

Cameron Clinic of Oriental Medicine
1928 South 16th Street
Wilmington, NC 28401
(910) 342-0999
www.camclinic.com

What to expect on a first visit

What you need to do before your first visit.

1. Go to our website: **camclinic.com** and click on the link for **Pre-visit Forms**.
2. Print the pre-visit packet of forms which includes:
 - What to expect on your first visit
 - Office Policies
 - Patient Intake Form
 - Consent For Treatment
 - Privacy Policy
 - Metabolic Assessment
 - NTAF form
3. Complete the forms before your first visit.

If your initial appointment is scheduled with Nan Cameron, MSN, RN, LAc, please obtain:

1. Copies of lab results, x-ray, CT scans and MRI reports for the past 2 years. You may request these be faxed to our clinic ó 910-342-0993
2. If you have not had any lab work done in the past two years you may want to call the office and arrange to have a Comprehensive Wellness Panel completed before your first visit. This test screens for glucose, fluid and electrolytes, complete blood count, lipids, thyroid, liver and kidney function. The cost is \$97.00.
3. All your information should be received by our office a minimum of two weeks prior to your first visit. I want to have adequate time to review your information, before your first visit.

Expect your first visit to last about 1½ hours. We spend time talking about your concerns and goals for treatment. I will ask you different questions ó many you will expect and some will seem unusual or different from what you may have experienced when visiting other health care practitioners. As part of the examination I take your pulse and look at your tongue. If you are used to brushing your tongue, please **don't** do it on the days you come for a treatment. For best results, don't come to your appointment hungry or skip eating your breakfast or lunch. Acupuncture works with your body's energy and food is our energy source.

We will talk about your Chinese Medicine diagnosis and what it means. If you are scheduled to receive acupuncture you will receive your first treatment at the time of your appointment. Most patients enjoy treatments and find them relaxing. All needles are sterile and used only one time. You may feel a small prick lasting a couple of seconds when the needle is inserted. Once the needle is in place you may not feel anything or it might feel heavy or achy or even have a slight electric sensation, but it should not feel painful or uncomfortable.

Infrequently, there may be bruising or slight bleeding when needles are removed. Since everyone responds differently to treatments you may want to plan your schedule accordingly. Sometimes patients want to go home and take a nap, others may feel energized after their treatment. It is a good idea to not get overheated or chilled for several hours after receiving a treatment. You want to be sure to drink plenty of water. If you are planning to go out to dinner and have a glass of wine or a drink, go slow because you may find that it affects you more quickly than usual. Remember you are not yet superman or superwoman after your first treatment, so if you are feeling great after your treatment you will still want to take it easy. If you push yourself you may find that you feel worse than ever. As I like to tell patients, we need to learn to be our own best friend!

õFirst we must treat the root or core and then the branch or the symptomsö is a frequent saying in oriental medicine. Depending on the length and severity of your symptoms the length of treatment required will vary. Unfortunately there is no quick fix, but feeling healthy makes our life so much more enjoyable.

We want you to understand your treatment and will do our best to explain the process. If this is your first visit to an Oriental Medicine practitioner you are likely wondering about what's going to happen and may have many questions to ask. There are many variations of oriental medicine ó Traditional Chinese Medicine (TCM), 5 element, Japanese, and Korean styles, so even if it's not your first time receiving acupuncture there may be some differences.

Nan Cameron practices a style taught by Kiiko Matsumoto and TCM (Traditional Chinese Medicine), both are based on the Chinese classics and modern medical pathophysiology. This style is very õhands onö and is based on palpation of active reflexes on the abdomen (the hara), neck, back and their corresponding treatment points. This system of palpation and feedback gives the practitioner and patient immediate feedback on both diagnosis and treatment. A treatment session generally begins by first treating active reflexes in the abdomen and neck. Change in how these reflexes feel gives us both a measure of effectiveness. The treatment often consists of treating one set of reflexes with acupuncture, leaving the needles in for 15-20 minutes and then often treating another set of reflexes and leaving the needles in for 10-15 minutes.

Nan Cameron uses functional medicine concepts to help identify potential health issues and to help analyze and understand how all components of the human body ó physiology, environmental, and lifestyle ó interact or function. This is done thru patient interviews, physical examination and laboratory testing.

Brendan Cook practices a Japanese style of acupuncture based on the teachings of Shudo Denmai, and influenced by the work of Kiiko Matsumoto, as well as TCM. This particular style of acupuncture is very palpatory, involving the palpation of the abdomen, points and channels for the purposes of diagnosis. The treatments will often consist of one set of points to treat core or constitutional conditions, often referred to as õrootö conditions, and then another set to treat more symptomatic issues, which are often referred to as the õbranchö conditions.

We will talk about your Chinese medicine diagnosis, the assessment of your issues, additional testing that would be helpful, nutritional and herbal supplements that can be used and helpful information that you can incorporate into your health regime.

Your treatment may include other modalities, such as:

Moxa ó an herb that is burned. It has many different forms ó I may put it on the end of the needle to burn or even send you home with a type that looks like a big cigar.

Cups ó a vacuum is created inside a glass cup and then it is placed on different parts of the body. It may stay in one place or be moved over an area such as your back.

Guasha ó a form of bodywork often using a Chinese porcelain spoon that is massaged over specific body areas.

Electroacupuncture ó electricity can be added to the needles, pads or probes. If we use microcurrent pads there will be a one time charge.

Nutritional and Herbal Formulas

Herbal formulas are an important part of Oriental Medicine. Many different types of nutritional and herbal supplements are offered.

Chinese Herbal Formulas

These are prepared formulas generally in the form of pills, capsules or tinctures. Many of these are manufactured in China. The distributors I use test their products for the presence of heavy metals and other substances. A one week supply of pills will generally cost from between five and forty dollars. I use products from Golden Flower, Health Concerns, Evergreen, Blue Poppy, Kan, Herbal Times, Far East Summit and Mayway. Chinese patent medicines may not be designed specifically for you, so you may be required to take more than one formula to get the best results.

Granules

A weekly dose for one formula is approximately 42 ó 64 gms. The weekly cost for each formula is about \$15.00. The granules are mixed in water and may have a slightly unpleasant taste. Granules have the advantage of being tailored specifically for you and can be adjusted based on your response. For an additional charge we can make these into capsules for you or you may purchase supplies to make your own capsules.

Nutritional Supplements and Foods

We have a wide selection of nutritional supplements including: probiotics, fish oil, vitamins, to name only a few products that are available in the office. Need organic coconut oil or sea salt - we can help. Looking for a shampoo or moisturizer that has no additives ó we have it.

About Us

We make every effort to stay on time. Please help us and try to get to the office 5-10 minutes before your scheduled treatment. This will give you time to get a drink of water, go to the bathroom or sit for a few minutes and take time to catch your breath. We often like to see patients weekly in the beginning. If you only scheduled your first visit, you may want to call and schedule additional appointments.

Frequently asked questions

I scheduled a first visit with Brendan because I couldn't get in to see Nan for a month, but I would still like see Nan.

You have a couple of options. You may schedule an acupuncture follow up visit with either Nan or Brendan. Follow up visits consist of 10-15 minutes of face to face discussion and an acupuncture treatment. If your first time to see Nan or Brendan in clinic is at a follow up visit, you can expect us to check in with you and follow your current treatment plan. Our goal is that you should feel that you get a great acupuncture treatment no matter who you see.

You may schedule a consultation (no acupuncture) with Nan. For you to get the most out of this visit I will need all of your lab and diagnostic information to review before your visit. I prepare an assessment report with findings and recommendations for you.

What is your cancellation policy?

A minimum of 24 hours notice is required for cancellation of appointments, unless there is a true emergency e.g. hospitalization, death in the family. Failure to notify the office will result in a charge for the missed visit.

The staff of the Cameron Clinic looks forward to helping you achieve your health care goals.

Sincerely,

Nan Cameron, MSN, RN, LAc

Rev.7/28/08, 1/29/10, 10/6/10, 5/17/11, 10/1/11

Cameron Clinic of Oriental Medicine
1928 South 16th Street
Wilmington, NC 28401
(910) 342-0999

Office Hours

Nan Cameron, MSN, RN, LAc

Tuesday, Wednesday, and Thursday 10a-5:30p

Brendan Cook, LAc

Monday 1p-8p

Tuesday 10a-5:30p

Wednesday 10a-6:30p

Thursday 12p-8p

Friday 10a-6:30p

Saturday 9a-1p

Important: Please notify our office 48 hours in advance if you must cancel your appointment. Patients are billed for cancellations with less than 24 hours notice (except in cases of emergency e.g. death in family or hospitalization).

Office Policy

We WELCOME you to our office and assure you that you will be receiving the best care available. Our acupuncturists, Nan Cameron, MSN, RN, LAc and Brendan Cook, LAc are happy to work with your physician and will send your physician monthly progress reports if requested.

Health and accident policies are an arrangement between you and your insurance company. All services will be charged directly to you and you will be personally responsible for payment.

It is customary to pay for professional services when rendered. We ask that you pay for your first visit with cash, check or Visa/MasterCard. We realize that it may be inconvenient or difficult to pay at the time of each visit and will be happy to help you with a **written financial agreement**.

Fee schedule

Initial evaluation and treatment with Nan	\$165.00	Rife machine	\$15.00
Initial consult, no acupuncture with Nan	\$100.00	Consultation, 50 min.	\$60.00
Initial evaluation and treatment with Brendan	\$ 90.00	Consultation, 25 min.	\$30.00
Acupuncture Follow up visits with Nan	\$85.00		
Acupuncture Follow up visit with Brendan	\$75.00		

Acupuncture follow up visits include only 10-15 minutes of consultation time, we want to get you on the table for your treatment. If you want more time to discuss issues please set up a consultation visit. If we have time to spend more than 10-15 minutes of consultation time during an acupuncture visit with you the invoice will reflect the acupuncture treatment and consultation visits.

Herbal supplements, pads for microcurrent electrotherapy treatments are not included in the prices listed above

FOR PATIENTS INJURED ON THE JOB (Workers Compensation) Your employer is responsible for any costs in treating your work related injuries. If your injury is work related be sure and tell us before starting treatments. Preauthorization in writing is required before evaluation and treatment can begin. You are personally responsible for payment of any appointments cancelled with less than 24 hours notice.

FOR PATIENTS WITH INSURANCE we will provide you with a CMS1500 form which you may submit to your insurance company. We encourage you to check with your insurance company to find out their requirements for reimbursement to you. Medicare and Medicaid do not pay for acupuncture. We will be happy to assist you with this process. **If you request** a CMS1500, our receptionist will complete forms at the beginning of each month for the previous month. You will need to mail this form along with any additional paperwork required to you insurance company for reimbursement. If you have any questions please don't hesitate to talk with us.

Thank you for coming to our office for your health needs. We welcome your comments and suggestions.

Cameron Clinic of Oriental Medicine
1928 South 16th Street
Wilmington, NC 28401
Tel: (910) 342-0999

Consent for Treatment

I hereby authorize and direct Nan Cameron, MSN, RN, LAc and Brendan Cook, LAc to perform acupuncture and oriental medicine procedures such as obtaining a health history, performing pulse and tongue evaluation, manual palpation, observation, range of motion evaluation, muscle, orthopedic and neurological assessment, modes of manual or physical therapy, such as massage, heat and/or cold therapy, the use of magnets and electrical stimulation, cupping (the application of suction cups, usually on the back), the prescribing of Chinese herbs, homeopathic preparations and nutritional supplements, dietary recommendations, advice regarding exercise and lifestyle counseling.

I have had the opportunity to discuss questions with my practitioner, if I had any, regarding the nature and purpose of acupuncture and oriental medicine procedures. I understand that although acupuncture and oriental medicine procedures have helped many people, no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of western medicine, in the practice of Oriental Medicine there are some risks to treatment. I understand that while the risks include but are not limited to; bleeding, bruising, light-headedness, inflammations, infections, general aches, burns, discomfort at the location where the needle was inserted or radiating from that location, nerve pain, temporary aggravation of current symptoms or puncture of organs. In 35 years there have been 202 adverse events related to acupuncture (*Altern Ther Health Med 2003:9(1):72-83*). I do not expect the practitioner to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the practitioner's judgment based on the facts known at the time.

I have read or have had read to me, the above consent. By signing below I agree to treatment with the procedures listed above, if applicable to my specific situation. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Office policies

Appointments: All patients are seen on an appointment basis only. You are encouraged to schedule well in advance so that a convenient time may be reserved for you. Please be advised that the full treatment fee will be charged for missed or cancelled appointments unless 24 hours notice is given. **Initial** _____

Payments: We make every effort to keep costs reasonable. It is customary to pay for services at the time rendered. If this is not possible, you are required to discuss this in advance of your appointment so that a form of Financial Agreement may be completed before treatment begins. We accept cash, checks, Visa or Mastercard as payment. A \$25.00 fee will be charged for any returned checks. **Initial** _____

Insurance: Most insurance companies do not cover treatments. If your insurance does cover acupuncture we will provide you with a superbill within 30 days of treatment so that your insurance company may reimburse you for the cost of treatment.

To be completed by patient
Patient's signature or guardian

Date: _____
Print patient's name

Cameron Clinic of Oriental Medicine, Inc.
1928 South 16th Street
Wilmington, NC 28401

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make any significant change in our privacy practices, we will change this Notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us by using the information listed at the end of this notice.

Uses and disclosures of health information.

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to healthcare practitioners providing care to you.

Payment: We may use or disclose your health information to obtain payment for services we provide for you.

Healthcare Operations: We may use or disclose your health information in connection with healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing competence and evaluating performance of practitioners, accreditation, certification, licensing or credentialing activities.

Other circumstances in which your health information may be shared: Appropriate government authorities may be notified if we suspect you are a victim of abuse or neglect or domestic violence or a possible victim of other crimes. This disclosure will only be made when there is reason to believe there is a serious threat to your health and safety or the health and safety of others.

We may also be required to disclose to government authorities health information necessary to complete public health investigations or threats to national security or where required by law.

Your authorization: You may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us authorization you may revoke it in writing at anytime. Unless specifically stated in this Notice, we may only share your health information with your permission, with family, friends or personnel helping with your care. In case of an emergency, where you are unable to tell us what you want we will use our best judgment in sharing your health information.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders, such as voicemails or postcards or letters.

Marketing: Cameron Clinic of Oriental Medicine may send information to you about treatment alternatives and other health related benefits that we think you may find useful or beneficial.

Patient rights: You have a right to request reasonable restrictions on certain uses or disclosures of your health information, and we will make every effort to honor your requests. For example, you have a right to review and copy your patient record. Duplication of the material will involve a per page fee. In addition, you have a right

to request that we communicate with you in a certain way. You may wish for us to only contact you at a specific number. You have a right to ask us for a description of how your information was used by our office for any reason other than treatment or payment. **Amendment:** You have a right to request that we amend your health information. Your request must be in writing and it must explain why it should be amended.

Questions and complaints: We encourage you to express any concerns you have regarding the privacy of your health information. You have a right to file a complaint with the Department of Health and Human Services if you believe your privacy rights have been compromised.

Contact Information:

Nan Cameron, MSN, RN, LAc
1928 South 16th Street
Wilmington, NC 28401
Tel: (910)342-0999
Fax: (910)342-0993

We will attempt to call you prior to your appointment as a reminder. The best number to call me is _____ . I understand this is done as a courtesy only. I am responsible for remembering the appointments that I schedule.

I, _____ have received a copy of this Notice of Privacy Practices. I understand that my health information will be used and disclosed consistent with Notice.

Patient Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Cameron Clinic of Oriental Medicine
New Patient Intake Form

today's date: _____

Name:	SS#	Birthdate: / /
	Marital Status:	Age:
Address:	<input type="checkbox"/> M <input type="checkbox"/> F	Ht. Wt.
Home Phone:	Work Phone:	Occupation:
Cell phone:	email:	
Emergency Contact - Name and Phone:		
Email address:		
Allergies (medication, food, etc.)		
Referred by/How did you hear about us?:		
Reason for visit today?	Have you had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you had this condition?		
Is it getting worse?	Does it bother your: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> other What?	
What seemed to be the initial cause?		
What seems to make it better?		
What seems to make it worse?		
Are you under the care of a physician now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what?		
Who is your physician?	Phone:	
What treatments are you getting for this condition? (physical therapy, massage, yoga, aromotherapy, etc.)		
Current Medications:		
Current Nutritional or Herbal supplements:		

Family Medical History:

- Heart disease Diabetes Cancer High Blood Pressure
 Stroke Asthma Seizures Alcoholism

Your Past Medical History

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> TB |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

List any hospitalizations you have had during the past 5 years: _____

Surgeries: (list) _____

Your Diet

Appetite: Low Coffee Soft Drinks Sugar Artificial Sweetener
 Normal Tea Salty Food Stevia
 High Thirst for water: #glass/day _____

Average daily menu:

Morning _____ Snack _____

Snack _____ Evening _____

Noon _____ Snack _____

Digestive enzymes. Brand _____

Probiotics. List what organisms are included and the # of organisms/capsule (or bring in your bottle)

Fish oil. Brand _____ . _____ mg EPA _____ mg DHA

Vitamin D. _____ IU/day (Look to see if it is included in different supplements, such as calcium or vitamins or supplements for bone health.)

My blood type is: O A B AB

I use: table salt sea salt kosher salt

What oils do you use: coconut oil olive oil butter margarine peanut oil

Other: _____

I have trouble eating: milk dairy gluten meat shrimp soy salad

Other: _____

Has your digestion changed in the last six months? yes no

If yes, how? _____

Please bring any recent blood work such as Vitamin D levels, thyroid levels, results from any saliva tests.

Your Lifestyle

Alcohol Marijuana Stress Tobacco Drugs Occupational Hazards

Exposure to chemicals Exposure to mold

Regular Exercise: Type: _____ How Often _____

General Symptoms

Poor appetite Poor sleep Body feels heavy Chills
 Excess appetite Sleep too much Cold hands/feet Night sweats
 Strongly like cold drinks Dream disturbed sleep Poor circulation Sweat easily
 Strongly like hot drinks Fatigue Shortness of breath Muscle cramps
 Recent weight loss/gain Lack of strength Fever Vertigo or dizziness
 Bleed or bruise easily Peculiar tastes (describe) _____

Head, Eyes, Ears, Nose, Throat

Glasses Night blindness Sores on lips/tongue Recurrent sore throat
 Headaches Glaucoma Dry mouth Swollen glands
 Red eyes Cataracts Excessive saliva Lumps in throat
 Itchy eyes Teeth problems Sinus problems Enlarged thyroid
 Spots in eyes Grinding teeth Excessive phlegm Nose bleeds
 Poor vision TMJ Color of phlegm _____ Ringing in ears
 Blurred vision Facial pain _____ Poor hearing
 Dry eyes Gum problems Other: _____

If yes, to sinus problems, headaches, facial pain please complete the following section. Check any items that apply to you.

As a child I had frequent colds As a child I remember being treated with antibiotics

I have had antibiotics in the last 6 months I have had a yeast infection in the past 12 months

I do sinus washes I use saline nasal sprays My house has mold

I am sensitive to smells. Type _____ I am sensitive to chemicals

I have been exposed to chemicals, fertilizers, paints, hair dye, other: _____

Respiratory

- Difficulty breathing when lying down
- Tight chest
- Cough
- Asthma/wheezing
- Pneumonia
- Wet or Dry? _____
- Thick or Thin? _____
- Color of phlegm _____
- Cough blood

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain
- Palpitations
- Phlebitis
- Blood clots
- Fainting
- Difficult breathing
- Irregular heart beat
- Are you taking blood thinners or aspirin? Yes No

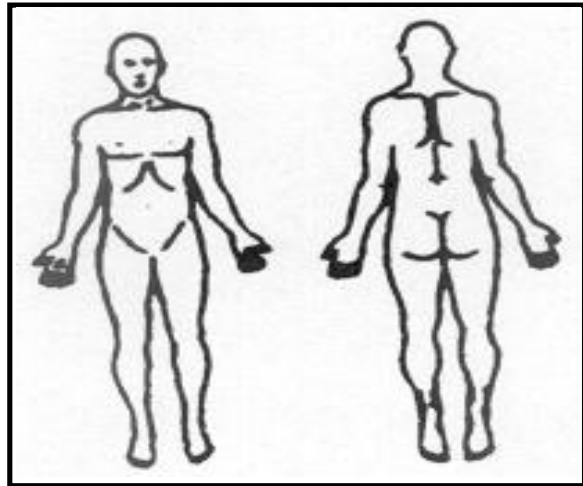
Gastrointestinal

- Nausea
- Vomiting
- Acid regurgitation
- Gas
- Hiccups
- Bloating
- Bad breath
- Diarrhea
- Constipation
- Use laxatives
- Black stools
- Bloody stools
- Mucus in stools
- Intestinal pain or cramping
- Itchy anus
- Burning anus
- Rectal pain
- Hemorrhoids
- Anal fissures
- Bowel Movements Frequency _____
- Color _____
- Formed or loose _____
- Strong odor: Yes No

Musculoskeletal

- Neck/Shoulder Pain
- Muscle pain
- Limited range of movement
- Upper back pain
- Low back pain
- Sciatica
- Numbness
- Joint pain
- Rib pain
- Paralysis

Mark areas of pain on the diagram



Skin and Hair

- Rashes
- Hives
- Ulcerations
- Eczema
- Psoriasis
- Acne
- Dandruff
- Itching
- Hair loss
- Change in hair/skin texture
- Fungal infections

Other hair or skin problems: _____

Neuropsychological

- Seizures
- Depression
- Tics
- Poor memory
- Easily stressed
- Abuse survivor
- Irritability
- Anxiety
- Considered or attempted suicide
- Seeing a therapist

Other: _____

Genitourinary

- Pain on urination
- Frequent urination
- Urgent urination
- Kidney stone
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Venereal disease
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Impotence
- Premature ejaculation
- Testicular self exam

Gynecology

Age menses began _____	Duration of Flow _____	<input type="checkbox"/> Vaginal discharge color _____	<input type="checkbox"/> Breast lumps
Length of cycle _____	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Vaginal sores	<input type="checkbox"/> # pregnancies _____
<input type="checkbox"/> Date last period began _____	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Vaginal odors	<input type="checkbox"/> # live births _____
Age of menopause _____	<input type="checkbox"/> Clots	<input type="checkbox"/> Breast self exam	<input type="checkbox"/> # abortions _____
Other: _____	<input type="checkbox"/> PMS	Date of last PAP exam _____	<input type="checkbox"/> # premature births _____

If you have problems with fatigue, chronic pain, thyroid, chronic fatigue syndrome, fibromyalgia or infertility please complete the following section:

I have monitored my basal metabolic temperature in the past. If yes, what were your results _____

I have had chronic, recurrent infections for most of my life.

I would describe my mother as "healthy" I would describe my father as "healthy"

My eyebrows are thinner than they used to be, especially the outside third.

My skin has become dry, cold, rough, scaly I feel colder than I used to be

I get hot easily my symptoms get worse when I get overheated cold makes my symptoms worse My fatigue is not relieved by rest or sleep I have problems thinking straight I have used birth control pills I have had mononucleosis I have had yeast infections

Metabolic Assessment Form

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

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

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

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

Category I			
Feeling that bowels do not empty completely	0	1	2 3
Lower abdominal pain relief 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 of "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			
Excessive belching, burping, or bloating	0	1	2 3
Gas immediately following a meal	0	1	2 3
Offensive breath	0	1	2 3
Difficult bowel movements	0	1	2 3
Sense of fullness during and after meals	0	1	2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2 3
Category III			
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 from antacids, food, milk, 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 IV			
Roughage and fiber cause constipation	0	1	2 3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2 3
Pain, tenderness, soreness on left side under rib cage	0	1	2 3
Excessive passage of gas	0	1	2 3
Nausea and/or vomiting	0	1	2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	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

Category V			
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
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 VI			
Crave sweets during the day	0	1	2 3
Irritable if meals are missed	0	1	2 3
Depend on coffee to keep yourself going or started .	0	1	2 3
Get lightheaded 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 VII			
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
Category VIII			
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 IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 X				
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 gain 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 falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Category XI				
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 XII				
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 XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (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 evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3
Category XV (Males only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in 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
Decrease in 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 XVI (Menstruating Females Only)				
Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 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 breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Category XVII (Menopausal Females Only)				
How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcoholic beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

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

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

Do you smoke? _____ If yes, how many times a day: _____

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

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

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

Health Questionnaire (NTAF)

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

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

SECTION A

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

SECTION B

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

SECTION C

SECTION C1

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

SECTION C2

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

SECTION 1 - S

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

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

SECTION 2 - D

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

SECTION 3 - G

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

SECTION 4 - ACH

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

Medication History*

Please circle any of the following medication you have been or are currently taking.

Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators

Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers

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

Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)

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

Cholinesterase Inhibitors (reversible)

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

Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Fluanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder

Flumazenil

Monoamine Oxidase Inhibitors (MAOI)

Marplan, Aurorix, Manerix, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Sertonegic Antidepressants (NaSSaa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitors

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Seropram, Cipralext, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers

Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despiramin, Duloxetine

Tricyclic Antidepressants (TCAs)

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

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