APPOINTMENT INSTRUCTIONS

1. To best serve you, please return your completed paperwork at least one week prior to your initial appointment.

2. In your initial visit, you will be given preliminary tests, determined by your practitioner based on your intake paperwork. These are all non-invasive and done in-office. Tests may include:
   - Meta Oxy Urine Analysis (determines cellular inflammation)
   - HRV Heart Rate Variability Testing (assesses the functioning of the nervous system)
   - Body Composition
   - Oligo Scan (determines heavy metal toxicity and mineral levels)

3. To prepare for these tests:
   - Knowing your blood type is a prerequisite for the Oligo Scan. Blood Type tests are available for purchase.
   - Please refrain from alcohol, exercise, and sauna use for 8 hours prior to your appointment.
   - Please come prepared to give a small urine sample.
   - Please avoid natural diuretics (such as caffeine) and supplements on the day of your visit.
   - If possible, do not drink fluids 1 hour prior to your appointment.
   - Please take any medications as directed by your medical doctor.

4. What do you need to bring?
   - You are welcome to bring your significant other with you to your initial visit. It will help you on your health journey to have the understanding and support of loved ones.
   - Please bring copies of any recent lab work (done within one year) to your appointment.

5. What is the policy on rescheduling this appointment?
   - Should you need to reschedule your initial appointment, our clinic requires at least 72 hours notice.
   - Since there is a great deal of preparatory work for your visit, there will be a 10% administrative charge for all cancellations of an initial appointment.
   - No refund will be given in the event of late arrival or no-show because we have set aside this time for you in our schedule.

PLEASE DO NOT WEAR ANY TYPE OF FRAGRANCES, AS WE HAVE CHEMICALLY SENSITIVE CLIENTS.

Total Health
NUTRITION CENTER

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clinic@totalhealthinc.com

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Name:				Date:			
Address:				Unit:			
City:				State:		Zip:	
Phone	Home:		Mobile:		Work:		
Email Address:							

Date of Birth:		Gender: □ Male□ Female

Age:		Height:		Weight:	

Physical Activity Level: Please choose one: __ No exercise, __Some exercise, __Moderate exercise, __Athletic

Status:

☐Married
☐Separated
☐Divorced
☐Widowed
☐Single
☐Partnership

Live with:

☐Spouse
☐Partner
☐Parents
☐Children
☐Friends
☐Alone

Education:

Occupation: Hours per week: ☐Retired

Primary Care Provider

In case of emergency, whom should we contact?

Name	Relationship	Address	Phone

Do you consume alcoholic beverages? If yes, how much and how frequently? _____

Do you use (or have you used in the past)tobacco products? If so, how much and how often?_____

Do you consume caffeinated beverages and/or soda? If so, which products?_____

How did you hear about our Wellness and Nutrition Program?

_____

_____

What are your major health concerns? Please list when each symptom began and be as descriptive as possible.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What are your current prescription medications, how long have you been on them and what health issues are they addressing?

What are your current vitamins and/or supplements?

What hobbies do you, or have you enjoyed?

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

Is there anything else in your medical history that you consider to be relevant? (even from childhood)?

Please list past or present allergies, including allergies to medications.

Please list all past surgeries and the condition treated, including dates.

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Heavy Metals

☐Yes	☐No	Do you have amalgam (silver) fillings in your teeth? If yes, how many? _____
☐Yes	☐No	Have you ever had an amalgam removed? If yes, how many?_____
☐Yes	☐No	If you had amalgams removed, was it done by a biological dentist using a safe protocol?
☐Yes	☐No	Did your mother have amalgam when pregnant with you?
☐Yes	☐No	Have you ever worked in a dental office? If so, how long? _____
☐Yes	☐No	Do you have any dental crowns, bridges, root canals, tooth extractions or dental devices? If so, please circle.
☐Yes	☐No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
☐Yes	☐No	Have you noticed any adverse reactions to these shots?
☐Yes	☐No	Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?
☐Yes	☐No	Do you use conventional deodorant and/or aluminum pots and pans?

General Toxin Exposures

☐Yes	☐No	Have you ever had any major chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
☐Yes	☐No	Do you have your house sprayed with pesticides, herbicides (ex. Round-up) or insect repellant?
☐Yes	☐No	Do you use conventional skin care products and sunscreen?
☐Yes	☐No	Do you use conventional cosmetics, perfume or cologne?
☐Yes	☐No	Do you get your hair colored or use aerosol hairspray? If so, please circle.
☐Yes	☐No	Do you get your nails done? If so, how often? _____
☐Yes	☐No	Do you use air fresheners in your house, work or car?
☐Yes	☐No	Do you drink filtered water? If so, what type of filter do you have?_____
☐Yes	☐No	Do you drink bottled water? If so, what kind?_____
☐Yes	☐No	Does your spouse or other family members work around chemicals?

Mold

☐Yes	☐No	Do you see or smell mold at home, work, school or in your vehicle?
☐Yes	☐No	Have you ever had water damage at home, work or school?
☐Yes	☐No	Does spending time in your basement cause or worsen your symptoms?
☐Yes	☐No	Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
☐Yes	☐No	Do you experience chronic sinus infections or asthma symptoms?

Health/Family History

☐Yes	☐No	Do you or anyone in your family have a history of cancer?
☐Yes	☐No	Do you or anyone in your family have a history of autoimmune disorders?
☐Yes	☐No	Do you or anyone in your family have a history of heart disease or stroke?
☐Yes	☐No	Do you or anyone in your family have a history of mental illness?
☐Yes	☐No	Have you ever been diagnosed with or suspect Lyme Disease?
☐Yes	☐No	Have you ever been in an auto accident, fallen or received a major physical injury?

Microbiome Health

☐Yes	☐No	Do you get foul or sulfur smelling gas, distention, bloating, belching, or acid reflux? If so, please circle.
☐Yes	☐No	Are you sensitive to supplements?
☐Yes	☐No	Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?
☐Yes	☐No	Have you taken birth control or Hormone Replacement Therapy for any length of time?
☐Yes	☐No	Have you been on antibiotics for any extended period of time as a child or as an adult?
☐Yes	☐No	Were you caesarian delivered?
☐Yes	☐No	Were you breast fed? If so, how long? _____
☐Yes	☐No	Do you have a daily bowel movement? If so, how many times per day? _____

Please keep an accurate three-day food and drink diary

	DAY ONE	DAY TWO	DAY THREE
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			

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Dietary Information

How many adults and children do you feed in your family?_____

How often do you eat out per week?_____

What restaurants do you frequently eat at?_____

Where do you grocery shop? _____

Do you have any known food allergies or intolerances?_____

Do you have any strong food cravings or dislikes?_____

Do you follow any particular diet? (Paleo, Keto, Gluten-free, Dairy-free, etc.)_____

Who prepares the food at home?_____

Who does the grocery shopping?_____

Do you enjoy cooking?_____

How can we best help your improve your nutrition?_____

_____

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Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug; NEITHER is a mineral, trace element, amino acid, herb, or homeopathic remedy.

Although a vitamin, a mineral, trace element, amino acid, or herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, supplement recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body. We may use a Metatron Class II FDA approved BioFeedback device. This is biofeedback and is not able to diagnosis a medical condition, or treat a specific condition.

I have read and understand the above information:

_____ _____

Signature Date

SYMPTOM SURVEY FORM

INSTRUCTIONS: Fill in only the boxes which apply to you.

☒	☐	☐	**MILD** (occurred once or twice last 6 months)
☐	☒	☐	**MODERATE** (occurred once or twice last month)
☐	☐	☒	**SEVERE** (chronic, occurred once or twice last week)
☐	☐	☐	Leave **BLANK** if they don't apply to you

	1	2	3	**Group 1**
1	☐	☐	☐	Acid foods upset
2	☐	☐	☐	Get chilled often
3	☐	☐	☐	"Lump" in throat
4	☐	☐	☐	Dry mouth-eyes-nose
5	☐	☐	☐	Pulse speeds after meal
6	☐	☐	☐	Keyed up – fail to calm
7	☐	☐	☐	Cut heals slowly
8	☐	☐	☐	Gag easily
9	☐	☐	☐	Unable to relax: startles easily
10	☐	☐	☐	Extremities cold, clammy
11	☐	☐	☐	Strong light irritates
12	☐	☐	☐	Urine amount reduced
13	☐	☐	☐	Heart pounds after retiring
14	☐	☐	☐	"Nervous" stomach
15	☐	☐	☐	Appetite reduced
16	☐	☐	☐	Cold sweats often
17	☐	☐	☐	Fever easily raised
18	☐	☐	☐	Neuralgia-like pains
19	☐	☐	☐	Staring, blinks little
20	☐	☐	☐	Sour stomach often

	1	2	3	**Group 2**
21	☐	☐	☐	Joint stiffness on rising
22	☐	☐	☐	Muscle-leg-toe cramps at night
23	☐	☐	☐	"Butterfly" stomach, cramps
24	☐	☐	☐	Eyes or nose watery
25	☐	☐	☐	Eyes blink often
26	☐	☐	☐	Eyelids swollen, puffy
27	☐	☐	☐	Indigestion soon after meals
28	☐	☐	☐	Always seems hungry; feels light headed often
29	☐	☐	☐	Digestion rapid
30	☐	☐	☐	Vomiting frequent
31	☐	☐	☐	Hoarseness frequent
32	☐	☐	☐	Breathing irregular
33	☐	☐	☐	Pulse slow, feels irregular
34	☐	☐	☐	Gagging reflex slow
35	☐	☐	☐	Difficulty swallowing
36	☐	☐	☐	Constipation, diarrhea alternating
37	☐	☐	☐	"Slow starter"
38	☐	☐	☐	Get "chilled" infrequently
39	☐	☐	☐	Perspire easily
40	☐	☐	☐	Circulation poor, sensitive to cold
41	☐	☐	☐	Subject to colds, asthma, bronchitis

	1	2	3	**Group 3**
42	☐	☐	☐	Eat when nervous
43	☐	☐	☐	Excessive appetite
44	☐	☐	☐	Hungry between meals
45	☐	☐	☐	Irritable before meals
46	☐	☐	☐	Get "shaky" if hungry
47	☐	☐	☐	Fatigue, eating relieves
48	☐	☐	☐	"Lightheaded" if meals delayed
49	☐	☐	☐	Heart palpitates if meals missed or delayed
50	☐	☐	☐	Afternoon headaches
51	☐	☐	☐	Overeating sweets upsets
52	☐	☐	☐	Awaken after a few hours' sleep – hard to get back to sleep
53	☐	☐	☐	Crave candy or coffee in afternoons
54	☐	☐	☐	Moods of depression – "blues" or melancholy
55	☐	☐	☐	Abnormal craving for sweets or snacks

	1	2	3	Group 4
56	☐	☐	☐	Hands & feet go to sleep easily, numbness
57	☐	☐	☐	Sigh frequently, "air hunger"
58	☐	☐	☐	Aware of "breathing heavily"
59	☐	☐	☐	High altitude discomfort
60	☐	☐	☐	Opens windows in closed rooms
61	☐	☐	☐	Susceptible to colds and fevers
62	☐	☐	☐	Afternoon "yawner"
63	☐	☐	☐	Get "drowsy" often
64	☐	☐	☐	Swollen ankles, worse at night
65	☐	☐	☐	Muscle cramps, worse during exercise; get "charley horses"
66	☐	☐	☐	Shortness of breath on exertion
67	☐	☐	☐	Dull pain in chest or radiating into left arm, worse on exertion
68	☐	☐	☐	Bruise easily, "black and blue" spots
69	☐	☐	☐	Tendency to anemia
70	☐	☐	☐	"Nose bleeds" frequently
71	☐	☐	☐	Noises in head or ringing ears
72	☐	☐	☐	Tension under breastbone, or feeling of "lightness" worse on exertion

	1	2	3	Group 5
73	☐	☐	☐	Dizziness
74	☐	☐	☐	Dry Skin
75	☐	☐	☐	Burning feet
76	☐	☐	☐	Blurred vision
77	☐	☐	☐	Itching skin and feet
78	☐	☐	☐	Excessive falling hair
79	☐	☐	☐	Frequent skin rashes
80	☐	☐	☐	Bitter, metallic taste in mouth in mornings
81	☐	☐	☐	Bowel movements painful or difficult
82	☐	☐	☐	Worrier, feels insecure
83	☐	☐	☐	Feeling queasy; headache over eyes
84	☐	☐	☐	Greasy foods upset
85	☐	☐	☐	Stools light colored
86	☐	☐	☐	Skin peels on foot soles
87	☐	☐	☐	Pain between shoulder blades
88	☐	☐	☐	Use Laxatives
89	☐	☐	☐	Stools alternate from soft to watery
90	☐	☐	☐	History of gallbladder attacks or gallstones
91	☐	☐	☐	Sneezing attacks
92	☐	☐	☐	Dreaming, nightmare type bad dreams
93	☐	☐	☐	Bad breath (halitosis)
94	☐	☐	☐	Milk products cause distress
95	☐	☐	☐	Sensitive to hot weather
96	☐	☐	☐	Burning or itching anus
97	☐	☐	☐	Crave Sweets

	1	2	3	Group 6
98	☐	☐	☐	Loss of taste for meat
99	☐	☐	☐	Lower bowel gas several hours after eating
100	☐	☐	☐	Burning stomach sensations, eating relieves
101	☐	☐	☐	Coated tongue
102	☐	☐	☐	Pass large amounts of foul-smelling gas
103	☐	☐	☐	Indigestion ½ - 1 hour after eating; may be up to 3-4 hours
104	☐	☐	☐	Mucous colitis or "irritable bowel"
105	☐	☐	☐	Gas shortly after eating
106	☐	☐	☐	Stomach "bloating" after eating

	1	2	3	Group 7A
107	☐	☐	☐	Insomnia
108	☐	☐	☐	Nervousness
109	☐	☐	☐	Can't gain weight
110	☐	☐	☐	Intolerance to heat
111	☐	☐	☐	Highly emotional
112	☐	☐	☐	Flush easily
113	☐	☐	☐	Night sweats
114	☐	☐	☐	Thin, moist skin
115	☐	☐	☐	Inward trembling
116	☐	☐	☐	Heart palpitates
117	☐	☐	☐	Increased appetite without weight gain
118	☐	☐	☐	Pulse fast at rest
119	☐	☐	☐	Eyelids and face twitch
120	☐	☐	☐	Irritable and restless
121	☐	☐	☐	Can't work under pressure

	1	2	3	Group 7B
122	☐	☐	☐	Increase in weight
123	☐	☐	☐	Decrease in appetite
124	☐	☐	☐	Fatigue easily
125	☐	☐	☐	Ringing in ears
126	☐	☐	☐	Sleepy during day
127	☐	☐	☐	Sensitive to cold
128	☐	☐	☐	Dry or scaly skin
129	☐	☐	☐	Constipation
130	☐	☐	☐	Mental sluggishness
131	☐	☐	☐	Hair coarse, falls out
132	☐	☐	☐	Headaches upon arising, wear off during day
133	☐	☐	☐	Slow pulse, below 65
134	☐	☐	☐	Frequency of urination
135	☐	☐	☐	Impaired hearing
136	☐	☐	☐	Reduced initiative

	1	2	3	Group 7C
137	☐	☐	☐	Failing memory
138	☐	☐	☐	Low blood pressure
139	☐	☐	☐	Increased sex drive
140	☐	☐	☐	Headaches, "splitting or rending" type
141	☐	☐	☐	Decreased sugar tolerance

	1	2	3	Group 7D
142	☐	☐	☐	Abnormal thirst
143	☐	☐	☐	Bloating of abdomen
144	☐	☐	☐	Weight gain around hips or waist
145	☐	☐	☐	Sex drive reduced or lacking
146	☐	☐	☐	Tendency to ulcers, colitis
147	☐	☐	☐	Increased sugar tolerance
148	☐	☐	☐	Women: menstrual disorders
149	☐	☐	☐	Young girls: lack of menstrual function

	1	2	3	Group 7E
150	☐	☐	☐	Dizziness
151	☐	☐	☐	Headaches
152	☐	☐	☐	Hot flashes
153	☐	☐	☐	Increased blood pressure
154	☐	☐	☐	Hair growth on face or body (female)
155	☐	☐	☐	Sugar in urine (not diabetes)
156	☐	☐	☐	Masculine tendencies (female)

	1	2	3	Group 7F
157	☐	☐	☐	Weakness, dizziness
158	☐	☐	☐	Chronic fatigue
159	☐	☐	☐	Low blood pressure
160	☐	☐	☐	Nails weak, ridged
161	☐	☐	☐	Tendency to hives
162	☐	☐	☐	Arthritic tendencies
163	☐	☐	☐	Perspiration increase
164	☐	☐	☐	Bowel disorders
165	☐	☐	☐	Poor circulation
166	☐	☐	☐	Swollen ankles
167	☐	☐	☐	Crave salt
168	☐	☐	☐	Brown spots or bronzing of skin
169	☐	☐	☐	Allergies – tendency to asthma
170	☐	☐	☐	Weakness after colds, influenza
171	☐	☐	☐	Exhaustion – muscular and nervous
172	☐	☐	☐	Respiratory disorders

	1	2	3	Group 8
173	☐	☐	☐	Apprehension
174	☐	☐	☐	Irritability
175	☐	☐	☐	Morbid fears
176	☐	☐	☐	Never seems to get well
177	☐	☐	☐	Forgetfulness
178	☐	☐	☐	Indigestion
179	☐	☐	☐	Poor appetite
180	☐	☐	☐	Craving for sweets
181	☐	☐	☐	Muscular soreness
182	☐	☐	☐	Depression; feeling of dread
183	☐	☐	☐	Noise sensitivity
184	☐	☐	☐	Acoustic Hallucinations
185	☐	☐	☐	Tendency to cry without reason
186	☐	☐	☐	Hair is coarse and/or thinning
187	☐	☐	☐	Weakness
188	☐	☐	☐	Fatigue
189	☐	☐	☐	Skin Sensitive to touch
190	☐	☐	☐	Tendency toward hives
191	☐	☐	☐	Nervousness
192	☐	☐	☐	Headache
193	☐	☐	☐	Insomnia
194	☐	☐	☐	Anxiety
195	☐	☐	☐	Anorexia
196	☐	☐	☐	Inability to concentrate; confusion
197	☐	☐	☐	Frequent stuffy nose; sinus infections
198	☐	☐	☐	Allergy to some foods
199	☐	☐	☐	Loose joints

	1	2	3	FEMALE ONLY
200	☐	☐	☐	Very easily fatigued
201	☐	☐	☐	Premenstrual tension
202	☐	☐	☐	Painful menses
203	☐	☐	☐	Depressed feelings before menstruation
204	☐	☐	☐	Menstruation excessive and prolonged
205	☐	☐	☐	Painful breasts
206	☐	☐	☐	Menstruate too frequently
207	☐	☐	☐	Vaginal discharge
208	☐	☐	☐	Hysterectomy / ovaries removed
209	☐	☐	☐	Menopausal hot flashes
210	☐	☐	☐	Menses scanty or missing
211	☐	☐	☐	Acne, worse at menses
212	☐	☐	☐	Depression of long standing

	1	2	3	MALE ONLY
213	☐	☐	☐	Prostate trouble
214	☐	☐	☐	Urination difficult or dribbling
215	☐	☐	☐	Night urination frequent
216	☐	☐	☐	Depression
217	☐	☐	☐	Pain on inside of legs or heels
218	☐	☐	☐	Feeling of incomplete bowel evacuation
219	☐	☐	☐	Lack of energy
220	☐	☐	☐	Migration aches and pains
221	☐	☐	☐	Tire too easily
222	☐	☐	☐	Avoids activity
223	☐	☐	☐	Leg nervousness at night
224	☐	☐	☐	Diminished sex drive