Confidential Patient Information

Date:

Name:_____ Email:_____

Address:_____City:_____State:____ Zip:_____

Phone #s: (H)_____(C)_____(W)_____

Age:_____ Birth Date:_____ Sex:____ No. of children:_____ Children's ages:__ _____

Marital Status: Married/Partner name:_____ Single___ Divorced___ Widowed____

Occupation:_____ Employer:_____

Business Address:_____

Referred to our office by:_____

Contact in case of emergency:_____ Phone:_____

Address:_____

Please list your major health concerns in order of importance:

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

Please give more details about above concerns if applicable (ex. When it began, cause, previous treatment)

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

Patient name:_____ Date:_____

Metabolic Assessment

Please circle the appropriate number on all questions below. 0 is least/never to 4 as the most/always

Category I

Feeling that bowels do not empty completely	0 1 2 3 4
Abdominal pain relieved by passing stool or gas	0 1 2 3 4
Alternating constipation and diarrhea	0 1 2 3 4
Diarrhea	0 1 2 3 4
Constipation	0 1 2 3 4
Hard, dry, or small stool	0 1 2 3 4
Coated tongue or "fuzzy" debris on tongue	0 1 2 3 4
Pass large amount of foul-smelling gas	0 1 2 3 4
More than 3 bowel movements daily	0 1 2 3 4
Use laxatives frequently	0 1 2 3 4

Category II

Increasing frequency of food reactions	0 1 2 3 4
Unpredictable food reactions	0 1 2 3 4
Aches, pains, and swelling throughout the body	0 1 2 3 4
Unpredictable abdominal swelling	0 1 2 3 4
Frequent bloating and distention after eating	0 1 2 3 4
Abdominal intolerance to sugars and starches	0 1 2 3 4

Category III

Intolerance to smells	0 1 2 3 4
Intolerance to jewelry	0 1 2 3 4
Intolerance to shampoo, lotion, detergents, etc	0 1 2 3 4
Multiple smell and chemical sensitivities	0 1 2 3 4
Constant skin outbreaks	0 1 2 3 4

Category IV

Excessive belching, burping, or bloating	0 1 2 3 4
Gas immediately following a meal	0 1 2 3 4
Offensive breath	0 1 2 3 4
Sense of fullness during and after meals	0 1 2 3 4
Difficulty digesting raw vegetables; undigested food found in stools	0 1 2 3 4

Category V

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

Category VI

Fiber causes constipation	0 1 2 3 4
Indigestion and fullness last 2-4 hours after eating	0 1 2 3 4
Pain, tenderness, soreness on left side under rib cage	0 1 2 3 4
Excessive passage of gas	0 1 2 3 4
Nausea and/or vomiting	0 1 2 3 4
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0 1 2 3 4
Frequent urination	0 1 2 3 4
Increased thirst and appetite	0 1 2 3 4

Category VII

Abdominal distention after consumption of fiber, starches and sugar	0 1 2 3 4
Abdominal distention after certain probiotic or natural supplements	0 1 2 3 4
Lowered gastrointestinal motility, constipation	0 1 2 3 4
Raised gastrointestinal motility, diarrhea	0 1 2 3 4
Alternating constipation and diarrhea	0 1 2 3 4
Suspicion of nutritional malabsorption	0 1 2 3 4
Frequent use of antacid medication	0 1 2 3 4
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes No

Category VIII

Greasy or high-fat foods cause distress	0 1 2 3 4
Lower bowel gas and/or bloating several hours after eating	0 1 2 3 4
Bitter metallic taste in mouth, especially in the morning	0 1 2 3 4
Unexplained itchy skin	0 1 2 3 4
Yellowish cast to eyes	0 1 2 3 4
Stool color alternates from clay to brown	0 1 2 3 4
Reddened skin, especially palms	0 1 2 3 4
History of gallbladder attacks or stones	0 1 2 3 4
Have you had your gallbladder removed?	Yes No

Patient name:_____ Date:_____

Category IX

Acne and unhealthy skin	0 1 2 3 4
Excessive hair loss	0 1 2 3 4
Overall sense of bloating	0 1 2 3 4
Bodily swelling for no reason	0 1 2 3 4
Hormone imbalances	0 1 2 3 4
Weight gain	0 1 2 3 4
Poor bowel function	0 1 2 3 4
Excessively foul-smelling sweat	0 1 2 3 4

Category X

Crave sweets during the day	0 1 2 3 4
Irritable if meals are missed	0 1 2 3 4
Depend on coffee to keep going/get started	0 1 2 3 4
Get light-headed if meals are missed	0 1 2 3 4
Eating relieves fatigue	0 1 2 3 4
Feel shaky, jittery, or have tremors	0 1 2 3 4
Agitated, easily upset, nervous	0 1 2 3 4
Poor memory/forgetful	0 1 2 3 4
Blurred vision	0 1 2 3 4

Category XI

Fatigue after meals	0 1 2 3 4
Crave sweets during the day	0 1 2 3 4
Eating sweets does not relieve cravings for sugar	0 1 2 3 4
Must have sweets after meals	0 1 2 3 4
Waist girth is equal or larger than hip girth	0 1 2 3 4
Frequent urination	0 1 2 3 4
Increased thirst and appetite	0 1 2 3 4
Difficulty with losing weight	0 1 2 3 4

Category XII

Cannot stay asleep	0 1 2 3 4
Crave salt	0 1 2 3 4
Slow starter in the morning	0 1 2 3 4
Afternoon fatigue	0 1 2 3 4
Dizziness when standing up quickly	0 1 2 3 4
Afternoon headaches	0 1 2 3 4
Headaches with exertion or stress	0 1 2 3 4
Weak nails	0 1 2 3 4

Category XIII

Cannot fall asleep	0 1 2 3 4
Perspire easily	0 1 2 3 4
Under a high amount of stress	0 1 2 3 4
Weight gain when under stress	0 1 2 3 4
Wake up tired even after 6 or more hours of sleep	0 1 2 3 4
Excessive perspiration or perspiration with little or no activity	0 1 2 3 4

Category XIV

Edema and swelling in ankles and wrists	0 1 2 3 4
Muscle cramping	0 1 2 3 4
Poor muscle endurance	0 1 2 3 4
Frequent urination	0 1 2 3 4
Frequent thirst	0 1 2 3 4
Crave salt	0 1 2 3 4
Abnormal sweating from minimal activity	0 1 2 3 4
Alteration in bowel regularity	0 1 2 3 4
Inability to hold breath for long periods	0 1 2 3 4
Shallow, rapid breathing	0 1 2 3 4

Category XV

Tired/sluggish	0 1 2 3 4
Feel cold—hands, feet, all over	0 1 2 3 4
Require excessive amounts of sleep to function properly	0 1 2 3 4
Increase in weight even with low-calorie diet	0 1 2 3 4
Gain weight easily	0 1 2 3 4
Difficult, infrequent bowel movements	0 1 2 3 4
Depression/lack of motivation	0 1 2 3 4
Morning headaches that wear off as the day progresses	0 1 2 3 4
Outer third of eyebrow thins	0 1 2 3 4
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0 1 2 3 4
Dryness of skin and/or scalp	0 1 2 3 4
Mental sluggishness	0 1 2 3 4

Category XVI

Heart palpitations	0 1 2 3 4
Inward trembling	0 1 2 3 4
Increased pulse even at rest	0 1 2 3 4
Abnormal blood pressure	0 1 2 3 4
Pain over heart, chest	0 1 2 3 4
Night sweats	0 1 2 3 4
Chronic cough	0 1 2 3 4

Patient name:_____ Date:_____

Category XVII

Headache	0 1 2 3 4
Neck/Shoulder/Arm Pain	0 1 2 3 4
Pain between shoulders	0 1 2 3 4
Low back/Leg pain	0 1 2 3 4
Arthritis	0 1 2 3 4
Swollen joints	0 1 2 3 4
Foot trouble	0 1 2 3 4
Muscle weakness	0 1 2 3 4
Tremors	0 1 2 3 4
Spinal curvature (scoliosis)	0 1 2 3 4
Poor posture	0 1 2 3 4

Category XVIII

Skin eruptions/Rash	0 1 2 3 4
Itching	0 1 2 3 4
Dryness	0 1 2 3 4
Bruises easily	0 1 2 3 4
Varicose veins	0 1 2 3 4
Hives	0 1 2 3 4
Exzema/Psoriasis	0 1 2 3 4
Shingles	0 1 2 3 4

Category XIX

Frequent colds	0 1 2 3 4
Sore throats/Tonsillitis	0 1 2 3 4
Thyroid problem	0 1 2 3 4
Deafness	0 1 2 3 4
Earache	0 1 2 3 4
Ear discharge	0 1 2 3 4
Ear noises	0 1 2 3 4
Nose bleeds	0 1 2 3 4
Sinus trouble	0 1 2 3 4
Dental decay	0 1 2 3 4
Gum trouble	0 1 2 3 4
Fever blisters	0 1 2 3 4
Poor vision	0 1 2 3 4

Do you wear glasses? Yes No Contacts? Yes No

Near sighted? Yes No Far sighted? Yes No

Astigmatism? Yes No Other?_____

Category XX *(Males Only)*

Urination difficulty or dribbling	0 1 2 3 4
Frequent urination	0 1 2 3 4
Pain inside of legs or heels	0 1 2 3 4
Feeling of incomplete bowel emptying	0 1 2 3 4
Leg twitching at night	0 1 2 3 4

Category XXI *(Males Only)*

Decreased libido	0 1 2 3 4
Decreased spontaneous morning erections	0 1 2 3 4
Decreased fullness of erections	0 1 2 3 4
Difficulty maintaining morning erections	0 1 2 3 4
Spells of mental fatigue	0 1 2 3 4
Inability to concentrate	0 1 2 3 4
Episodes of depression	0 1 2 3 4
Muscle soreness	0 1 2 3 4
Decreased physical stamina	0 1 2 3 4
Unexplained weight gain	0 1 2 3 4
Increase in fat distribution around chest and hips	0 1 2 3 4
Sweating attacks	0 1 2 3 4
More emotional than in the past	0 1 2 3 4

Category XXII *(Menopausal Females Only)*

How many years have you been menopausal? _____yrs.

Since menopause, do you ever have uterine bleeding? Yes No

Hot flashes	0 1 2 3 4
Mental fogginess	0 1 2 3 4
Disinterest in sex	0 1 2 3 4
Mood swings	0 1 2 3 4
Depression	0 1 2 3 4
Painful intercourse	0 1 2 3 4
Shrinking breasts	0 1 2 3 4
Facial hair growth	0 1 2 3 4
Acne	0 1 2 3 4
Increased vaginal pain, dryness, or itching	0 1 2 3 4

Menstruating Females (see page 9)

Patient name:_____ Date:_____

Check the following conditions you have had

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Cancer
Type _____
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Malaria
☐ Measles
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Shingles
☐ Tuberculosis
☐Ulcer
☐ Venereal Disease
Type_____
☐ Whooping Cough

Family Medical History (check any that apply)

☐ Asthma ☐ Allergies ☐ Alzheimer ☐ Arthritis
☐ Cancer ☐ Cardiovascular disease ☐ Diabetis ☐ Kidney Disease
☐ Mental illness/depression ☐ Stroke ☐ Other (specify) _____

Personal Medical History

List any **accidents** or **injuries** you have had and when they occurred:_____

_____

_____

List any **surgeries** you have had, please include dates: :_____

_____

_____

List **hospitalization** and/or **major illnesses** and dates: :_____

_____

_____

List any prescription or over-the-counter drugs you **currently** take :_____

_____

_____

List any prescription or over-the-counter drugs you have taken for **any length of time**: (e.g. Tums, Tylenol, etc.) ____

_____

_____

List any **herbs**, **vitamins**, or **supplements** you take _____

_____

_____

__Y __N Do you wear orthotics or foot support?

__Y __N Are you exposed to herbicides or pesticides in or around your home?

__Y __N Are you exposed to or in contact with chemicals or fumes in your work place?

__Y __N Have you recently been exposed to new carpet, paint, furniture, car, etc.?

__Y __N Do you or did you use a microwave oven?

__Y __N Do you or did you use aluminum pans?

__Y __N Do you or did you use body deodorants that contain aluminum?

__Y __N Do you follow a particular diet? Which one? _____

__Y __N Do you have tattoos? Where: _____

__Y __N Do you have body piercings? Where: _____

__Y __N Do you or did you have orthodontics? When: _____

How much water do you drink per day? _____glasses Type? (circle) city bottled distilled spring

What do you drink? ___cups/day coffee ___cups/day tea ___cans/day soda (__regular __diet)
___beers/wk ___glasses wine/wk ___mixed drinks/wk

__Y __N Do you smoke? ___packs/day

How many times per week do you eat out? _____

List the three best foods you eat? _____, _____, _____

List the three worst foods you eat? _____, _____, _____

List any exercise, sports or hobbies:_____

_____

How long has it been since you felt really good?_____

(Confidential! Will not be released with medical records)

__Y __N Have you ever used recreational drugs? Which ones, how often and over what length of time?

_____

_____

Patient name:_____ Date:_____

NEUROLOGICAL ASSESSMENT

- Are you left or right handed?..... Right Left
- Have you had a head injury?……When?..... Yes No
- Do you currently experience or have a past history of vertigo or balance disorders?..... Yes No
- Do you get motion sickness easily (car sick or sea sick)? ..... Yes No
- Do you find that your balance is getting worse? ..... Yes No
- Do quick flashes of light or loud noises bother you? ..... Yes No
- Do you experience blurriness in your vision or have double vision? ..... Yes No
- Do you have floaters or halos in your visual field?..... Yes No
- Do you have difficulty discriminating similar shades of color?..... Yes No
- Does working on a computer cause you fatigue, headaches or other symptoms? ..... Yes No
- Have you noticed clumsiness in hand coordination? ..... Yes No
- Do you frequently bump into walls or objects?..... Yes No
- Does your hand shake slightly when reaching for something?..... Yes No
- Are you easily affected by alcohol?..... Yes No
- Have you noticed uneven sweating or temperature on one side of your body?..... Yes No
- Have you had a pelvic floor injury or dysfunction?..... Yes No
- Do you gag easily?..... Yes No
- Do you have any changes in smell or smell foul things that are not present?..... Yes No
- Do you have any difficulty with taste or taste things differently than what you are eating?..... Yes No
- Do you have a history of difficulty with swallowing or eating?..... Yes No
- Do you feel like you are hypersensitive to pain compared to other people you know?..... Yes No
- Does it take you a long time to “warm-up” for exercise?..... Yes No
- Do you feel like your body is not your own sometimes?..... Yes No
- Do you find yourself searching for words frequently when you speak?..... Yes No
- Do you have difficulty with short-term memory? ..... Yes No
- Have you been told you have or noticed any memory loss of past events?..... Yes No
- Do you have any ringing or pressure in your ears? ..... Yes No
- Do you have difficulty learning new things?..... Yes No
- Do you get confused about dates, passage of time, or place?..... Yes No
- Do you have difficulty finding words when speaking?..... Yes No
- Do you have difficulty recognizing familiar faces?..... Yes No
- Do you have difficulty planning and organizing daily events?..... Yes No
- Do you get lost often or have a hard time with directions?..... Yes No
- Do you have difficulty misplacing things and an inability to retrace steps?..... Yes No
- Have you noticed your ability to concentrate is getting worse? ..... Yes No
- Does driving cause you fatigue, headaches or any other symptoms?..... Yes No
- Have you lost your interest in hobbies and functions you used to enjoy? ..... Yes No
- Do you have a hard time motivating yourself to engage in activities?..... Yes No
- Has your handwriting changed in recent years? ..... Yes No
- Do you have difficulty staying focused and concentrating for extended periods of time?..... Yes No

Patient name:_____ Date:_____

Women Only Gynecological History

Date of last menstrual cycle_____ Length of cycle_____ Time between cycles_____
Any recent changes in normal menstrual flow? _____ Age at first period _____
Number of children____ Number of pregnancies ____ Number of C-sections_____ Number of Miscarriages _____
Date of last gynecological exam (PAP, mammogram)_____ Results_____
Are you currently using any method of birth control? __Yes __ No If Yes, what method?_____
If birth control pills? Type_____ Dates used _____
Have you ever (or currently) used any bio-identical hormones (i.e. DHEA, progesterone, estrogen, testosterone)? __Y __N
If yes, what dose and length of time. _____ Are you pregnant? Yes___ No___
Do you have: Endometriosis_____ Infertility _____ Fibrocystic breasts _____ Fibroids_____ Ovarian cysts _____
Reproductive cancer _____ Pelvic inflammatory disease _____ Genital Herpes _____ STD _____
If menopausal, how was the transition?_____

_____

_____

Check the symptoms you experience regularly <u>one to two weeks before your period:</u>

___ Anxiety
___ Irritability/Aggressiveness
___ Engage in self-destructive behavior
___ Weight gain
___ Abdominal bloating
___ Tender, swollen and/or painful breasts
___ Craving for sweets
___ Increased appetite
___ Fatigue
___ Headaches
___ Shaky or clumsy
___ Depressed
___ Insomnia/difficulty sleeping

Check the symptoms and/or behaviors that <u>occur during your period:</u>

___ Cramping in lower abdomen or pelvic area
___ Low back aches
___ Diarrhea
___ Nausea or vomiting
___ Headaches
___ Unusual fatigue
___ Weight gain/bloating
___ Painful and/or swollen breasts
___ Irritability/ Mood swings
___ Depression

Check any of the following statements that <u>describe your menstrual cycle, energy level or reproductive function:</u>

___ Heavy prolonged menstrual bleeding/clotting
___ Menstrual bleeding that exceeds 5 days
___ Absence of periods for 3 months or more
___ Vaginal itching, burning, dryness
___ Menstruation that occurs too frequently (21-24 days)
___ Irregular periods (once every 3-6 months)
___ Menstrual cycle 36 days or longer
___ Unusually light or heavy periods
___ Bleeding or spotting between periods
___ Abnormal vaginal discharge
___ Frequent urination

Check the symptoms that occur <u>throughout the month:</u>

___ Hot flashes/night sweats
___ Incontinence/Urinary leakage
___ Vaginal infections
___ Vaginal discharge
___ Change in sexual desire
___ Difficulty with orgasm
___ Painful intercourse

Typical Daily Food Intake

Name:_____ Date:_____

Please list what you eat in a typical day. Be sure to include an approximate amount of each item.

Breakfast

Meat & Dairy _____
Vegetables & Fruit _____
Bread, Cereals, Grains _____
Fats (butter, oil, etc.) _____
Candy, Sweets _____
Water (oz.) _____
Other drinks _____

Mid-Morning Snack _____

Lunch

Meat & Dairy _____
Vegetables & Fruit _____
Bread, Cereals, Grains _____
Fats (butter, oil, etc.) _____
Candy, Sweets _____
Water (oz.) _____
Other drinks _____

Mid-Day Snack _____

Dinner

Meat & Dairy _____
Vegetables & Fruit _____
Bread, Cereals, Grains _____
Fats (butter, oil, etc.) _____
Candy, Sweets _____
Water (oz.) _____
Other drinks _____

Nighttime Snack _____

Patient name:_____ Date:_____

Policies of Healthspring Holistic Center

In order to facilitate your treatment:

1. Wear or bring comfortable, loose clothes if possible (shorts, sweat suits, etc.). Gowns are also provided.
2. This is a fragrance free facility. You will not be treated if you have any fragrance on at arrival.
3. Remove jewelry, especially necklaces, earrings, and watches before treatment. This is for your safety and our convenience.

Fees:

New patient exam and consultation (approximately 1 hour)	$255.00
Follow up visit, report & treatment (approximately 40 minutes)	$170.00
Regular office visit/adjustment (approximately 30 minutes)	$125.00
Brief office visit/adjustment (approximately 15-20 minutes)	$85.00
Extended office visit/adjustment (approximately 40 minutes)	$170.00

Financial Policy:

- Payment is due in full for all services rendered at the time of your visit. We accept cash, personal checks, VISA, MasterCard, and Discover. We do not accept or file insurance.
- We will provide you with a superbill to file with your insurance carrier, if you so desire. There is a $15 charge per claim should you need any further paperwork and/or phone calls from our office to your insurance carrier. Ultimately, all disputes between you and your carrier are your responsibility.
- We do accept patients over 64, however, we do not accept Medicare assignments. If you are a participant in the Medicare Part B program, you will be required to sign a waiver of liability. The doctor or receptionist will explain our Medicare procedures to you as there are specific state law requirements we must follow.
- If you are requesting treatment as the result of an automobile accident or an on-the-job injury, please let us know immediately. Since we do not accept assignment for Personal Injury Cases, there will be a fee for any additional paperwork requirements.
- All nutritional supplements, books, orthopedic supports or any other items purchased must be paid for in full at the time of purchase. Our 100% Money Back Guarantee: If your find you cannot take any of the recommended supplements for any reason, you can bring them back for an exchange or full refund within **30 days** of purchase.

Cancellation Policy

We have a **24-hour notice requirement** for cancellation of appointments. If you miss an appointment without proper notification you will be asked to pay for it before another appointment is scheduled. Please make every effort to be on time for your appointments.

Patient Consent

I hereby state that the information in this form is true and correct. I understand I am personally responsible for payment on the day of service. I authorize Dr. Janeah Saadeh to examine, perform diagnostic tests and do what she deems necessary in her best judgment and in accord with the state statutes, for the care and management of my condition.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian's Signature for minor Date