



AlignLife[®]

The Center for Natural Health

Comprehensive Health Appraisal

Please fill this packet out in its entirety to allow the doctor to best evaluate your case. The packet contains a two day diet analysis and therefore must be filled out two days before your appointment.

www.AlignLife.com

What Should I Expect?

Your experience through the Comprehensive Health Assessment will put you on a journey to a new level of health. We have designed this program for those people who are committed to changing their health and willing to become an active participant in the process.

INITIAL CONSULTATION:

The initial consultation will outline a holistic method of approach for your problem by understanding more about you, your lifestyle, your genetic make up, your health history and your diet. Instead of focusing on the disease the person has, we focus on the PERSON that has the disease. The underlining cause of most disease is usually an organ or system of your body that has lost its "organ reserve". What happens when your gas tank goes lower than the tank reserve? Your car stops. When you stress an organ system for decades due to excess stress, poor dietary choices, lack of nutrition, deficient sleep, lack of exercise and a build up of toxicity you will lose your organ reserve which will result in organ dysfunction (disease) and eventually a symptom. Our goal is not to solely focus on the symptom, but the underlining cause of the condition.

LABORATOR TESTING:

The doctor may recommend special laboratory testing to further evaluate your condition. Testing may be completed from blood, urine, saliva or feces. After it is received an individual program will be designed to assist your body in obtaining health. The doctor will set up consultations over a period of time to evaluate and discuss your progress (rates are below).

PAYMENTS:

Since our process and programs are completely different than conventional medicine they are not reimbursed from insurance companies. Although payment is required at the time of service you have the option to apply for our cost effective payment plan, Care Credit. This program helps to make the investment in your health comfortable and stress free. Ask one of our team members about the program if you are interested.

QUESTIONS:

It is important to ask as many questions as possible to empower yourself to understand that your body was designed to be healthy. We will focus on your body's natural ability to heal and we look forward to taking this journey with you.

Nutrition Staff Consultations	Doctor Consultations (In Office or Over Phone)	Examinations
Up to 15 min - \$20	Up to 15 min - \$50	Brief - \$30
Up to 30 min - \$40	Up to 30 min - \$100	Extended - \$50
Up to 45 min - \$60	Up to 45 min - \$150	
Up to 1 hour - \$80	Up to 1 hour - \$200	

I understand the above information: _____ (signature) _____ (date)



Terms of Acceptance for Nutritional Care

We solely provide any suggested nutritional advice or dietary advice, and the adjunctive schedule of nutrition to upgrade the quality of foods and nutrients in your diet and to support the normal processes of your body.

We use diagnostic testing to find dysfunction in the organ systems of the body. We will not use any of the diagnostic testing to diagnose and/or treat disease, but only to enhance the function of the human body. Regardless of what the disease is called, we do not offer to treat it.

A vitamin, mineral, trace element, amino acid or herb is not a drug. Although any of these substances may have an effect on any disease process or symptom, this does not mean that anyone can be misrepresented or classify them as drugs.

I understand *the objectives pertaining to my nutritional care in this office.*

Therefore, I accept nutritional care on this basis.

(Signature)

(Date)

Patient Information

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

E-Mail Address: _____

Birth Date: _____ Gender: M F Marital Status: _____

Social Security Number: _____ Employer: _____

Referred by: _____ Chiropractor: _____

Name all pills that you take (prescriptive, over the counter, vitamins, herbs, etc.):

- | | |
|-----------|-----------|
| 1. _____ | 11. _____ |
| 2. _____ | 12. _____ |
| 3. _____ | 13. _____ |
| 4. _____ | 14. _____ |
| 5. _____ | 15. _____ |
| 6. _____ | 16. _____ |
| 7. _____ | 17. _____ |
| 8. _____ | 18. _____ |
| 9. _____ | 19. _____ |
| 10. _____ | 20. _____ |

Last Blood Test _____ Doctor's Name _____

[Bring all blood tests that you have had done over the last 1-2 years.]

Have you ever had any allergy testing? Yes _____ No _____

If Yes, circle any that apply: Skin Scratch Test Blood Test

Are you aware of any allergies to foods or airborne compounds? If so, please list them below.

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Primary Complaints

Please list below the five or more main complaints you have in the order of importance.

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

Put an X in those boxes applicable to you in the "yes" or "no" space. If lines are provided, write your answer.

Family History													
	Dad	Mom	Brothers			Sisters			Spouse	Children			
Age (if living)													
Health (G) good (B) bad													
Cancer													
Tuberculosis													
Diabetes													
Heart trouble													
High blood pressure													
Stroke													
Epilepsy													
Nervous breakdown													
Asthma, hives, hay fever													
Blood disease													
Age (at death)													
Cause of death													

Personal History									
Have you ever had?	Yes	No	Have you ever had?	Yes	No	Have you ever had?	Yes	No	
Scarlet fever			Gonorrhea Syphilis			Concussion			
Diphtheria			Anemia			Head Injury			
Small pox			Jaundice			Ever knocked unconscious			
Pneumonia			Migraine headaches			Food Chemical Drug Poisoning			
Pleurisy			Tuberculosis			Explain:			
Undulant fever			Diabetes						
Rheumatic fever Heart disease			Cancer						
St. Vitus Dance			High blood pressure Low blood pressure						
Arthritis Rheumatism			Nervous breakdown						
Any Bone disease Joint disease			Hay fever Asthma			Any other diseases:			
Neuritis Neuralgia			Hives Eczema						
Bursitis Sciatica Lumbago			Frequent colds Frequent sore throat						
Polio Meningitis			Any Broken bones Cracked bones						
Bright's disease			Recurrent Dislocations			Weight Now: _____ One year ago: _____ Max: _____ When: _____			

Surgery								
Have you had removed?	Yes	No	Have you had removed?	Yes	No	Have you had?	Yes	No
Tonsils			Ovary Ovaries			Hernia repaired		
Appendix			Hemorrhoids			Hospital for illness		
Gall Bladder			Ever have a transfusion?			Explain:		
Uterus			Blood Plasma					
Other operations			Explain:					

X-Rays				
Ever have X-Rays of:	Yes	No	Date	Disease Present
Chest				
Stomach Colon				
Gall Bladder				
Extremities				
Back				

Habits							
Do you...	Yes	No	Do you use...	Never	Occasionally	Frequently	Daily
Exercise adequately?			Laxatives				
How?			Vitamins				
			Sedatives				
Do weight resistance exercises?			Tranquilizers				
() days a week			Sleeping Pills				
() hours a day			Alcoholic beverages				
Like your work?			Aspirin				
() hours a day			Cortisone pills or injections				
indoors outdoors			Caffeinated beverages				
Watch television?			() cups a day				
() hours a day			Tobacco cigarettes				
Read?			() packs a day				
() hours a day			Cigars Pipe				
Vacation?			Chewing tobacco				
() weeks a year			Snuff				
Ever treated for alcoholism?			Appetite depressants				
Ever treated for drug abuse?			Thyroid meds: Yes ___ Gr. Daily No, but in past Never				
Recreation: Do you participate in sports or hobbies, which give you relaxation at least 3 hours a week?			Have you ever taken?				
			Insulin Tablets for diabetes				
			Hormone shots Hormone tablets				

Sleep: ___ hours a night Hours of sleep: from ___ to ___ Take naps **Y N**
 Trouble getting asleep **Y N** Trouble staying asleep **Y N** Use sleeping aids **Y N**
 Awaken rested **Y N** Quality of Sleep (circle) 1 2 3 4 5 6 7 8 9 10
 Comments _____

Stress: Circle one of the following. "1" is the least and "10" is the greatest.
 Stress at work 1 2 3 4 5 6 7 8 9 10 Stress at home 1 2 3 4 5 6 7 8 9 10

Water Intake: Type of water: Distilled Reverse Osmosis Spring Carbon filtered Well Tap
 Number of 8 oz. glasses of water a day _____

Are Your Health Problems Yeast Connected?	Yes	No
Have you taken repeated "rounds" of antibiotic drugs?		
Have you been troubled by premenstrual tension, abdominal pain, menstrual problems, vaginitis, prostatitis, or loss of sexual interest? (Circle all that apply)		
Does exposure to tobacco, perfume and other chemical odors provoke moderate to severe symptoms? (Circle all that apply)		
Do you crave sugar, breads, or alcoholic beverages? (Circle all that apply)		
Do you have recurrent digestive symptoms?		
Do you suffer from fatigue, depression, poor memory, or "nerves"? (Circle all that apply)		
Do you suffer from hives, psoriasis, eczema or other chronic skin rashes? (Circle all that apply)		
Have you ever taken birth control pills?		
Do you suffer from headaches, muscle and joint pains or incoordination? (Circle all that apply)		
Do you feel bad all over, yet the cause has not been found?		
If you have 3 or 4 "yes" answers, yeasts possibly play a role in causing your symptoms. If you have 5 or 6 "yes" answers, yeasts probably play a role in causing your symptoms. If you have 7 or more "yes" answers, your symptoms are almost certainly yeast-connected. Copyright 1983, William G. Crook, M.D.		

Immune Balance	Yes	No
Do you easily catch colds or flu bugs? (Circle all that apply)		
Are you slow to recover from infections?		
Do you have swollen lymph nodes in neck, armpit, or groin? (Circle all that apply)		
Do you have seasonal allergies?		
Do you experience chronic sinus congestion or post-nasal drip? (Circle all that apply)		
Do you feel worse (within a few hours to two days) after eating certain foods?		
Do you have dark circles under your eyes?		
Do you experience asthma?		
Have you ever been diagnosed with an autoimmune disease?		
Do you experience joint pain?		
Do you suffer from itching of eyes, nose, palate, throat, or skin? (Circle all that apply)		
Are you sensitive to molds, dust, pets, or other parts of the environment? (Circle all that apply)		
Is there a history of cancer in your family?		
Does your diet consist of daily or almost daily intake of any wheat products (breads, pastas, cereals)?		
Do you crave sugar?		
Have you had prolonged or repeated courses of antibiotics at any time in your life?		
Are you having diminished energy or "foggy thinking" processes? (Circle all that apply)		

Nutrition & Digestion	Yes	No
Do you include fast food in your diet?		
Are you on a vegan diet (vegetarian, with no eggs or dairy)?		
Do you have more than 3 alcoholic drinks per week?		
Do you experience belching, bloating, or persistent fullness after eating? (Circle all that apply)		
Do you have a poor appetite?		
Do you have a bad taste in your mouth?		
Have you had a partial or complete loss of taste? (Circle all that apply)		
Do you have intolerance to specific foods?		
Do you have trouble swallowing?		
Do you have a history of anemia?		
Do you see undigested food in your stool or a greasy film on the toilet water? (Circle all that apply)		
Do you have difficulty gaining weight?		
Do you experience acid reflux/heartburn?		
Do you use acid blocking drugs (e.g., Pepcid AC) or antacids? (Circle all that apply)		
Do you use digestive aids (enzymes)?		
Are your fingernails soft brittle, or dotted with white spots? (Circle all that apply)		
Are you prone to muscle cramps?		
Do you have poor night vision?		
Is your skin dry, easily bruised, or slow to heal when injured? (Circle all that apply)		

Endocrine Balance	Yes	No
Do you suffer from chronic stress?		
Do you feel worse from skipping a meal or after eating sweets? (Circle all that apply)		
Do you suddenly feel dizzy upon standing?		
Do you have difficulty sleeping, or wake not feeling refreshed? (Circle all that apply)		
Do you feel more tired or depressed during the winter months?		
Have you had a loss of body hair (men & women) and/or scalp hair (women)?		
Are you sensitive to minor weather changes?		
Does your skin tan without sun exposure?		
Do you crave salt?		
Have you noted mood swings?		
Have you been told you have high blood pressure?		
Have you been told you have high cholesterol or triglycerides in your blood?		
Is there a family history of osteoporosis?		
Has there been a decline in your sex drive?		
Do you suffer from fatigue, constipation, weight gain, dry skin, or chilliness? (Circle all that apply)		
Do you have excess weight around your middle?		
Have you experienced an increase in thirst or urination?		
Do you feel worse during your pre-menstrual time? (women)		
Do you have a history of infertility or miscarriage? (women)		
Have you experienced changed in your menstrual periods? (women)		
Have you felt worse since menopause? (women)		
Have you felt tired or less motivated since turning age 50 or so? (men)		

Detoxification & Elimination		Yes	No
Do you have a history of exposure to chemical or toxic metals in your work or home environment?			
Do you have amalgam (silver) fillings?			
Do you include large fish in your diet (tuna, swordfish, and halibut)?			
Are you sensitive to smells such as car exhaust, perfumes, household cleaners, and cigarette smoke? (Circle all that apply)			
Do you currently take more than one regular medication?			
Are you prone to side effects from medication?			
Do you have trouble with thinking or memory?			
Have you become more sensitive to alcohol?			
Do you have a history of liver disease, hepatitis or mononucleosis? (Circle all that apply)			
Are your muscles stiff or sore, or do they fatigue quickly?			
Do you have frequent headaches?			
Do you have oral sores, dental caries, or gingivitis?			
Do you suffer from constipation and/or diarrhea? (Circle all that apply)			
Do you have dry, hard, or small stool?			
Do you experience frequent gas or bloating?			
Do you suffer from abdominal discomfort or cramping?			
Have you had 2 or more courses of antibiotics in the past year?			
Has there been any foreign travel?			
Have you ever had water from a well or stream?			

General Musculoskeletal					
Do you experience?	Yes	No	Do you experience?	Yes	No
Muscle aches			Tendonitis		
Joint pain			Sciatica		
Joint stiffness			Migraines		
Neck pain			Tension Headaches		
Middle back pain			TMJ		
Lower back pain			Chronic Sinusitis		
Rib pain			Chronic middle ear infections		
Chest pain			Hip pain		
Foot pain			Tingling/numbness of extremities		
Swelling of joints			Weakness of extremities		
Facial pain			Decreased range of motion		
Shoulder pain			Bursitis		
Other:					

DIET ANALYSIS

- Keep an **accurate** record of every food and beverage you consume. Write it down as you eat to help you remember exactly what you ate.
- Be honest. It is important to note everything, including water, to get the most accurate results.
- If eating fast or prepared food, write down the name of the restaurant or brand name with the type of food, e.g., McDonald's Big Mac or Kraft Macaroni and Cheese.
- Try to get an idea of portions by looking at labels. This will make the analysis as accurate as possible. You need to measure meat in ounces, and vegetables, sauces and most other foods in cups ($\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$ or 1). See below for serving size estimating techniques. You can just count eggs.
- Write down how it was cooked (fried, baked, steamed, etc.).
- Keep a two-day record, one day on the weekend and the other on a weekday. Try to pick "normal days" so we can get a true picture of your diet.
- Mail or bring in the diet, and after we complete the analysis we will call you to set up a convenient time for a consultation.

Examples of recording the food

Date / Time	Food / Beverage	Quantity	Preparation Method
1/5/03 6:45AM	Eggs	4	Scrambled
1/5/03 5:30PM	Chicken Breast	3.5 oz	Baked
1/5/03 5:30PM	Mixed Vegetables (carrots, broccoli, cauliflower)	2 Cups	Steamed
1/6/03 12:00PM	McDonald's Big Mac	2	

Serving Size Estimating Techniques

- 3 ounces of meat is about the size and thickness of a deck of playing cards or an audio cassette tape.
- A medium apple or peach is about the size of a tennis ball.
- 1 ounce of cheese is about the size of 4 stacked dice.
- $\frac{1}{4}$ cup of ice cream is about the size of a racquetball or tennis ball.
- 1 cup of mashed potatoes or broccoli is about the size of your fist.
- 1 teaspoon of butter or peanut butter is about the size of the tip of your thumb,
- 1 ounce of nuts or small candies equals one handful.

If you have any questions, please don't hesitate to call our office.

