

# Wellness Dimensions, llc

TODAYS DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

CLIENT'S NAME: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (M) \_\_\_\_\_

NICKNAME: " \_\_\_\_\_ "

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_ GENDER: MALE OR FEMALE

WEIGHT \_\_\_\_\_ LBS BLOOD TYPE \_\_\_\_\_ ( POS OR NEG )

MARITAL STATUS: MARRIED DIVORCED WIDOWED SINGLE

PARENTS/GUARDIANS NAMES: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK # W EXT: ( ) \_\_\_\_\_ EXT \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY PHONE: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

DATE OF LAST MEDICAL EXAM + REASON FOR VISIT: \_\_\_\_\_

NAME OF PRIMARY CARE PHYSICIAN (PCP): DR: \_\_\_\_\_

PCP PHONE NUMBER: ( ) \_\_\_\_\_ PCP FAX: ( ) \_\_\_\_\_

DATE OF MOST RECENT LAB WORK: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*PLEASE INCLUDE COPIES OF LABS & PERTINENT MEDICAL RECORDS (< 6 MONTHS) WITH THIS FORM\*\***

## HOW DID YOU FIND US . . .

INTERNET  DOCTOR  FAMILY/FRIEND \_\_\_\_\_

PROMOTION / EVENT  PATIENT: \_\_\_\_\_

OTHER: \_\_\_\_\_

# Wellness Dimensions, LLC

PLEASE LIST CURRENT HEALTH CONDITIONS AND YOUR GOALS FOR MAKING THIS APPOINTMENT:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

ADDITIONAL COMMENTS:

DO YOU HAVE ANY KNOWN ALLERGIES AND/OR SENSITIVITIES TO:

DRUGS / MEDICATIONS (PLEASE LIST): (IF NONE - PLEASE MARK NONE)

\_\_\_\_\_  
\_\_\_\_\_

FOODS (PLEASE LIST): (IF NONE - PLEASE MARK NONE)

\_\_\_\_\_  
\_\_\_\_\_

ENVIRONMENTAL ITEMS / CHEMICALS (PLEASE LIST): (IF NONE - PLEASE MARK NONE)

\_\_\_\_\_  
\_\_\_\_\_

- AS A GENERAL RULE, DO YOU REQUIRE: NORMAL\_\_\_\_, LOW\_\_\_\_, OR HIGH\_\_\_\_ DOSES OF MEDICATIONS / SUPPLEMENTS, ETC TO GET DESIRED EFFECTS?

PLEASE EXPLAIN: IF NOT NORMAL: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- CAN YOU SWALLOW CAPSULES     YES     NO     YES, BUT WITH SOME DIFFICULTY

# Wellness Dimensions, LLC

PLEASE LIST ALL RX AND OVER THE COUNTER MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING

Medication	Dosage	Freq	How long	Reason for taking

Supplement Name	Dosage	Freq	Source	Reason for taking

## DO YOU FOLLOW ANY SPECIAL FOOD RESTRICTIONS

SOY     DAIRY     WHEAT     GLUTEN     CORN     EGGS     YEAST     SUGAR

OTHER INFORMATION YOU FEEL IS IMPORTANT:

# Wellness Dimensions, llc

PLEASE LIST THE NUMBER OF SERVINGS PER DAY OF EACH OF THE FOLLOWING ITEMS:

SODA \_\_\_\_\_ DIET SODA \_\_\_\_\_ ALCOHOL \_\_\_\_\_ COFFEE \_\_\_\_\_ WATER \_\_\_\_\_ DAIRY \_\_\_\_\_ TEA \_\_\_\_\_ MEAT \_\_\_\_\_  
CARBS \_\_\_\_\_ FAST FOOD \_\_\_\_\_ FRUIT \_\_\_\_\_ VEGGIES \_\_\_\_\_ NUTS & SEEDS \_\_\_\_\_ SALT \_\_\_\_\_ OTHER \_\_\_\_\_

INDICATE THE AMOUNT OF EACH OF THE FOLLOWING THAT YOU USE:

CIGARETTES \_\_\_\_\_ PACKS PER DAY, FOR \_\_\_\_\_ YEARS CHEWING TOBACCO \_\_\_\_\_ TIMES PER DAY, FOR \_\_\_\_\_ YEARS  
RECREATIONAL DRUGS (LIST TYPE AND HOW OFTEN AND HOW LONG): \_\_\_\_\_

EXERCISE: PLEASE INDICATE YOUR EXERCISE HABITS BELOW:

WHAT TYPE OF EXERCISE DO YOU PERFORM? \_\_\_\_\_

HOW FREQUENTLY DO YOU EXERCISE? \_\_\_\_\_ DAYS PER WEEK - HOW MANY HOURS PER DAY \_\_\_\_\_

HOW LONG HAVE YOU BEEN EXERCISING CONSISTENTLY? \_\_\_\_\_ YEARS / MONTHS

WHAT IS YOUR CURRENT WEIGHT? \_\_\_\_\_ LBS 1 YEAR AGO: \_\_\_\_\_ LBS IDEAL WEIGHT? \_\_\_\_\_

PSYCHOLOGICAL/EMOTIONAL/MENTAL (CIRCLE ANY THAT APPLY)

DEPRESSION ANXIETY PANIC ATTACKS ANGER AGITATION MEMORY DISTURBANCES PERSONALITY CHANGES  
HALLUCINATIONS HEADACHES MIGRAINES SLEEP DISTURBANCES OTHER: \_\_\_\_\_

HAVE YOU EXPERIENCED ANY MAJOR GRIEFS, REGRETS R TRAUMATIC EXPERIENCES:

Birth to 10 years	10 to 20	20 to 30	30 to 40	40 plus

HAVE YOU EVER CONSIDERED SUICIDE? YES NO IF YES PLEASE EXPLAIN

HAVE YOU EVER ATTEMPTED SUICIDE? YES NO IF YES PLEASE EXPLAIN

HAVE YOU EVER UTILIZED PSYCHOLOGICAL COUNSELING OF ANY KIND? IF SO, PLEASE EXPLAIN

DO YOU SUFFER FROM ANY OF THE FOLLOWING FEARS OR PHOBIAS?

HEIGHTS CROWDS INSECTS LONELINESS THE DARK THUNDERSTORMS DEATH IMPENDING DOOM DOGS CATS  
SNAKES MICE WATER CLOSED-IN-SPACES FINANCIAL CONCERNS SPIDERS SCORPIONS PUBLIC SPEAKING  
OTHER: \_\_\_\_\_

# *Wellness Dimensions, LLC*

## FAMILY HISTORY

	SELF	MOTHER	FATHER	SIBLINGS	CHILDREN	GRANDPARENTS
ADD/ADHD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
AUTISM, PDD, ASPERGER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ANEMIA - TYPE _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ARTHRITIS - TYPE _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ALCOHOLIC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ALLERGIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ASTHMA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BIRTH DEFECTS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BIRTH TRAUMA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BLOOD PRESSURE - HIGH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CANCER - TYPE _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHOLESTEROL - HIGH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHRONIC FATIGUE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COLITIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CONVULSIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DEPRESSION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DIABETES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DRUG ADDICTIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ECZEMA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EPILEPSY/SEIZURES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FIBROMYALGIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GALL BLADDER DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GASTRITIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GERD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GLASSES /CONTACTS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEADACHES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEART DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV / AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEMORRHOIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEPATITIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HYPOGLYCEMIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IRRITABLE BOWEL SYND (IBS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
AUTOIMMUNE DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MENTAL ILLNESS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OSTEOPOROSIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RHEUMATIC FEVER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LYMES DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SHINGLES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEIZURES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INSOMNIA / SLEEP DISORDER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STROKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
THYROID DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ULCER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ULCERATIVE COLITIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ABNORMAL WEIGHT GAIN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ABNORMAL WEIGHT LOSS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PROSTATE ISSUES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**SOCIAL HISTORY**

DO YOU ENJOY YOUR JOB / CAREER? YES NO PLEASE EXPLAIN IF NO:

\_\_\_\_\_

**RECREATIONAL ACTIVITIES, SPORTS PLAYED AND HOBBIES:**

- \_\_\_\_\_  CURRENT  PAST
- \_\_\_\_\_  CURRENT  PAST
- \_\_\_\_\_  CURRENT  PAST
- \_\_\_\_\_  CURRENT  PAST
- \_\_\_\_\_  CURRENT  PAST

**FEMALE:** PLEASE CIRCLE ANY THAT APPLY TO YOU

HYSTERECTOMY TUBAL LIGATION BREAST CANCER CERVICAL CANCER PERI-MENOPAUSAL MENOPAUSAL STD'S  
HOT FLASHES IRREGULAR MENSES VAGINAL DISCHARGE PAINFUL PERIODS FIBROCYSTIC BREASTS PCOS  
ENDOMETRIOSIS DISCHARGE FROM BREAST DECREASED LIBIDO INCREASED LIBIDO UTERINE CANCER  
UTERINE FIBROIDS VAGINAL YEAST INFECTIONS HEAVY MENSES PMS OTHER: \_\_\_\_\_

DATE OF LAST MENSES: \_\_\_\_/\_\_\_\_/\_\_\_\_ # OF DAYS OF MENSES: \_\_\_\_ CYCLE LENGTH: \_\_\_\_ DAYS

DATE OF LAST PAP SMEAR: \_\_\_\_/\_\_\_\_/\_\_\_\_ HAVE YOU EVER HAD ABNORMAL PAP: YES NO

EVER BEEN ON BIRTH CONTROL, HRT, OR IUD? YES NO

WHAT TYPE, WHEN HOW LONG? \_\_\_\_\_

# OF PREGNANCIES (G) \_\_\_\_\_ # OF LIVE BIRTHS (P) \_\_\_\_\_ # OF MISCARRIAGES \_\_\_\_\_

# OF ABORTIONS \_\_\_\_\_

# *Wellness Dimensions, LLC*

**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 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
- Frequent use of laxatives      0 1 2 3

## Category II

- Excessive belching, burping      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/veggies - see food in stools      0 1 2 3
- Excessing bloating during and/or after meals      0 1 2 3

## Category III

- Stomach pain, burning or aching 1-4 hours after eating      0 1 2 3
- Frequent use of antacids      0 1 2 3
- Feeling hungry an hour or two after eating      0 1 2 3
- Heartburn when lying down or bending forward      0 1 2 3
- Temp relief from antacids, food, milk, carbonated drinks      0 1 2 3
- Cramping pain and tenderness just under sternum      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 IX

## 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 m      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
- Notice you have a hard time detoxifying      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, 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
- Increased thirst & 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 XIV (Male Only)

# *Wellness Dimensions, LLC*

Cannot fall asleep	0 1 2 3	Urination difficulty or dribbling	0 1 2 3
Perspire easily	0 1 2 3	Urination frequent	0 1 2 3
Under high amounts of stress	0 1 2 3	Pain inside of legs or heels	0 1 2 3
Weight gain when under stress	0 1 2 3	Feeling of incomplete bowel evacuation	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3	Leg nervousness at night	0 1 2 3
Excessive perspiration or perspire w minimal activity	0 1 2 3		
No reason for elevated Blood Pressure	0 1 2 3		

## Category X

Tired, sluggish	0 1 2 3
Feel cold - hands, feet, all over	0 1 2 3
Require excessive amts of sleep to function properly	0 1 2 3
Broken and/or peeling fingernails	0 1 2 3
Increase in weight gain even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Constipation - difficult bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches, 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	0 1 2 3
Dryness of Skin and/or Scalp	0 1 2 3
Mental Sluggishness	0 1 2 3
Foggy thinking	0 1 2 3
Low Basal body temperature	0 1 2 3
Elevated Cholesterol and/or Triglycerides	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
Increase in frequency of headaches	0 1 2 3
Notice rapid weight gain	0 1 2 3
Blood pressure increasing	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 / Joint soreness that is unusual	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
Hot Flashes	0 1 2 3
Bone loss (bone density issues)	0 1 2 3

## Category VI (Menstruating Females Only)

Are you perimenopausal	Yes	No
Alternating menstrual cycle	Yes	No
Extended menstrual cycle, greater than 32 days	Yes	No
Shortened menstrual cycle, 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 break outs	0 1 2 3	

## Category XVII (Menopausal Females Only)

How many years have you been menopausal?	<input type="text"/>
Do you ever have uterine bleeding since menopause?	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
Increased vaginal dryness and itching	0 1 2 3
Facial hair growth and/or acne	0 1 2 3

# Wellness Dimensions, LLC

## CONTEXT OF CARE

WHY DID YOU CHOOSE TO COME TO THIS CLINIC?

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DO YOU THINK THE SIGNS AND SYMPTOMS YOU ARE EXPERIENCING COULD BE PURPOSEFUL OR FOR A REASON? COULD THEY BE THE BODY'S WISDOM SAYING "I NEED SOME HELP... LET'S CHANGE A FEW THINGS IN MY LIFE"??

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HOW LONG DO YOU THINK/FEEL IT WILL TAKE TO RESOLVE THESE CONDITIONS? (PLEASE EXPLAIN)

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HOW STRONG IS THE POSSIBILITY FOR YOU TO MAKE SOME NECESSARY LIFESTYLE CHANGES IF DETERMINED THIS WILL BE NECESSARY TO ACHIEVE YOUR GOALS. PLEASE RATE ON SCALE OF 1 TO 10 WITH 10 BE THE STRONGEST YOUR WILLINGNESS TO MAKE NECESSARY LIFESTYLE CHANGES:

1      2      3      4      5      6      7      8      9      10



## FINANCIAL AGREEMENT

THANK YOU FOR CHOOSING WELLNESS DIMENSIONS, LLC AS PART OF YOUR HEALTH AND WELLNESS TEAM. WE DO NOT TAKE LIGHTLY THE DECISION YOU HAVE MADE TO ENTRUST US IN PROVIDING YOU AND/OR YOUR FAMILY ADVICE FOR THE CONCERNS TO BE DISCUSSED.

PLEASE READ THE FOLLOWING FINANCIAL POLICY, SIGN, AND SUBMIT AS PART OF YOUR "NEW PATIENT INTAKE FORM". NEW PATIENTS ARE ASKED TO FILL OUT OUR INTAKE FORM PRIOR TO THEIR APPOINTMENT.

## FUNCTIONAL MEDICINE FEES

**INITIAL (NEW PATIENT) CONSULTATION FEES** (BASED ON TIME AND COMPLEXITY):

- RANGES FROM \$260 - \$500 (AVG LENGTH IS 60 - 120 MINUTES)

**FOLLOW-UP CONSULTATION AND LAB REVIEW FEES** (BASED ON TIME AND COMPLEXITY):

- \$55 PER 15 MINUTES (AVG 30 TO 60 MINUTES)

**VENIPUNCTURE:**

- \$20 PER DRAW

**LABORATORY TESTING:**

- RANGES FROM \$10 PER TEST TO \$2500 PER TEST DEPENDING ON THE TEST

**RX NUTRITIONALS:**

- VARIES FROM CASE TO CASE

**PLEASE NOTE: A 50% DEPOSIT FEE IS REQUIRED WHEN SCHEDULING A NEW PATIENT CONSULTATION. IF APPOINTMENTS ARE CANCELLED OR RE-SCHEDULED TWO BUSINESS DAYS PRIOR TO YOUR APPOINTMENT, DEPOSIT AMOUNT IS FULLY TRANSFERABLE TO ANOTHER DATE OR REFUNDABLE (LESS \$25.00 CANCELLATION FEE).**

- THE REMAINDER OF YOUR BALANCE IS DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, AMEX, AND DISCOVER

**IT IS STRONGLY RECOMMENDED TO SCHEDULE 75 MINUTES FOR NEW PATIENT CONSULTATIONS.**

**PLEASE NOTE THAT WE DO NOT FILE FOR INSURANCE. IN ADDITION, WE CANNOT ACCEPT MEDICARE OR MEDICAID FROM ANY STATE.** WE WILL GIVE YOU A COPY OF YOUR RECEIPT AT THE COMPLETION OF YOUR APPOINTMENT FOR YOU TO SUBMIT TO YOUR INSURANCE COMPANY. THE RECEIPT YOU WILL RECEIVE INCLUDES THE STANDARD BILLING AND CODING INFORMATION, WHICH IS REQUIRED BY INSURANCE COMPANIES WHEN YOU FILE YOUR CLAIM. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. THE BILL IS YOUR RESPONSIBILITY AT THE TIME OF SERVICES, REGARDLESS OF YOUR INSURANCE COMPANY'S CONTRIBUTION. PLEASE BE AWARE THAT SOME, AND PERHAPS ALL, OF THE SERVICES PROVIDED MAY BE "NON-COVERED" SERVICES AND NOT CONSIDERED REASONABLE AND NECESSARY UNDER YOUR INSURANCE PLAN. YOU ARE RESPONSIBLE FOR PAYMENT IN FULL REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES. WE THINK YOU WILL FIND THAT THESE PROCEDURES ARE SIMILAR TO OTHER OFFICES THAT OFFER ALTERNATIVE MEDICINE TREATMENTS. INSURANCE COMPANIES THAT REQUIRE ADDITIONAL INFORMATION CREATE AN ADDED BURDEN AND EXPENSE TO OUR OFFICE – PLEASE BE AWARE OF THE FOLLOWING CHARGES:

**CHARGES FOR ADDITIONAL INFORMATION INCLUDE:**

COPIES: \$0.25 PER PAGE; SHORT/LONG INSURANCE FORM: \$15.00/\$25.00; MEDICAL LETTER OF NECESSITY: \$40.00-50.00 (IF DRAFTED BY PATIENT & E-MAILED IN WORD DOCUMENT-\$20.00-30.00); NARRATIVE REPORT: \$100.00- \$250.00; ADMINISTRATIVE TIME WILL BE CHARGED ACCORDINGLY AT \$25.00 PER HOUR AND/OR DOCTOR'S TIME AS THE RATES COMMENSURATE WITH APPOINTMENTS. WE CANNOT SEND OUT THIS INFORMATION UNTIL FEES ARE PRE-PAID.

**HEALTH CARE PRIVACY NOTICE**

**IF YOU WOULD LIKE A MORE DETAILED NOTICE - PLEASE ASK FOR A COPY**

WELLNESS DIMENSIONS IS COMMITTED TO PROVIDING OUR PATIENTS WITH QUALITY HEALTH AND WELLNESS SERVICES DELIVERED WITH INTEGRITY AND COMPASSION. FULFILLING THIS COMMITMENT REQUIRES THE EFFORTS OF OUR STAFF AND DOCTORS WORKING TOGETHER AS A TEAM TO PROVIDE YOU WITH THE BEST EXPERIENCE POSSIBLE. PATIENT SATISFACTION AND EXCEEDING YOUR EXPECTATIONS AND INDUSTRY STANDARDS IS A VITAL INTEREST TO ALL OF US AT WELLNESS DIMENSIONS, LLC.

THIS OFFICE IS REQUIRED BY LAW TO ABIDE BY THE TERMS OF THIS HEALTH CARE PRIVACY NOTICE AS WELL AS OTHER APPLICABLE FEDERAL AND STATE LAWS GOVERNING PRIVACY PRACTICES IN HEALTH CARE. OUR OFFICE MAY CHANGE AND/OR MODIFY THE TERMS OF THIS NOTICE AT ANYTIME WITHOUT ADDITIONAL NOTICE TO YOU EXCEPT TO PUBLICLY POST IN OUR OFFICE AND/OR MAKE AVAILABLE TO PATIENTS ANY UPDATED NOTICES. PHOTOCOPY OF THIS NOTICE IS AVAILABLE TO YOU UPON REQUEST.

OUR OFFICE IS COMMITTED TO MAINTAINING THE PRIVACY OF YOUR PROTECTED HEALTH INFORMATION (PHI). PHI IS INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC INFORMATION THAT MAY BE RELATED TO YOUR PRESENT, FUTURE AND PAST HEALTH INFORMATION AND THE CARE AND TREATMENT YOU RECEIVE FROM OUR OFFICE. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE AND DIRECT QUESTIONS, MISUNDERSTANDINGS OR CONCERNS TO SOMEONE IN OUR OFFICE.

OUR OFFICE MAY USE AND DISCLOSE YOUR PHI FOR HEALTH CARE DELIVERY PURPOSES. YOUR PHI MAY BE USED AND/OR DISCLOSED WITHOUT YOUR WRITTEN AUTHORIZATION BY THE DOCTORS AND STAFF OF THIS OFFICE FOR THE PURPOSE OF YOUR CARE AND TREATMENT; PAYING YOUR HEALTH CARE BILLS; AND TO SUPPORT THE OPERATIONS OF THE PRACTICE. YOUR DOCTOR AND THE STAFF WILL TAKE ALL REASONABLE MEASURES TO MAINTAIN THE CONFIDENTIALITY OF YOUR PHI.

THE PRIVACY RULE ALLOWS YOU THE RIGHT TO REVIEW AND RECEIVE COPIES OF YOUR HEALTH CARE RECORDS AS IT RELATES TO YOUR HEALTH AND WELLNESS CARE. THE REQUEST MUST BE IN WRITING, ALLOWING YOUR PROVIDER 30 DAYS TO RESPOND. YOUR PROVIDER MAY DENY YOUR REQUEST IF IT MAY CAUSE HARM TO YOU OR ANOTHER PERSON. YOUR PROVIDER MAY CHARGE A COPY FEE, WHICH WILL BE IN COMPLIANCE WITH STATE LAW. YOUR PROVIDER WILL COMPLY WITH ANY REASONABLE REQUEST TO HAVE CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION IF NOT DOING SO ENDANGERS YOU.

YOU MAY REQUEST TO HAVE AN AMENDMENT PLACED ON YOUR RECORD IF YOU DISAGREE WITH ANYTHING IN YOUR RECORD. THIS DOES NOT MEAN THAT ANYTHING WILL BE REMOVED OR CHANGED AND THE PROVIDER HAS THE RIGHT TO RESPOND WITH A REBUTTAL STATEMENT IF HE FEELS IT IS NECESSARY. YOU MAY REVOKE AUTHORIZATION, IN WRITING, AT ANY TIME, EXCEPT IN THE EVENT THAT THE PROVIDER HAS ACTED AS INDICATED IN THE DOCTORS AUTHORIZATION NOTICE.

YOU HAVE THE RIGHT TO FILE A WRITTEN COMPLAINT WITH OUR OFFICE IF YOU BELIEVE THAT ANY OF OUR PRIVACY RIGHTS HAVE BEEN VIOLATED. YOU CAN OBTAIN A COMPLAINT FORM WITH THE OFFICE OF CIVIL RIGHTS. ALL COMPLAINTS MUST BE FILED WITHIN 180 DAYS OF WHEN YOU KNEW OR SHOULD HAVE KNOWN THAT THE VIOLATION OCCURRED. THE PRIVACY LAW PROHIBITS OUR OFFICE FROM TAKING ANY RETALIATORY ACTIONS AGAINST ANYONE WHO FILES A COMPLAINT. A MORE DETAILED, UPDATED AND COMPREHENSIVE HEALTH CARE PRIVACY NOTICE IS AVAILABLE FOR YOUR REVIEW IN THE OFFICE.

**LABORATORY INFORMED CONSENT**

WELLNESS DIMENSIONS, LLC OFFERS LABORATORY TESTING FOR THE PURPOSE OF BIOCHEMICAL ASSESSMENT OF OUR CLIENTS. WE UTILIZE ASSESSMENTS AS A TOOL TO ASSIST YOU AND YOUR PRACTITIONER IN THE DEVELOPMENT OF A THERAPEUTIC REGIMEN. IF FINDINGS FROM THESE LABORATORY ASSESSMENTS WARRANT A REFERRAL TO ANOTHER PRACTITIONER, THIS WILL BE DISCUSSED WITH YOU.

SINCE NUTRITIONAL DEFICIENCIES AND BIOCHEMICAL ABNORMALITIES MAY OR MAY NOT BE ASSOCIATED WITH A SPECIFIC DISEASE(S), IT IS IMPORTANT FOR YOU TO UNDERSTAND FULLY THAT OUR SOLE CONCERN IN YOUR CASE WILL BE YOUR NUTRITIONAL PROGRAM AND YOUR ABILITY TO METABOLIZE AND UTILIZE THE NUTRIENTS YOU CONSUME. THE LABORATORY ASSESSMENTS ARE TOOLS USED WITH SUCCESS TO IDENTIFY ABNORMALITIES AND TO ASSIST IN THE DEVELOPMENT OF YOUR NUTRITIONAL PROGRAM AND OTHER NECESSARY RECOMMENDATIONS.

WE DO NOT TREAT OR CURE ANY SPECIFIC DISEASE. THE NUTRITIONAL RECOMMENDATIONS MADE BASED ON LABORATORY TESTS, PHYSICAL AND CLINICAL FINDINGS, HISTORY AND SYMPTOMS, DOES NOT CONSTITUTE TREATMENT OF ANY SPECIFIC DISEASE OR AFFLICTION, RATHER A SUPPORT AND BALANCING OF NORMAL PHYSIOLOGY.

# Wellness Dimensions, llc

IN THE MANAGEMENT OF CLIENTS AND THEIR HEALTH CONCERNS, WE ROUTINELY RECOMMEND A VARIETY OF DIFFERENT VITAMINS, MINERALS, ENZYMES, HERBS, HOMEOPATHICS, PHYTOPHARMACEUTICALS AND OTHER NUTRITIONAL SUBSTANCES AND MODALITIES. IN THE EVENT THAT ANY VITAMIN, MINERAL, FOOD, OR NUTRITIONAL SUBSTANCE IS RECOMMENDED TO YOU, WE WANT YOU TO UNDERSTAND THAT ITS PURPOSE WILL BE FOR:

1. THE IMPROVEMENT OF YOUR OVERALL NUTRITIONAL STATUS AND HOMEOSTASIS
2. TO IMPROVE YOUR METABOLIC FUNCTION
3. TO IMPROVE YOUR OVERALL SENSE OF WELL-BEING

HOWEVER, YOU MAY NOT RECEIVE ANY OF THESE BENEFITS BECAUSE THEY DO NOT OCCUR PREDICTABLY WITH EVERY SINGLE CLIENT, AND IN SOME CLIENTS THEY MAY NOT OCCUR AT ALL.

WHILE ALL REGULATORY AGENCIES AND ASSOCIATIONS MAY NOT BE IN AGREEMENT, WE AT WELLNESS DIMENSIONS, LLC ARE CERTAIN THAT NUTRITIONAL STATUS AND BIOCHEMICAL HOMEOSTASIS ARE ESSENTIAL FOR OPTIMAL HEALTH AND WELL BEING.

## CONSENT AND SIGNATURE

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY HEALTH AND WELLNESS AND MUST FULLY COMMIT AND PARTICIPATE FOR HEALING TO TAKE PLACE. I AM VOLUNTARILY CHOOSING TO USE INTEGRATIVE/FUNCTIONAL/NATUROPATHIC/HOLISTIC MEDICINE TO OPTIMIZE MY HEALTH AND WELL BEING. BY SIGNING BELOW, I ACKNOWLEDGE AND UNDERSTAND THAT THIS TYPE OF MEDICAL TREATMENT IS NOT CONSIDERED 'STANDARD OF CARE' IN CONVENTIONAL MEDICAL CIRCLES AND THAT I VOLUNTARILY AM CHOOSING THIS TYPE OF HEALTH CARE BECAUSE I BELIEVE THAT IT WILL BE OF BENEFIT TO ME. I ALSO AGREE THAT I HAVE READ AND FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICIES, FEES, AND PROCEDURES. THE SIGNATURE BELOW ALSO GIVES CONSENT FOR THE TREATMENT OF THE MINOR (IF LESS THAN 18) FOR WHOM I AM LEGALLY RESPONSIBLE.

\_\_\_\_\_  
SIGNATURE OF PATIENT/RESPONSIBLE PARTY

DATE: \_\_\_\_\_

\_\_\_\_\_  
PRINT NAME