Was the past 3 days of food your typical dietary intake? ☐ No ☐Yes if No explain ____________________________________
____

How many meals do you typically eat per day**?** _____ if not 3 meals per day, which meals do you skip most often? ________________

How often do you eat out? ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month Where? ______________________________

List the three worst foods you eat during the week: ___________________ ____________________ ____________________

List the three healthiest foods you eat during the week: ___________________ ____________________ ____________________

DRUGS, MEDICATIONS, SUPPLEMENTS (*Please list current medications and supplements being taken, include over the counter medication)*

Medications: ☐ None ☐ Allergies ☐ Anti-Depressants ☐ Blood Pressure ☐ Insulin ☐ Muscle Relaxers
☐ Nerve Pills ☐ Pain Killers ☐ Cholesterol ☐ Other: ____

Drug/Supplement Name	Taken for What or Condition?	Taken How Often?	Aprox. Start Date	Results/Side effects experiencing?

Antibiotics: # of antibiotic prescribed or taken in past year: _______ Avg. # prescribed or taken per year for past 5 years: _________

TOXIC EXPOSURE

To your knowledge, have you ever had long-term exposure to chemicals, pesticides, herbicides, radiation, or heavy metals?
☐ No ☐Yes, explain ____

DENTAL WORK (*Please indicate how many of the following you have:)*

☐ Silver Fillings ________ ☐ Gold Crowns or inlays ________ ☐ Root Canals ________ ☐ Braces ☐ Bleeding Gums

☐ Composites (tooth-colored) _________ ☐ Stainless steel crowns or inlays ________ ☐ Root Canals with EndoCal ________

☐ Extractions ________ ☐ Porcelain crowns or inlays ________ ☐ Posts ________ ☐ Sensitive Teeth ________

☐ Bridgework ________ ☐ DeGussa Porcelain crowns or inlays ________ ☐ Implants ________ ☐ Bad Bite ________

☐ Partial or Full Dentures ________ ☐ Veneers ________ ☐ Temporaries ________ ☐ New Cavities ________

Have you had any teeth extracted? (wisdom teeth, four bicuspid extraction, etc?) ☐ No ☐Yes _________________________________

Have you had dental surgery? (gum surgery, jaw surgery, etc?) ☐ No ☐Yes____

Do you need further dental work? ☐ No ☐Yes, if so what?____

REVIEW OF SYSTEMS *(Please mark ALL boxes that apply.)*

Constitutional: ☐ Chills ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss ☐ Fatigue ☐ Fever ☐ Daytime Drowsiness
☐ *I deny any constitutional issues*

Eye/Vision: ☐ Blindness ☐ Double Vision ☐ Eye Pain ☐ Photophobia ☐ Tearing ☐ Blurry Vision ☐ Cataracts
☐ *I deny any eye/vision issues* ☐ Change in Vision ☐ Glaucoma ☐ Field Cuts ☐ Itchy Eyes ☐ Wear Glasses / Contacts

Ears, Nose and Throat: ☐ *I deny any E/N/T issues*
☐ Bleeding ☐ Fainting ☐ Nasal Congestion ☐ Ear Drainage ☐ Post Nasal Drip ☐ Runny Nose
☐ Discharge ☐ Headaches ☐ Sinus Infections ☐ Ear Infections ☐ Hoarseness ☐ TMJ Problems
☐ Dizziness ☐ Smell Loss ☐ Dental Implants ☐ Hearing Loss ☐ Ear Pain ☐ Snoring
☐ Sore Throats (frequent) ☐ Tinnitus (ringing in ears) ☐ Difficulty Swallowing

Respiration: ☐ Asthma ☐ Coughing up blood ☐ Sputum production ☐ Cough ☐ Shortness of breath ☐ Wheezing
☐ *I deny any respiratory issues*

Cardiovascular: ☐ *I deny any cardiovascular issues*
☐ Angina (chest pain or discomfort) ☐ Heart Murmur ☐ Palpitations (irregular or forceful heart beats)
☐ Claudication (leg pain/achiness) ☐ Heart Problems ☐ Paroxysmal Nocturnal Breathing (waking at night with shortness of breath)
☐ Swelling of legs ☐ Ulcers
☐ Varicose Veins ☐ Orthopnea (difficulty breathing while lying down)

Gastrointestinal: ☐ *I deny any gastrointestinal issues*
☐ Abdominal Pain ☐ Belching ☐ Indigestion ☐ Difficulty Swallowing ☐ Vomiting Blood
☐ Rectal Bleeding ☐ Diarrhea ☐ Jaundice ☐ Abnormal Stool Caliber (quality)
☐ Black/Tarry Stools ☐ Heartburn ☐ Nausea ☐ Abnormal Stool Color
☐ Constipation ☐ Hemorrhoids ☐ Vomiting ☐ Abnormal Stool Consistency

Female: ☐ *I deny any female issues*
☐ Birth Control Therapy ☐ Cramps ☐ Irregular Menstruation ☐ Vaginal Discharge
☐ Breast Lump/Pain ☐ Frequent Urination ☐ Urine Retention
☐ Burning Urination ☐ Hormone Therapy ☐ Vaginal Bleeding

Male: ☐ Burning Urination ☐ Frequent Urination ☐ Erectile Dysfunction
☐ *I deny any male issues* ☐ Prostate Problems ☐ Urination Retention ☐ Hesitancy/Dribbling

Endocrine: ☐ *I deny any endocrine issues*
☐ Cold Intolerance ☐ Excessive Appetite ☐ Excessive Thirst ☐ Goiter ☐ Hair Loss
☐ Voice Change ☐ Excessive Hunger ☐ Frequent Urination ☐ Heat Intolerance ☐ Diabetes
☐ Unusual Hair Growth

Skin: ☐ *I deny any skin issues*
☐ Nail Texture Changes ☐ Hair Loss ☐ Itching ☐ Varicosities ☐ Skin Color Changes
☐ Hair Growth ☐ Hives ☐ Rash ☐ Skin Lesions/Ulcers ☐ History of Skin Disorders
☐ Paresthesia (numbing/prickling/tingling)

Nervous System: ☐ *I deny any nervous system issues*
☐ Dizziness ☐ Limb Weakness ☐ Numbness ☐ Sleep Disturbance ☐ Tremors
☐ Facial Weakness ☐ Loss of Consciousness ☐ Seizures ☐ Strokes
☐ Headaches ☐ Loss of Memory ☐ Stress ☐ Unsteadiness of Gait

Psychological: ☐ *I deny any psychological issues*
☐ Anxiety ☐ Depression ☐ Mood Changes ☐ Convulsions ☐ Appetite Changes
☐ Insomnia ☐ Memory Loss ☐ Confusion ☐ Bipolar Disorder ☐ Other

Allergy: ☐ Anaphylaxis (history of sneezing) ☐ Food Intolerance ☐ Itching ☐ Sneezing ☐ Nasal Congestion
☐ *I deny any allergy issues*

Hematology: ☐ Anemia ☐ Blood Clotting ☐ Bleeding ☐ Fatigue ☐ Bruises Easily
☐ *I deny any hematology issues* ☐ Blood Transfusions ☐ Lymph Node Swelling

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Metabolic Assessment Form

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

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Category I

- Feeling that bowels do not empty completely 0 1 2 3
- Lower abdominal pain relieved by passing stool or gas 0 1 2 3
- Alternating constipation and diarrhea 0 1 2 3
- Diarrhea 0 1 2 3
- Constipation 0 1 2 3
- Hard, dry, or small stool 0 1 2 3
- Coated tongue or "fuzzy" debris on tongue 0 1 2 3
- Pass large amount of foul-smelling gas 0 1 2 3
- More than 3 bowel movements daily 0 1 2 3
- Use laxatives frequently 0 1 2 3

Category II

- Increasing frequency of food reactions 0 1 2 3
- Unpredictable food reactions 0 1 2 3
- Aches, pain, and swelling throughout the body 0 1 2 3
- Unpredictable abdominal swelling 0 1 2 3
- Frequent bloating and distention after eating 0 1 2 3
- Abdominal intolerance to sugars and starches 0 1 2 3

Category III

- Intolerance to smells 0 1 2 3
- Intolerance to jewelry 0 1 2 3
- Intolerance to shampoo, lotion, detergents, etc. 0 1 2 3
- Multiple smell and chemical sensitivities 0 1 2 3
- Constant skin outbreaks 0 1 2 3

Category IV

- Excessive belching, burping, or bloating 0 1 2 3
- Gas immediately following a meal 0 1 2 3
- Offensive breath 0 1 2 3
- Difficult bowel movement 0 1 2 3
- Sense of fullness during and after meals 0 1 2 3
- Difficulty digesting fruits and vegetables; undigested foods found in stools 0 1 2 3

Category V

- Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3
- Use antacids 0 1 2 3
- Feel hungry an hour or two after eating 0 1 2 3
- Heartburn when lying down or bending forward 0 1 2 3
- Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3
- Digestive problems subside with rest and relaxation 0 1 2 3
- Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3

Category VI

- Roughage and fiber cause constipation 0 1 2 3
- Indigestion and fullness last 2-4 hours after eating 0 1 2 3
- Pain, tenderness, soreness on left side under rib cage 0 1 2 3
- Excessive passage of gas 0 1 2 3

Category VI (continued)

- Nausea and/or vomiting 0 1 2 3
- Stool undigested, foul smelling, mucous like, greasy, or poorly formed 0 1 2 3
- Frequent urination 0 1 2 3
- Increased thirst and appetite 0 1 2 3

Category VII

- Greasy or high-fat foods cause distress 0 1 2 3
- Lower bowel gas and/or bloating several hours after eating 0 1 2 3
- Bitter metallic taste in mouth, especially in the morning 0 1 2 3
- Burpy, fishy taste after consuming fish oils 0 1 2 3
- Difficulty losing weight 0 1 2 3
- Unexplained itchy skin 0 1 2 3
- Yellowish cast to eyes 0 1 2 3
- Stool color alternates from clay colored to normal brown 0 1 2 3
- Reddened skin, especially palms 0 1 2 3
- Dry or flaky skin and/or hair 0 1 2 3
- History of gallbladder attacks or stones 0 1 2 3
- Have you had your gallbladder removed? Yes No

Category VIII

- Acne and unhealthy skin 0 1 2 3
- Excessive hair loss 0 1 2 3
- Overall sense of bloating 0 1 2 3
- Bodily swelling for no reason 0 1 2 3
- Hormone imbalances 0 1 2 3
- Weight gain 0 1 2 3
- Poor bowel function 0 1 2 3
- Excessively foul-smelling sweat 0 1 2 3

Category IX

- Crave sweets during the day 0 1 2 3
- Irritable if meals are missed 0 1 2 3
- Depend on coffee to keep going/get started 0 1 2 3
- Get light-headed if meals are missed 0 1 2 3
- Eating relieves fatigue 0 1 2 3
- Feel shaky, jittery, or have tremors 0 1 2 3
- Agitated, easily upset, nervous 0 1 2 3
- Poor memory/forgetful 0 1 2 3
- Blurred vision 0 1 2 3

Category X

- Fatigue after meals 0 1 2 3
- Crave sweets during the day 0 1 2 3
- Eating sweets does not relieve cravings for sugar 0 1 2 3
- Must have sweets after meals 0 1 2 3
- Waist girth is equal or larger than hip girth 0 1 2 3
- Frequent urination 0 1 2 3
- Increased thirst and appetite 0 1 2 3
- Difficulty losing weight 0 1 2 3

Metabolic Assessment Form (continued)

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

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

Category XII
- 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

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

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

Category XV
- 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

Category XVI
- 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

Category XVII
- Increased sex drive 0 1 2 3
- Tolerance to sugars reduced 0 1 2 3
- "Splitting" – type headaches 0 1 2 3

Category XVIII (*Males Only*)
- Urination difficulty or dribbling 0 1 2 3
- Frequent urination 0 1 2 3
- Pain inside of legs or heels 0 1 2 3
- Feeling of incomplete bowel emptying 0 1 2 3
- Leg twitching at night 0 1 2 3

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

Category XX (*Menstruating Females Only*)
- Perimenopausal Yes No
- Alternating menstrual cycle length Yes No
- Extended menstrual cycle (greater than 32 days) Yes No
- Shortened menstrual cycle (less than 24 days) Yes No
- Pain and cramping during periods 0 1 2 3
- Scanty blood flow 0 1 2 3
- Heavy blood flow 0 1 2 3
- Breast pain and swelling during menses 0 1 2 3
- Pelvic pain during menses 0 1 2 3
- Irritable and depressed during menses 0 1 2 3
- Acne 0 1 2 3
- Facial hair growth 0 1 2 3
- Hair loss/thinning 0 1 2 3

Category XXI (*Menopausal Females Only*)
- Since menopause, do you ever have uterine bleeding? Yes No
- Hot flashes 0 1 2 3
- Mental fogginess 0 1 2 3
- Disinterest is 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

Brain Health and Nutrition Assessment Form™ (BHNAF)

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

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SECTION 1

- Low brain endurance for focus and concentration 0 1 2 3
- Cold hands and feet 0 1 2 3
- Must exercise or drink coffee to improve brain function 0 1 2 3
- Poor nail health 0 1 2 3
- Fungal growth on toenails 0 1 2 3
- Must wear socks at night 0 1 2 3
- Nail beds are white instead of pink 0 1 2 3
- The tip of the nose is cold 0 1 2 3

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals 0 1 2 3
- Feel energized after meals 0 1 2 3
- Difficulty eating large meals in the morning 0 1 2 3
- Energy levels drops in the afternoon 0 1 2 3
- Crave sugar and sweets in the afternoon 0 1 2 3
- Wake up in the middle of the night 0 1 2 3
- Difficulty concentrating before eating 0 1 2 3
- Depend on coffee to keep going 0 1 2 3

SECTION 3

- Fatigue after meals 0 1 2 3
- Sugar and sweet cravings after meals 0 1 2 3
- Need for a stimulant, such as coffee, after meals 0 1 2 3
- Difficulty losing weight 0 1 2 3
- Increased frequency on urination 0 1 2 3
- Difficulty falling asleep 0 1 2 3
- Increased appetite 0 1 2 3

SECTION 4

- Always have projects and things that need to be done 0 1 2 3
- Never have time for yourself 0 1 2 3
- Not getting enough sleep or rest 0 1 2 3
- Difficulty getting regular exercise 0 1 2 3
- Feel that you are not accomplishing your life's purpose 0 1 2 3

SECTION 5

- Dry and unhealthy skin 0 1 2 3
- Dandruff or a flaky scalp 0 1 2 3
- Consumption of processed foods that are bagged or boxed 0 1 2 3
- Consumption of fried foods 0 1 2 3
- Difficulty consuming raw nuts or seeds 0 1 2 3
- Difficulty consuming fish (not fried) 0 1 2 3
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats 0 1 2 3

SECTION 6

- Difficulty digesting foods 0 1 2 3
- Constipation or inconsistent bowel movements 0 1 2 3
- Increased bloating or gas 0 1 2 3
- Abdominal distention after meals 0 1 2 3
- Difficulty digesting protein-rich foods 0 1 2 3
- Difficulty digesting starch-rich foods 0 1 2 3
- Difficulty digesting fatty or greasy foods 0 1 2 3
- Difficulty swallowing supplements or large bites of food 0 1 2 3
- Abnormal gag reflex Yes No

SECTION 7

- Brain fog (unclear thoughts or concentration) Yes No
- Pain and inflammation Yes No
- Noticeable variations in mental speed Yes No
- Brain fatigue after meals 0 1 2 3
- Brain fatigue after exposure to chemicals, scents, or pollutants 0 1 2 3
- Brain fatigue when the body is inflamed 0 1 2 3

SECTION 8

- Grain consumption leads to tiredness 0 1 2 3
- Grain consumption makes it difficult to focus and concentrate 0 1 2 3
- Fell better when bread and grains are avoided 0 1 2 3
- Grain consumption causes the development of any symptoms 0 1 2 3
- A 100% gluten-free diet Yes No

Brain Health and Nutrition Assessment Form™ (BHNAF)

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

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SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease — Yes No
- Family members who have been diagnosed with an autoimmune disease — Yes No
- Family members who have been diagnosed with celiac disease or gluten sensitivity — Yes No
- Changes in brain function with stress, poor sleep, or immune activation — 0 1 2 3

SECTION 10

- A loss of pleasure in hobbies and interests — 0 1 2 3
- Feel overwhelmed with ideas to manage — 0 1 2 3
- Feelings of inner rage or unprovoked anger — 0 1 2 3
- Feelings of paranoia — 0 1 2 3
- Feelings of sadness for no reason — 0 1 2 3
- A loss of enjoyment in life — 0 1 2 3
- A lack of artistic appreciation — Yes No
- Feelings of sadness in overcast weather — 0 1 2 3
- A loss of enthusiasm for favorite activities — 0 1 2 3
- A loss of enjoyment in favorite foods — 0 1 2 3
- A loss of enjoyment in friendships and relationships — 0 1 2 3
- Inability to fall into deep, restful sleep — 0 1 2 3
- Feelings of dependency on others — 0 1 2 3
- Feelings of susceptibility to pain — 0 1 2 3

SECTION 11

- Feelings of worthlessness — 0 1 2 3
- Feelings of hopelessness — 0 1 2 3
- Self-destructive thoughts — 0 1 2 3
- Inability to handle stress — 0 1 2 3
- Anger and aggression while under stress — 0 1 2 3
- Feelings of tiredness, even after many hours of sleep — 0 1 2 3
- A desire to isolate yourself from others — 0 1 2 3
- An unexplained lack of concern for family and friends — 0 1 2 3
- An inability to finish tasks — 0 1 2 3
- Feelings of anger for minor reasons — 0 1 2 3

SECTION 12

- A decrease in visual memory (shapes and images) — 0 1 2 3
- A decrease in verbal memory — 0 1 2 3
- Occurrence of memory lapses — 0 1 2 3
- A decrease in creativity — 0 1 2 3
- A decrease in comprehension — 0 1 2 3
- Difficulty calculating numbers — 0 1 2 3
- Difficulty recognizing objects and faces — 0 1 2 3
- A change in opinion about yourself — 0 1 2 3
- Slow mental recall — 0 1 2 3

SECTION 13

- A decrease in mental alertness — 0 1 2 3
- A decrease in mental speed — 0 1 2 3
- A decrease in concentration quality — 0 1 2 3
- Slow cognitive processing — 0 1 2 3
- Impaired mental performance — 0 1 2 3
- An increase in the ability to be distracted — 0 1 2 3
- Need coffee or caffeine sources to improve mental function — 0 1 2 3

SECTION 14

- Feelings of nervousness or panic for no reason — 0 1 2 3
- Feelings of dread — 0 1 2 3
- Feelings of a "knot" in your stomach — 0 1 2 3
- Feelings of being overwhelmed for no reason — 0 1 2 3
- Feelings of guilt about everyday decisions — 0 1 2 3
- A restless mind — 0 1 2 3
- An inability to turn off the mind when relaxing — 0 1 2 3
- Disorganized attention — 0 1 2 3
- Worry over things never thought about before — 0 1 2 3
- Feelings of inner tension and inner excitability — 0 1 2 3

Brain Function Assessment Form™ (BFAF)

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

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SECTION 1

- A decrease in attention span 0 1 2 3
- Mental fatigue 0 1 2 3
- Difficulty learning new things 0 1 2 3
- Difficulty staying focused and concentrating for extended periods of time 0 1 2 3
- Experiencing fatigue when reading sooner than in the past 0 1 2 3
- Experiencing fatigue when driving sooner than in the past 0 1 2 3
- Need for caffeine to stay mentally alert 0 1 2 3
- Overall brain function impairs your daily life 0 1 2 3

SECTION 2

- Twitching or tremor in your hands and legs when resting 0 1 2 3
- Handwriting has gotten smaller and more crowded together 0 1 2 3
- A loss of smell to foods 0 1 2 3
- Difficulty sleeping or fitful sleep 0 1 2 3
- Stiffness in shoulders and hips that goes away when you start to move 0 1 2 3
- Constipation 0 1 2 3
- Voice has become softer 0 1 2 3
- Facial expression that is serious or angry 0 1 2 3
- Episodes of dizziness or light-headedness upon standing 0 1 2 3
- A hunched over posture when getting up and walking 0 1 2 3

SECTION 3

- Memory loss that impacts daily activities 0 1 2 3
- Difficulty planning, problem solving, or working with numbers 0 1 2 3
- Difficulty completing daily tasks 0 1 2 3
- Confusion about dates, the passage of time, or place 0 1 2 3
- Difficulty understanding visual images and spatial relationships (addresses and locations) 0 1 2 3
- Difficulty finding words when speaking 0 1 2 3
- Misplacement of things and inability to retrace steps 0 1 2 3
- Poor judgment and bad decisions 0 1 2 3
- Disinterest in hobbies, social activities, or work 0 1 2 3
- Personality or mood changes 0 1 2 3

SECTION 4

- Reduced function in overall hearing 0 1 2 3
- Difficulty understanding language with background or scatter noise 0 1 2 3
- Ringing or buzzing in the ear 0 1 2 3
- Difficulty comprehending language without perfect pronunciation 0 1 2 3
- Difficulty recognizing familiar faces 0 1 2 3
- Changes in comprehending the meaning of sentences, written or spoken 0 1 2 3
- Difficulty with verbal memory and finding words 0 1 2 3
- Difficulty remembering events 0 1 2 3
- Difficulty recalling previously learned facts and names 0 1 2 3
- Inability to comprehend familiar words when read 0 1 2 3
- Difficulty spelling familiar words 0 1 2 3
- Monotone, unemotional speech 0 1 2 3
- Difficulty, understanding the emotions of others when they speak (nonverbal cues) 0 1 2 3
- Disinterest in music and a lack of appreciation for melodies 0 1 2 3
- Difficulty with long-term memory 0 1 2 3
- Memory impairment when doing the basic activities of daily living 0 1 2 3
- Difficulty with directions and visual memory 0 1 2 3
- Noticeable differences in energy levels throughout the day 0 1 2 3

SECTION 5

- Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects 0 1 2 3
- Difficulty comprehending written text 0 1 2 3
- Floaters or halos in your visual field 0 1 2 3
- Dullness of colors in your visual field during different times of the day 0 1 2 3
- Difficulty discriminating similar shades of color 0 1 2 3

Brain Function Assessment Form™ (BFAF)

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

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SECTION 6

- Have you had a head injury — Yes No
- Difficulty with detailed hand coordination — 0 1 2 3
- Difficulty with making decisions — 0 1 2 3
- Difficulty with suppressing socially inappropriate thoughts — 0 1 2 3
- Socially inappropriate behavior — 0 1 2 3
- Decisions made based on desires, regardless of the consequences — 0 1 2 3
- Difficulty planning and organizing daily events — 0 1 2 3
- Difficulty motivating yourself to start and finish tasks — 0 1 2 3
- A loss of attention and concentration — 0 1 2 3

SECTION 7

- Hypersensitivities to touch or pain — 0 1 2 3
- Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall — 0 1 2 3
- Frequently bumping into the wall or objects — 0 1 2 3
- Difficulty with right-left discrimination — 0 1 2 3
- Handwriting has become sloppier — 0 1 2 3
- Difficulty with basic math calculations — 0 1 2 3
- Difficulty finding words for written or verbal communication — 0 1 2 3
- Difficulty recognizing symbols, words, or letters — 0 1 2 3

SECTION 8

- Difficulty swallowing supplements or large bites of food — 0 1 2 3
- Bowel motility and movements slow — 0 1 2 3
- Bloating after meals — 0 1 2 3
- Dry eyes or dry mouth — 0 1 2 3
- A racing heart — 0 1 2 3
- A flutter in the chest or an abnormal heart rhythm — 0 1 2 3
- Bowel or bladder incontinence, resulting in staining your underwear — 0 1 2 3

SECTION 9

- A decrease in movement speed — 0 1 2 3
- Difficulty initiating movement — 0 1 2 3
- Stiffness in your muscles (not joints) — 0 1 2 3
- A stooped posture when walking — 0 1 2 3
- Cramping of your hand when writing — 0 1 2 3

SECTION 10

- Abnormal body movements (such as twitching legs) — 0 1 2 3
- Desires to flinch, clear your throat, or perform some type of movement — 0 1 2 3
- Constant nervousness and a restless mind — 0 1 2 3
- Compulsive behaviors — 0 1 2 3
- Increased tightness and tone in specific muscles — 0 1 2 3

SECTION 11

- Vertigo or balance disorders current or in the past — Yes No
- Difficulty with balance, or balance that is noticeably worse on one side — 0 1 2 3
- Do you feel your balance is getting worse — Yes No
- A need to hold the handrail or watch each step carefully when going down stairs — 0 1 2 3
- Episodes of dizziness — 0 1 2 3
- Nausea, car sickness, or seasickness — 0 1 2 3
- A quick impact after consuming alcohol — 0 1 2 3
- A slight hand shake when reaching for something — 0 1 2 3
- Back muscles that tire quickly when standing or walking — 0 1 2 3
- Chronic neck or back muscle tightness — 0 1 2 3

IMPORTANT QUESTIONS (*Please take several minutes to answer these questions so we can help you get better faster, circle as many that apply)*

1. How have you taken care of your health in the past?

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify): ___________________

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

6. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

____

____

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7. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

____

____

____

8. What are you most concerned with regarding your problem?

____

____

9. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

____

____

10. What would be different/better without this problem? Please be specific.

____

____

11. What do you desire most to get from working with us?

____

____

12. What is that worth to you?

____

____

13. Regarding cost of care, this specialized form of care will require out of pocket expenses. We will do our best to find a way to make this work within your financial means. Will this present a problem for you?

____

14. Considering your history and current health problems, would you say... (**please check ONE**)

☐ I am "sick and tired of being sick and tired" and am willing to do whatever is necessary to end my current problems and recover my health.

☐ I would like to see improvement in my health and symptoms as long as treatment options fit into my schedule and finances.

☐ I would like improvements in my current health, but am more concerned about future health problems. I am looking for preventative health options.

☐ I would like rapid improvement in my problems without a long term commitment to lifestyle changes.

☐ I am unable to make changes to my diet or lifestyle and cannot afford any time or financial commitments at this time. I just am looking for more information.

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Additional information regarding your health you think we may need to know:

Financial Terms of Acceptance and Consent

1. I understand this care does not promote or practice medicine, any decisions about medication changes or alterations must be discussed with your medical doctor. Many of the treatments used to help support your condition including brain-based therapies, spinal decompression therapy, rehabilitation therapy, infrared light therapy, metabolic evaluations, oxygen or vibration therapy may not be covered by insurance and may not be reimbursable.
2. All insurance assignment patients must pay their deductibles in full, and the co-payment at the time of service, unless other arrangements are made with the front desk.
3. Patients that receive insurance checks directly for reimbursement of services performed by Integrated Healthcare of Georgia agree to forward those checks directly to our office within 10 days of receipt.
4. The patient acknowledges and agrees to be responsible to Integrated Healthcare of Georgia for any costs incurred in collecting checks that are denied due to insufficient funds, stopped payments, or any other reason. A service charge of $30.00 will be charged for any check upon which payment is denied.
5. If the patient chooses to finance care through a 3rd party, the patient understands that the financing companies are separate and distinct entities and are not affiliated with Integrated Healthcare of Georgia or Dr. John C. Thomas. Therefore, we are not responsible for any dispute between the patient and the financing company.
6. It is impossible for the doctors to know exactly how many treatments the patient will need to reach maximum recovery. The treatment plan listed above is an approximation and may be adjusted according to patient presentation. Furthermore the treatments in this program do not include other services in the office including cervical pillows, lumbar supports, cervical traction units, heel lifts, nutritional supplements, orthotics, home equipment not indicated, or maintenance care.
7. In the event that the patient terminates the treatment prematurely, the patient is responsible for all care they have received at the time of termination minus any discounts offered, and will be refunded any pro-rated fees owed based on the current fee schedule. The fee schedule for each service is available at the front desk. We cannot legally refund any fees for service already performed, even if the patient is not satisfied with the results of the treatment. Refunds are issued within 30 days.

I hereby consent to the performance of examination, diagnosis, diagnostic X-rays, and any treatment listed above, on me (or the patient named above, for whom I am legally responsible) by Dr. John C. Thomas and/or other professionals working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. John C. Thomas and Integrated Healthcare of Georgia. I understand and I am informed that there is the unlikely possibility of adverse events from examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains, increased symptoms and pain, or no improvement of symptoms or pain. I agree that if I suspect any adverse event that I will inform Dr. Thomas immediately. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. *I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I understand that this clinic does not treat disease or any medical diagnosis.* I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

NOTE: Due to the cutting edge nature of our care, Insurance does not pay for Neurological Services, Functional Medicine/Nutrition, or most lab testing. You will have to pay for services in this office. Some major medical insurance may pay for standard lab testing, but more functional tests are falling outside their coverage and are as a result cash-basis. We have contracted with several discount labs which offer a discount off retail blood test prices as well. Most functional tests, including salivary tests, stool tests, food antibody tests and immune panels are non-covered and are therefore the responsibility of the patient.

By signing below, I acknowledge that I understand and agree to all terms of acceptance. I also acknowledge that any questions that I have regarding treatment, or my financial obligation, have been met to my satisfaction. I understand that this is a legal and binding document.

TO BE COMPLETED BY THE PATIENT

Printed Name:__________________________ Signature:__________________________ Date:____________

TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name:________________________________ Patient's Signature:________________________________

Date Signed: ___________ Signature of Representative:____

Relationship or Authority of Patient's Representative:____

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