## 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)
    - HQ Heart Rate Variability Testing (assesses the functioning of the nervous system)
    - Body Composition, including cellular hydration and bone mineral content

3. To prepare for these tests:

    - Please refrain from alcohol, exercise & 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 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?**

    - We highly encourage you to bring your spouse to this appointment. 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 to prepare for your visit, there will be a 10% administrative charge for all cancellations of an initial appointment or a program.**

    - No refund will be given in the event of a 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 VERY SENSITIVE CLIENTS**

**N82 W15485 Appleton Ave**
**Menomonee Falls, WI 53051**
**262-251-2929**
**www.totalhealthinc.com**

**3800 S. Moorland Road**
**New Berlin, WI 53151**
**262-505-5229**
**www.totalhealthinc.com**

| | | | | | |
|---|---|---|---|---|---|
| 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 ☐Widowed
☐Separated ☐Single
☐Divorced ☐Partnership

Live with:

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

Education:

Occupation: Hours per week: ☐Retired

| Employer | Work Address |
|---|---|
| | |

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?_____

How did you hear about our Wellness and Nutrition Program?

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

What are your current medications, how long have you been on them and what health issues were 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)?

What is your employment history? Please provide brief summary, including dates if possible.

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

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

Please explain your housing history (type of homes, where and when).

_____

_____

_____

_____

_____

## Patient History

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

### Mercury

| | | |
|---|---|---|
| ☐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 | Have you had any dental crowns? If yes, how many?_____ |
| ☐Yes | ☐No | Have you had any bridges? |
| ☐Yes | ☐No | Have you had any root canals? |
| ☐Yes | ☐No | Have you had any tooth extractions? |
| ☐Yes | ☐No | Do you have any dental implants, retainers or other metal in your mouth? Explain:_____ |
| ☐Yes | ☐No | Did you wear contact lenses during the 1980's or early 1990's? |
| ☐Yes | ☐No | Did you take oral contraceptives during the 1980's or early 1990's? |
| ☐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 have any tattoos with red ink? |
| ☐Yes | ☐No | Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon? |

### Lead

| | | |
|---|---|---|
| ☐Yes | ☐No | Does your occupation involve soldering or metal salvage? |
| ☐Yes | ☐No | Have you done any old home repair or sandblasting? If so, when?_____ |
| ☐Yes | ☐No | Do you do a lot of painting? |
| ☐Yes | ☐No | Was your home built before 1978? |
| ☐Yes | ☐No | Have you ever worn cosmetics containing kohl (make-up with dark black or deep red pigment)? |
| ☐Yes | ☐No | Are you around a lot of fake leather or vinyl? |
| ☐Yes | ☐No | Do you get stomach aches in the morning? |

## General Toxicity

| | | |
|---|---|---|
| ☐Yes | ☐No | Have you ever lived near a golf course, freeway or tension wires? If yes, please explain. |
| ☐Yes | ☐No | Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.) |
| ☐Yes | ☐No | Do you have your house sprayed with pesticides for pest control? |
| ☐Yes | ☐No | Do you spray herbicide (weed killers) in or around your home? |
| ☐Yes | ☐No | Do you use conventional insect repellants on yourself or family? |
| ☐Yes | ☐No | Do you use conventional sunscreen? |
| ☐Yes | ☐No | Do you use conventional perfume or cologne regulary? |
| ☐Yes | ☐No | Do you get your hair colored? If so, is it on the scalp? |
| ☐Yes | ☐No | Do you use aerosol hairspray? |
| ☐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 | Do you have a water filtration system for your entire house or shower filtration? If so, what type?_____ |
| ☐Yes | ☐No | Does your spouse or other family members work around chemicals? |
| ☐Yes | ☐No | Can you think of any other toxic exposures you may have had? Explain:_____ |

## Mold

How old is the house you are living in? _____ How long have you lived there? _____

Have you noticed any new symptoms since moving in?_____ If so, what?_____

| | | |
|---|---|---|
| ☐Yes | ☐No | Do you see mold growing at home, work or school? |
| ☐Yes | ☐No | Have you ever had water damage at home, work or school? |
| ☐Yes | ☐No | Does your home, workplace or school have a damp or mildew smell? |
| ☐Yes | ☐No | Does spending time in your basement cause or worsen your symptoms? |
| ☐Yes | ☐No | Does your basement ever get wet? |
| ☐Yes | ☐No | Do you have a crawl space? |
| ☐Yes | ☐No | Does your basement or crawl space have a sump pump? |
| ☐Yes | ☐No | Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms? |
| ☐Yes | ☐No | Does your car have a mildew smell? |
| ☐Yes | ☐No | Does anyone in your home have asthma like symptoms? |
| ☐Yes | ☐No | Does anyone in your family have chronic sinus infections or irritations? |

## Lyme

| | | |
|---|---|---|
| ☐Yes | ☐No | Have you ever been diagnosed with Lyme Disease? |
| ☐Yes | ☐No | Have you had dry sockets or infected tooth extractions? |
| ☐Yes | ☐No | Do you have small joint pain? |
| ☐Yes | ☐No | Have you ever been bitten by a tick or recluse spider? |
| ☐Yes | ☐No | Have you ever seen a bulls-eye rash appear on any part of your body? |
| ☐Yes | ☐No | Did the bulls-eye rash appear shortly following a tick, spider bite or time spent outdoors? |
| ☐Yes | ☐No | Was your mother ever diagnosed with Lyme Disease? |
| ☐Yes | ☐No | Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)? |

## Health History

| | | |
|---|---|---|
| ☐Yes | ☐No | Have any members of your family been diagnosed with Fibromyalgia, Chronic Fatigue or Multiple Chemical Sensitivities? |
| ☐Yes | ☐No | Does anyone in your family experience symptoms similar to yours? |
| | | What is your birth order (i.e. first born, second, third, etc.)? _____ |
| ☐Yes | ☐No | Do you have any history of kidney dysfunction? |
| ☐Yes | ☐No | Do you or any immediate family member have a history of cancer? |
| ☐Yes | ☐No | Do you have any history of heart disease, myocardial infarction (heart attack), etc.? |
| ☐Yes | ☐No | Are you currently having any thoughts of suicide? |
| ☐Yes | ☐No | Have you ever been diagnosed with bipolar disorder, schizophrenia or depression? |
| ☐Yes | ☐No | Do you have a history of strokes? |
| ☐Yes | ☐No | Have you ever been diagnosed with diabetes, thyroiditis, or heart disease? |
| ☐Yes | ☐No | Do you or anyone in your family have an autoimmune disorder? |
| ☐Yes | ☐No | Have you ever been in an auto accident, fallen or received a major physical injury? |
| ☐Yes | ☐No | Are you in menopause? |

## Microbiome Health

| | | |
|---|---|---|
| ☐Yes | ☐No | Do you get foul or sulfur smelling gas (distention, bloating, belching, feeling full and a noisy gut) after eating carbohydrates (ie. grains and vegetables) or fermented foods and/or probiotics? |
| ☐Yes | ☐No | Do you often have gas that has a sulfur or foul smell? |
| ☐Yes | ☐No | Are you sensitive to supplements? |
| ☐Yes | ☐No | Have you ever been vegan or vegetarian for any length of time? |
| ☐Yes | ☐No | Can you tolerate meat? |
| ☐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 | If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving? |
| ☐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 | Does your gut temporarily feel better after a round of antibiotics? |
| ☐Yes | ☐No | Do you have a daily bowel movement? If so, how many times per day? _____ |

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

**Point Scale**

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

| Column #1 | |
|---|---|
| | Anxiety |
| | Mood swings |
| | Enraged behavior or anger for no reason |
| | Excessive shyness, timidity, social phobia (not typical to your personality) |
| | Irritability (not typical to your personality) |
| | Low body temperature (below 97.5°) |
| | Insomnia (can't get to sleep or return to sleep |
| | Dizziness |
| | Sound in ears (ringing or hearing your heart beat) |
| | Psychological symptoms, even thoughts of suicide |
| | Sensitivity to sound |

| Column #2 | |
|---|---|
| | Sensitivity to light |
| | Fatigue after exercise (feeling worse) |
| | Poor night vision or seeing halos around lights |
| | Shortness of breath, with very little effort |
| | Excessive thirst and/or frequent urination |
| | Red eyes or tearing |
| | Blurred vision at times |
| | Morning stiffness |
| | Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners, laundry detergents |
| | Chronic fatigue or weakness |
| | Non-restful sleep |

| | |
|---|---|
| | Indecisiveness |
| | Feeling of being overwhelmed or fearful |
| | Metallic taste in your mouth |
| | Bad breath |
| | Bleeding gums |
| | Sensitive teeth |
| | Canker sores or other sores in the mouth |
| | Floaters, shadows or swimmers when you read or look into the sky |
| | Dyslexia or loss of place while reading, even as a child |
| | Swelling eyelids |
| | Peeling of top layer of skin (hands, feet) |
| | Dry skin |
| | Heart pain (angina) and you are under 45 years old |
| | Depression |
| | Gout (arthritic pain, especially in big toes) |
| | Pain in shoulders or upper back |
| | Twitching eyelids |
| | Anemia (low iron/hemoglobin on blood test) |
| | Wrist/ankle drop or weak extensor muscles |
| | Hairloss (not normal male pattern baldness) |

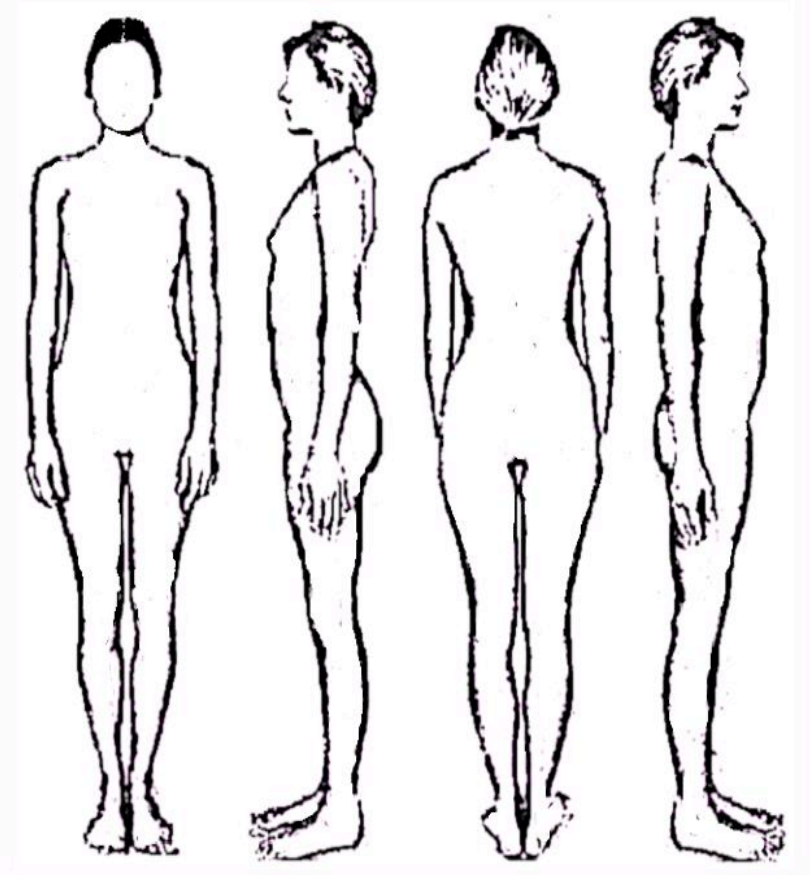
| | |
|---|---|
| | Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.) |
| | Trouble processing new information |
| | Word reversal or trouble finding words |
| | Sensitivity to touch |
| | Short-term memory loss |
| | Chronic sinus congestion |
| | Dry non-productive cough |
| | Muscle twitching |
| | Excessive sweating, especially at night |
| | Joint pain-not necessarily true arthritis-can move from joint to joint |
| | Difficulty losing weight regardless of diet or exercise |
| | Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis |
| | Frequent illness, prolonged illness or sick days |
| | Numbness or weakness in arms and legs |
| | Headaches |
| | Trouble adding or dividing numbers in your head |
| | Fluctuating constipation and diarrhea |
| | Stomach pain for no apparent reason |
| | Appetite swings |
| | Frequent muscle aches, cramps, unusual sharp sudden pains |
| | Rashes or rosacea |
| | Cold extremities (hands and feet) |

| | **Total Columns 1 & 2** |
|---|---|

# Scar/Trauma Sheet

Name: _____
Date: _____

**Directions:** **Please draw an "S" where you have scars, even if they are old (don't forget C-sections, episiotomies, surgeries, childhood injuries, etc.). Please draw an "X" where you have had trauma (for example, put an "X" on neck area if you had a whiplash injury from a car accident or an "X" on your hip if you fell on your hip at one time, etc.).**



# 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

Name: _____ Date: _____

## Please keep an accurate three-day food and drink diary.

| | DAY ONE | DAY TWO | DAY THREE |
|---|---|---|---|
| BREAKFAST | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| SNACK | | | |
| | | | |
| | | | |
| LUNCH | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| SNACK | | | |
| | | | |
| | | | |
| DINNER | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Name: _____ Date: _____

**Please list how many meals you eat out per week and where you typically consume these meals.**

**Breakfast: _____ Days per week.**

**Where: _____**

**Lunch: _____ Days per week.**

**Where: _____**

**Dinner: _____Days per week.**

**Where: _____**

**What time do you wake up in the morning? _____**

**Do you wake up hungry? _____**

**What time do you leave your house for work/school/errands? _____**

**What is your favorite food? _____**

**What is your favorite restaurant? _____**

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

**Do you have a monthly food budget? _____**

**Where do you grocery shop? _____**

**Do you like to entertain or go to gatherings? _____**

**What appliances do you use to prepare your food?**

_____

**Have you ever seen any of the documentaries on how food is processed? (Ex: Food Inc., King Corn, Food Matters, etc.)?_____**