Well Integrative Medicine

Amy S. Weiler, D.O.
5100 N. Ravenswood Ave., Ste 106
Chicago, IL 60640
Phone 773-784-7000
Fax 773-784-7190

Thank you for considering me as your physician.

There are many decisions in health care that need to be made and I consider choosing a physician and a practice that is right for you to be one of the most important. Medicine and the science of healing have evolved tremendously; expanding upon the traditional options of health care and creating some wonderful practice styles from which to choose.

Here at Well, we believe we offer just that – a unique model of practice to benefit our patients. My dream of offering this totally different, more personalized approach to health became a reality in 2010 when we opened Well. I am excited and honored to do this kind of medicine and serve those who seek out the individualized, relationship-based approach to healing that we offer. Since opening our doors, we've addressed our patients' health needs using integrative and functional medicine. Practicing in this way means thinking about the body as one integrated system, moving beyond a superficial diagnosis and discovering the root cause of illness. Using integrative and functional medicine, we want to answer the question "Why?" not just "What is the right drug for this disease?"

Applying this common sense and effective approach, we treat presenting symptoms as naturally as possible and then search beyond them for the underlying root cause of illness or pain. Together we then work to shift it, change it, and heal it whenever possible. It's the difference between "not sick" and real, lasting health and wellness, and the work creates some great breakthroughs.

How do we do it? I spend two to three times longer with patients than the average physician – 20 minutes minimum, frequently more. Because of that we see just 7-8 patients a day versus the national average of 25-30 per day. Unhurried appointments focusing on root cause produce better outcomes. In our first visit – usually 60-75 minutes in length, we meet face-to-face in a comfortable environment. This allows me the time to hear your story and begin working with you toward your desired outcomes. You will leave your appointment with a personalized wellness program that summarizes our recommendations and outlines the next steps for you to take on your wellness journey.

Given that the insurance-based healthcare industry rewards practices that focus on quantity of visits and procedures rather than quality and consultation, we have chosen a different path. We at Well want to provide more. In order to provide personalized integrative and functional medicine we have chosen a practice model that is program based and requires either monthly installments or payment at the time of service. You will find more information about our office policies and financial information in the new patient information packet.

Your next step in joining the practice is to complete and submit a detailed medical history and accompanying consent forms which you will find in this packet. Once this paperwork is completed and received by our office, a member of our staff will contact you to schedule your initial visit.

I invite you to join with me in this exciting and necessary paradigm shift in medicine while advancing your personal journey to optimal health and wellness.

All My Best,

Amy Weiler, DO

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New Patient Information and Checklist

Initial Appointment Checklist:

This is the checklist of items that need to be completed prior to scheduling your first appointment:

1. Read the Welcome Letter from Dr. Weiler
2. Read and Complete Forms:
    a. Wellness Program Options
    b. Registration Agreement and Acknowledgement
    c. New Patient Health History
3. Fax all completed forms and a copy of your identification to us at Well. Our fax number is 773-784-7190
4. Our staff will contact you to schedule your appointment after we have received all of your completed paperwork.

What to expect from your first visit:

- Dr. Weiler will spend about 60-75 minutes with you listening to your concerns, addressing any current health issues and evaluating your condition. She will partner with you to develop a treatment plan. This plan will include a recommended program option tailored to your needs and may also include laboratory tests and other types of testing, as well as referrals to medical specialists when necessary.
- Dr. Weiler's medical staff will assist you with any lab tests, specialist referrals and supplements you may need as your appointment ends.
- Dr. Weiler will have reviewed any medical records that we have received from your other healthcare providers before your visit.

Well Integrative Medicine - Program Options			
	9 Month	**6 Month**	**Open Access**
	Comprehensive Wellness Progam (one-on-one)	Optimal Wellness Program (*group and one-on-one options)	A La Carte Wellness Program
One-on-one Visits with Dr. Amy Weiler	Unlimited	4 scheduled visits included	All visits are paid out-of-pocket by patient at time of service)
Nutrition Consults with Functional Nutritionist	Unlimited	2 visits	Out-of pocket, paid by patient
Initial Functional Lab Kits	☑	☑	Out-of pocket, paid by patient
Supplements	☑	☑	25% Discount
Multi-Week Educational Curriculum	☑	☑	
Specialty Class Sessions	☑		

Reviewed by: **Date**:

X

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Registration Agreement and Acknowledgment

Date _____

Welcome! In order to serve you well, we will need the following information. All information will be held confidential.

Patient's Name	Date of Birth	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Gender ☐ Male ☐ Female
Address	City	State	Zip

Home Phone (May we leave a **confidential** message) ☐ Yes ☐ No	Cell Phone (May we leave a **confidential** message on this #) ☐ Yes ☐ No	Email Address (Would you like to be contacted via e-mail for practice updates?) ☐ Yes ☐ No

If child, parent or guardian's name

Name of Employer

Address	City	State/Zip	Work/Business Phone
Policy Holder Name (If not the patient)			Policy Holder's Date of Birth
Insurance Company Name	Insurance Policy ID #	Insurance Group #	Insurance Telephone #
Name and Address of Policy Holder's Employer			Work/Business Phone
Name of Person to Contact in Case of Emergency	Phone		Relationship to Patient

How did you hear about us? To better serve you, please give us the ***name and address*** of your preferred pharmacy

Patient, Parent, or Guardian Signature_____ Date _____

(revised 8/20/19)

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Authorization for Medical, Health and/or Nutrition Services: Pursuant to this Client Registration Agreement ("Agreement"), I/we authorize the professionals and staff at Well Integrative Medicine ("Well") to administer such medical, health care and/or nutrition services, treatments and procedures for me or my/our children as they deem appropriate and necessary under the applicable circumstances. I/we understand that they will prescribe an integrative program that may include conventional health care, nutritional therapies, homeopathy, functional medicine and other elements of integrative medicine. I/we acknowledge and agree that in connection with any births or adoptions, the doctor/patient relationship shall begin with the first physical examination and not at birth.

I/we understand that if any explanations as to benefits and/or risks and dangers of the prescribed treatments or services are unclear, it is my responsibility to ask for clarification before giving my consent. I/we understand that there have been and can be no warranties, representations or assurances of successful outcomes for me or my children. Nevertheless, I desire to pursue integrative medical treatment or nutrition services for myself or my children after reviewing the information herein and receiving answers to any questions related to this agreement. As a patient or parent seeking medical, health care and/or nutrition services, I/we understand that I/we are ultimately responsible for selecting and approving recommended treatments and services (or rejecting recommended treatments/services) for me or my children. I/we understand that Well believes that all parents/guardians should vaccinate their children.

I/we will report to Well any matters arising out of treatments or services and schedule a consultation to conduct appropriate follow-up. I/we will promptly seek medical attention from Well or another medical facility if any of us experience any unanticipated effects associated with treatments and services or if I/we or my children's condition worsens. If a medical emergency arises, I/we will call 911 or visit the nearest hospital emergency room.

Initials:_____. Please initial here and sign the last page to indicate you have read and accept the terms of this section. If patient is a minor, at least one parent and/or authorized legal guardian must initial and sign.

Scheduling Your Initial Consult: Please follow the procedure listed in the new patient checklist to book your appointment. Once we have received all of your paperwork we will call you to schedule your initial consult. Dr. Weiler values her patients' time and we strive to book appointments appropriately. When you schedule your initial consult, Dr. Weiler's staff will take credit card information from you to reserve your appointment. This information will be kept confidential in our secure electronic medical record system and your credit card will not be charged but will be used to guarantee your appointment.

After Hours Phone Coverage: We check telephone messages during business hours and respond to them on a regular basis throughout the week. Outside of regular business hours, if you feel that any medical matter is too urgent to wait for us to call you back the next business day, you may call our office at 773.784.7000 and press zero during the recorded message to be promptly connected with a live operator. Dr. Weiler or a covering medical professional will respond to you (usually in less than one hour). After hours phone calls that result in a referred visit to the emergency room or a next day acute office visit will not incur any charges. For all other after-hours calls there will charge (starting at $50) billed directly to your credit card. Of course, if you or your children are experiencing a medical emergency, please call 911 or go directly to an emergency room.

Cancellation Policy: I/we understand that the professional's time is reserved exclusively for my/our children's care for the duration of all scheduled visits. I/we understand that I/we are expected to keep all appointments as scheduled in order to ensure maximum progress in connection with treatment and care and that if I/we are late for an appointment, the visit will end at the scheduled time and I/we will be responsible for the cost of the full visit. If I/we need to cancel or reschedule an appointment, I/we will call during business hours at least two business days in advance. No charge will apply in this situation. As an illustration, if an appointment is on a Monday, canceling during business hours on the prior Thursday provides two business days' notice. I/we understand that if I/we cancel an appointment during business hours only one business day prior to the scheduled visit, I/we will be charged a fee equal to the greater of $75 or 50% of the cost of the scheduled appointment. I/we understand that if I/we cancel on the day of the appointment or fail to show, I/we will be charged a fee representing the full cost of the scheduled appointment.

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Email and Telephone Consultation Policy: In our practice, we do not recommend using email as a method of communication for corresponding with patients regarding medical concerns. We ask that patients call our office with any medical questions or concerns. We value face to face communication wherever possible and only discuss medical or confidential matters in person or over the phone. However, patients are welcome to use our secure email portal for non-urgent matters. In general, Well members will not be charged for brief and uncomplicated email questions. However, I/we understand and agree that where one or a series of emails takes 7-10 minutes or more to read and reply or is in lieu of an in-person or phone consultation, I/we will be billed at the current in–person consultation rate, which I/we authorize to be charged to the credit card on file. By sending an email, I/we acknowledge and agree that a prompt reply is NOT required or expected and acknowledge that I/we will not use email communications to deal with emergencies or other time sensitive issues. I/we also understand and agree that email communications may not be secure and the confidentiality of emails cannot be assured or guaranteed, but agree that this is my/our risk with respect to all email communications. Well may keep copies of email communications and such messages may be included in my/our children's or my health record. When any medical or health related matter requires an urgent response, I/we agree to call Well during business hours or to page the doctor after hours (773.784.7000). For all emergencies, I/we will call 911 or go directly to the nearest hospital emergency room.

Patients are allotted 2 complimentary brief calls (7-10 minutes in length) with the doctor per year. All other phone consultations will be billed at the same consultation rate as in-person visits, which I/we authorize to be charged to the credit card on file.

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Insurance Responsibility and Claims Management: I/we acknowledge that Well expects that all of its patients will maintain health insurance coverage. It is my/our responsibility to know my/our plan benefits and to obtain insurance advice from my/our own licensed insurance agent, broker or human resource professional. Given the uncertainty that pervades insurance decisions, I/we agree that Well is not responsible for any information related to my/our insurance that turns out to be incorrect. I/we agree that Well is not obligated to take action on my/our behalf against an insurance company related to any insurance claim or payment.

I/we will be responsible for all charges and fees incurred for treatments or services rendered to me or my children, even if my/our insurance company determines that any services are non-covered or excluded. I/we understand that insurance reimbursement may not be available for some services. I understand that my/our insurer and my/our children's insurer may not reimburse me/us for office visits, telephone consultations or emails including but not limited to circumstances where the focus of the consultation is on prevention, education, wellness, nutrition advice, herbal medicine, etc. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics, may also not be reimbursed. Additionally, I/we understand that the monthly program or membership fee paid for each patient will not be reimbursed by my/our children's insurer.

Well practitioners do not see, evaluate or treat worker's compensation cases.

Initials:_____. Please initial here and sign the last page to indicate you have read and accept the terms of this section. If patient is a minor, at least one parent and/or authorized legal guardian must initial and sign.

Financial Responsibility and Authorization for Payment: I/we understand that payment for all services, treatments, products and other fees will be required in advance for several programs, or at each visit and after each other service related matter. I/we authorize Well to charge all outstanding balances to my/our credit card indicated below. Well does not accept personal checks. I/we authorize this credit card (and all substituted credit cards) to be used to guarantee and pay for late cancellations and missed appointments and unpaid balances including those related to office visits, telephone/e-mail consultations, vaccines, charges for products and supplements and miscellaneous costs. I/we agree that if the credit card on file does not accept the charge, I/we will immediately make

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payment to Well for the amount due and will provide an alternative Visa/MC/AMEX/Discover account number upon request if my/our current credit card account is over limit, canceled or expired.

When I/we join Well for medical and health care services, I/we agree that Well has the right to assess a monthly program or membership fee for each patient based on the then applicable fee schedule for their corresponding treatment plan. I/we authorize Well to charge the initial fee to my/our credit card when I/we are admitted to the practice and renew the fee by charging the then applicable program or membership fee to the credit card on file unless I/we withdraw from the practice prior to the applicable anniversary date of joining the practice. I/we understand and agree that the renewal fee will increase periodically based on cost of living or other factors considered relevant by Well. If my/our program or membership at Well expires or I/we cancel the program or membership, Well is authorized to charge my/our credit card on file for any unpaid balances. My/our signature(s) below verify that I/we have reviewed and consent to the financial terms set forth herein.

Visa/MC/Amex (circle type) Card #: _____

Name on credit card: _____ Expiration Date:_____

Security Code:_____ Authorized Signature:_____

Health Information Release Authorization and Privacy Practices: Well is permitted by applicable federal and state privacy laws to use and disclose your protected health information (PHI) for treatment, payment and health care operations and for other purposes as required or permitted by law. Our Notice of Privacy Practices, as it may be amended from time to time (the "Notice"), is available by mail upon request or in person at our office. I/we authorize Well to release my/our children's PHI in connection with treatment, payment for services and its health care operations and as provided in the Notice, which is incorporated into this Agreement by reference. I/we understand that the Notice may be modified or amended by Well on the basis described in the Notice. I/we also authorize any physician or health care provider that I am/my children are seeing or have seen, to release their protected health information records to Well. This authorization extends to my protected health information records, if applicable.

Complaints, Comments and Questions: Well is committed to providing quality care and resolving favorably any complaint, problem, question or unsatisfactory experience that might occur in connection with Well's practice or services. For all members or prospective members, it is Well's policy that (i) if any person has a complaint or problem or unsatisfactory or negative experience related to our practice, services or products, that person immediately bring the matter to the attention of the practice privately, by email, phone or in person; and (ii) As it is the sincere desire of Well, it's practitioners and staff to provide quality care to patients, Well will investigate any such matter and attempt in good faith, to reasonably and appropriately resolve the matter. By signing this Agreement, I/we agree to comply fully with this policy. Simply put, Well requests it's patients to share any complaints or concerns about the practice with Well practitioners and staff quickly and directly rather than sharing frustrations with others or posting frustrations to social media before contacting the practice.

We at Well sincerely want our patients to give us the courtesy of sharing their concerns first with us, so we may have the opportunity to resolve any problems or issues quickly and thoughtfully with the patient.

Duration of Agreement, Revocations of Authorizations and Amendments: I/we may revoke the PHI release authorization in writing at any time and Well will attempt to accommodate all reasonable requests, however, I understand that in some circumstances related to treatment, payment or health care operations, Well may not be able to accommodate such requests. I further agree that in no event will any revocation of a prior authorization affect any of my other obligations in this Agreement. The rights and obligations of the parties herein shall be fully applicable. I/ my children am/are enrolled in this practice to receive medical and health care and for no other purpose. This Agreement and the Notice, along with any agreement to arbitrate, reflects the entire and exclusive agreement between us and supersedes any prior or other contemporaneous agreement. This Agreement may only be amended by a written document signed by Well and each of the undersigned.

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I/we have reviewed this Agreement and accept the above terms. I/we are authorized to sign this Registration Agreement and Acknowledgment for myself and/or my children and have executed it in Chicago, Illinois as of the _ day of_____ , 20 ___:

_____ _____

Patient/Parent or Guardian Signature Patient/Parent or Guardian Signature

_____ _____

Printed Name Printed Name

(Instruction: The authorized signer for the above credit card must initial this agreement in each place indicated and sign directly on the line above. Thank you.)

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New Adult Patient History Form

Dear *Well* patient:
Welcome to ***Well!*** To help establish you with our practice, please provide us with your complete health history—body, mind, and spirit. Thank you!

Personal History

Name: _____ Date of Birth ___/___/___ Age: _____

Occupation: _____ Birthplace: _____ Date of last Exam: _____

Your Doctor: _____ Referred to us by: _____

Main Concerns/Reasons for Appointment (If possible, rank in terms of importance to you).

1. _____
2. _____
3. _____

Note that we may not be able to address every problem during the course of one visit.

How long have you suffered from these concerns? _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

_____

What have you tried to do to resolve this/these problems that <u>did not work</u>?

_____

_____

What makes you feel better? What makes you feel worse?

_____

_____

What do you feel needs to happen for you to get better?

_____

_____

Are you visiting us to: ☐ resolve your immediate problem? ☐ begin a lifestyle program for optimized living? ☐ both? or ☐ other?:

_____

_____

Current Medications (prescription, non-prescription, birth control, vitamins, supplements and/or herbs)**:**
Name of Medication: *Dose:* *Times/Day:*

_____

_____

_____

_____

Allergies (including any drugs, foods, latex) – what was your reaction?

_____

_____

Recent Travel History:

_____

_____

Personal Current and Past Medical History:
Have you ever had any problems in the following areas? (Check all that apply.)

☐ Asthma
☐ Allergies
☐ Bladder problems
☐ Diabetes
☐ Epilepsy/seizures
☐ Gallbladder
☐ Headaches
☐ Heart problems
☐ Hepatitis
☐ High or low blood pressure
☐ HIV/AIDS
☐ Intestinal problems
☐ Kidney problems
☐ Liver problems
☐ Lung problems
☐ Menstrual problems
☐ Mood issues (anxiety, depression)
☐ Prostate problems
☐ Skin condition
☐ Sleep issues
☐ Stomach problems
☐ Thyroid problems
☐ Urinary problems
Other:_____

_____

_____

_____

Family Medical History:
Please list any medical problems for each of the following blood relatives:

Mother:_____

Father:_____

Siblings:_____

Maternal grandparents:_____

Paternal grandparents:_____

Do you have any relatives with any of the following illnesses? (If yes, please check and indicate which relative.)

	Relative/Relationship:		*Relative/Relationship:*
☐ Heart attack	_____	☐ Colon cancer	_____
☐ High cholesterol	_____	☐ Ovarian cancer	_____
☐ High blood pressure	_____	☐ Prostate cancer	_____
☐ Diabetes	_____	☐ Skin cancer	_____
☐ Breast cancer	_____	☐ Sickle cell disease	_____

Surgical/Hospitalization History:

List surgeries and/or hospitalizations: Date: Location:

_____

_____

_____

Health Screening History (Men and Women):

When was your last -- Tetanus _____ Hep B _____ Pneumonia _____ Flu Vaccine _____

Women – When was your last?

Pap smear: _____ What was the result? _____ Ever have abnormal pap? _____ Ever treated?_____

Mammogram: _____ What was the result? _____ Ever have abnormal mammogram?_____

Bone Density Scan:_____ What was the result? _____

Colonoscopy: _____ What was the result? _____

Men - When was your last?

PSA (blood test for prostate): _____ Do you perform testicular self-exams? Yes☐ No☐

Colonoscopy: _____ What was the result? _____

Dental History

Regular Brushing? Yes ☐No☐ Regular Flossing? Yes☐ No☐

Dental Procedures: _____ Ever had Silver Mercury Fillings? Yes☐ No☐

Sleep

Average number of hours of sleep per night: _____ Feel tired upon awakening? Yes☐ No☐

Problems with insomnia? Yes☐ No☐ Problems falling asleep? Yes☐ No☐

Problems with snoring? Yes☐ No☐ Use of sleeping aids? Yes☐ No☐

Environmental/Detoxification History

Do you have a known history of significant exposure to any harmful chemicals such as the following?

Herbicides Yes☐ No☐ Organic Solvents Yes☐ No☐

Insecticides (frequent visits of exterminator) Yes☐ No☐ Heavy Metals Yes☐ No☐

Pesticides Yes☐ No☐ Other:_____

Chemical Name, Date, Length of Exposure: _____

Have you been exposed to water leaks? Yes ☐ No☐

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? Yes ☐ No☐

Do you have any pets or farm animals? Yes ☐ No☐ If yes, explain: _____

Social History (Circle appropriate response.)

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

_____

Education Level: High School ☐ College ☐ Professional School ☐ Other _____

_____

Do you smoke cigarettes? Yes ☐ No ☐ If yes, how many packs per day and for how many years?

_____

Did you ever smoke? Yes ☐ No ☐ If yes, how many packs per day & for how many years? When did you quit?

_____

Do you drink alcohol? Yes ☐ No ☐ If yes, how much, what type, & how many drinks per week?

_____

If you do consume alcohol, please select the response to each item that best describes how you have felt and behaved over your whole life)

Have you ever felt you should cut down on your drinking? Yes ☐ No ☐

Have people annoyed you by criticizing your drinking? Yes ☐ No ☐

Have you ever felt bad or guilty about drinking? Yes ☐ No ☐

Have you ever had a drink 1st thing in the morning to steady your nerves or get rid of a hangover? Yes ☐ No ☐

Do you drink caffeinated beverages? Yes☐ No☐ If yes, what types and how many cups per day?

_____

Do you use recreational drugs? Yes☐ No☐ If yes, which ones and how often?

_____

Do you exercise regularly? Yes☐ No☐ If no, why not? If yes, how often? What do you do?

_____

Do you enjoy your job? Yes☐ No☐ If no, why not?

_____

Do you allow time to relax? Yes☐ No☐ If no, why not?

_____

Have you ever sought counseling? Yes☐ No☐ If yes, when and for what reason?

_____

Are you currently sexually active? Yes☐ No☐ If yes, do you practice safe sex?

_____

Are you satisfied with your sex life? Yes☐ No☐ If no, why not?

_____

Are you satisfied with your social life? Yes☐ No☐ If no, why not?

_____

Are you satisfied with your spiritual life? Yes☐ No☐ If no, why not?

_____

Do you practice meditation or relaxation? Yes☐ No☐ If yes, what type? How often?

_____

Have you ever experienced significant trauma or abuse? Yes☐ No☐ If yes, have you sought treatment? When?

_____

Do you wear a helmet when biking? Yes☐ No☐ N/A

_____

Diet

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Typical Snack(s): _____

Living Arrangement

How many people are living in the household? _____

Names/Relationship to you (including children):

_____

_____

Lifestyle/Self-Care Issues-Stress/Coping

Daily Stressors: Rate each on a scale from 1-10 (1 being the least stress and 10 being the most stress)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Resources for emotional support: Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other _____

Devices you use: (Circle appropriate responses.)

Eyeglasses ☐ Contact Lenses ☐ Hearing Aid ☐ Dentures ☐

Brace (Neck/Brace) ☐ Pacemaker ☐ IUD, Diaphragm ☐ Artificial Limbs ☐

If we were to sit down and discuss your life <u>3 years</u> from now and look back at today, what would have to have happened for you to be happy with your progress?(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

_____

_____

Where do you picture yourself being in the next 3-5 years if your health concerns in particular, are not taken care of?

_____

_____

_____

_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____

_____

_____

_____

What are your strengths that will enable you to accomplish your goals?

_____

_____

_____

_____

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and would enjoy a mentor to help you?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Do you have any other questions or would you like any information about a specific health related topic?

_____

_____

_____

_____

Patient Signature _____ **Date** _____

Provider Signature _____ **Date** _____

Neurotransmitter Assessment Form™ (NTAF)

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

Please circle the appropriate number 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 new things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament generally getting worse? 0 1 2 3
- Is your attention span decreasing? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you become fatigued when driving compared to in the past? 0 1 2 3
- How often do you become fatigued when reading compared to in 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 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 light-headedness 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

- How often do you get fatigued after meals? 0 1 2 3
- How often do you crave sugar and sweets after meals? 0 1 2 3
- How often do you feel you need stimulants, such as coffee, after meals? 0 1 2 3
- How often 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 increased? 0 1 2 3
- How often do you gain weight when under stress? 0 1 2 3
- How often do you have difficulty falling asleep? 0 1 2 3

SECTION 1

- Are you losing interest in hobbies? 0 1 2 3
- How often do you feel overwhelmed? 0 1 2 3
- How often do you have feelings of inner rage? 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 your 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

- 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

- How often do you feel anxious or panicked 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

- Do you feel your visual memory (shapes & images) has decreased? 0 1 2 3
- Do you feel your verbal memory has decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity decreased? 0 1 2 3
- Has your comprehension 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 a slower mental response? 0 1 2 3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Specific Sertonergic Antidepressants (NaSSAas)

- ☐ Remeron®
- ☐ Zispin®
- ☐ Avanza®
- ☐ Norset®
- ☐ Remergil®
- ☐ Axit®

Tricylic Antidepressants (TCAs)

- ☐ Elavil®
- ☐ Endep®
- ☐ Tryptanol
- ☐ Trepiline®
- ☐ Asendin®
- ☐ Asendis®
- ☐ Defanyl®
- ☐ Demolox®
- ☐ Moxadil®
- ☐ Anafranil®
- ☐ Norpramin®
- ☐ Pertofrane®
- ☐ Thaden™
- ☐ Prothiaden®
- ☐ Adapin®
- ☐ Sinequan®
- ☐ Tofranil®
- ☐ Janamine®
- ☐ Gamanil®
- ☐ Aventyl®
- ☐ Pamelor®
- ☐ Opipramol®
- ☐ Vivactil®
- ☐ Rhotrimine®
- ☐ Surmontil®

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil®
- ☐ Zoloft®
- ☐ Prozac®
- ☐ Celexa®
- ☐ Lexapro®
- ☐ Esertia®
- ☐ Luvox®
- ☐ Cipramil®
- ☐ Emocal®
- ☐ Seropram®
- ☐ Cipralex®
- ☐ Fontex®
- ☐ Priligy®
- ☐ Seromex®
- ☐ Seronil®
- ☐ Sarafem®
- ☐ Fluctin®
- ☐ Faverin®
- ☐ Seroxat®
- ☐ Aropax®
- ☐ Deroxat®
- ☐ Rexetin®
- ☐ Paroxat®
- ☐ Lustral®
- ☐ Serlain®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Norpramin®
- ☐ Cymbalta®

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

Monoamine Oxidase Inhibitors (MAOIs)

- ☐ Marplan®
- ☐ Aurorix®
- ☐ Manerix®
- ☐ Moclodura®
- ☐ Nardil®
- ☐ Adeline®
- ☐ Eldepryl®
- ☐ Azilect®
- ☐ Marsilid®
- ☐ Iprozid®
- ☐ Ipronid®
- ☐ Rivivol®
- ☐ Propilniazide®
- ☐ Zyvox®
- ☐ Zyvoxid®

Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)

- ☐ Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

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

GABA Antagonist Competitive Binder

- ☐ Romazicon®

Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax®
- ☐ Lexotanil®
- ☐ Lexotan®
- ☐ Librium®
- ☐ Klonopin®
- ☐ Valium®
- ☐ ProSom®
- ☐ Rohypnol®
- ☐ Magadon®
- ☐ Dalmane®
- ☐ Ativan®
- ☐ Loramet®
- ☐ Sedoxil®
- ☐ Dormicum®
- ☐ Serax®
- ☐ Restoril®
- ☐ Halcion®

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lunesta®
- ☐ Imovane®

Acetylcholine Receptor Agonists

- ☐ Urecholine®
- ☐ Evoxac®
- ☐ Anectine®
- ☐ Salagen®
- ☐ Isopto®
- ☐ Nicotine

Acetylcholine Receptor Antagonists Antimuscarinic Agents

- ☐ AtroPen®
- ☐ Scopace®
- ☐ Atrovent®
- ☐ Spiriva®

Acetylcholine Receptor Antagonists Ganglionic Blockers

- ☐ Inversine®
- ☐ Nicotine (high doses)
- ☐ Hexamethonium
- ☐ Arfonad®

Acetylcholine Receptor Antagonists Neuromuscular Blockers

- ☐ Atracurium
- ☐ Cisatracurium
- ☐ Doxacurium
- ☐ Metocurine
- ☐ Mivacurium
- ☐ Pancuronium
- ☐ Rocuronium
- ☐ Anectine®
- ☐ Tubocurarine
- ☐ Vecuronium
- ☐ Hemicholinium

Acetylcholinesterase Reactivators

- ☐ Protopam®

Cholinesterase Inhibitors (reversible)

- ☐ Aricept®
- ☐ Razadyne®
- ☐ Exelon®
- ☐ Cognex®
- ☐ THC
- ☐ Carbamate insecticides
- ☐ Enlon®
- ☐ Prostigmin®
- ☐ Antilirium®
- ☐ Mestinon®

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Flexyx®
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

SMGENTAF04(013013)

Please refer to prescribing physician for nutritional interactions with any medications you are taking.

Metabolic Assessment Form™

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

PART I

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

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number 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 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, pains, 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 movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of 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
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus 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

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
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
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 IX

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 X

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 XI

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

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Category XII

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 XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a 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 XIV

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 XV

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 XVI

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

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(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 XVIII *(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 XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes			No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

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

How many times do you eat fish per week? _____

How many times do you work out per week? _____

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

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

PART IV

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

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