



## Welcome to Atma Clinic

Congratulations on taking the first steps towards healing and optimal wellness! We are excited to journey alongside you as we work together to help you achieve your personal health goals.

### Communication:

- Excellent communication is part of excellent care. Please feel free to call, text or send us a message through your [patient portal](#) any time with any need. Lawrence office hours are Monday - Friday 8am-4pm. Overland Park office hours are Monday - Thursday, 8am-4pm. Calls received after these times will be returned on the next business day. Please leave a message. If a message is not left, your call will not be returned. If you have a more pressing need please send a detailed text message or email outlining your symptoms, concerns and questions. This will ensure we get adequate details to provide the appropriate response. You may also send your provider a direct message through your patient portal.
- **Atma clinic Lawrence phone number: 785-760-0695 email: [admin@atmaclinic.com](mailto:admin@atmaclinic.com)**
- **Atma clinic OP phone number: 913-568-0608 email: [info@atmaclinic.com](mailto:info@atmaclinic.com)**
- For pressing medical needs outside office hours please use the nurse line: 785-764-4050.
- Administrative issues may not be returned on weekends. However, all clinical issues should be returned in a timely manner. **We will answer phone calls within 24 hours.** We will answer any **patient portal messages or emails within 48 hours. If you do not hear back from us within these times, please contact us again.** If you still feel as if you are having difficulty getting a timely response please contact our clinic manager Sydney Georgie.
- Atma Clinic is committed to providing a safe, secure and respectful environment for our patients and staff. Any words or actions that are threatening or demeaning will not be tolerated and decisive actions taken to protect our patients and staff. Please notify Sydney Georgie or Crystal Olmsted immediately with concerns.

### Emergency Care Policy:

- Atma Clinic does not provide Emergency Services. **If you have a medical emergency call 911 and report to your nearest Emergency Room.** Similarly, we do not provide urgent care services. We cannot be responsible for any delays in care. Please contact the office once the situation has stabilized so that your provider can coordinate with the Emergency Room or Urgent Care staff as necessary.

### Appointment setting:

- When you need to schedule an appointment you may call, text or, go to the patient portal to request an appointment. At each appointment you will go through a routine doctor's office check-in. We will get blood pressure, pulse, review medical history and medications along with collecting any due payments.

### Appointment Cancellations:

- It is your responsibility to notify us at least 24 business hours in advance Monday thru Saturday if you need to cancel your appointment. **Missed appointments and late cancellations will be billed at the standard appointment rate.**

### Clinic Closure:

- We may cancel your appointment for inclement weather, or in the event of severe illness of your provider. Typically, we will close the clinic if there are icy conditions significant enough to create school closures or trigger other government notices. We will notify you as soon as the decision is made. If you have any questions about the adequacy of conditions on a given day, please call your rendering providers office to confirm your appointment.

### Lab protocol:

- Lab appointments are scheduled Monday-Friday mornings. For most labs you will need to be fasting. This means nothing to eat or drink besides water 10-12 hours prior to your appointment time. Please remember that it is fine to drink water and we encourage you to do so up until your appointment.
- Most blood work can be drawn by our staff in our office. Some blood work can be drawn elsewhere, if you desire. However, some specialty labs **MUST** be drawn in our office. **Please note that there is a \$25 venipuncture fee associated with in-house lab draws.** We do our best to schedule all draws in the same appointment to ensure that no more than one fee is applied.
- **Atma Clinic does not bill insurance for routine lab draws.** We have negotiated discounted prices with Labcorp for routine labs which you have access to with your membership.

### Supplements:

- There is a good chance that your plan will include a combination of herbs and supplements. We use an online dispensary called [Full Scripts](#) for prescribing. Once we have implemented your plan, you will receive an email with a link to your prescribed supplements. If at any time you are unable to login to your Full Scripts account or have any questions about a supplement, please give us a call. If you are able to find the exact prescribed supplement elsewhere for less cost please feel free to purchase it. If you get onto Full Scripts to re-order and your supplement is no longer available or on back stock please give our office a call so that we can send you an alternative.

### Financial Policy:

- **Payment is due at the time of service.** In certain cases, a payment plan may be offered. If a payment plan is arranged, it is your responsibility to ensure that the card on file remains active and to promptly update us with any changes to your payment information. Please note that a failed charge may incur a service fee of \$25.

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#### Main Office

1011 Westdale Road  
Lawrence, KS 66049  
785-760-0695  
admin@atmaclinic.com | atmaclinic.com

#### Overland Park Office

10590 Barkley St, Suite 202  
Overland Park, KS 66212  
913-568-0308  
info@atmaclinic.com | atmaclinic.com



Neela Sandal, MD  
Lauren Poull, MD  
Conner Keyeski, APRN, FNP-C  
Susan Dreger, APRN, FNP-C  
Lisa Cason, APRN  
David Lovely, LMAC, LPC, ACHt  
Ashley Combs, BSND

**General Information**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ Email \_\_\_\_\_

Genetic Background:  African American  Hispanic  Mediterranean  Asian  
 Native American  Caucasian  Northern European  
 Other \_\_\_\_\_

When, where and from whom did you last receive medical or health care? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

**Current Health Concerns**

*Please rank current and ongoing health concerns in order of priority*

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

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**Current Prescription Medications**

*Name of Medication*

*Dosage/Strength*

*Directions*


**Current Supplements**

*Name of Supplements (including brand name)*

*Dosage/Strength*

*Directions*


**Allergies***Name of Medication/Supplement/Food**Reaction*


**Surgical History***Type**Date**Comments*

Appendectomy		
Dental		
Gallbladder		
Hernia		
Tonsillectomy		
Joint Replacement		
Heart Surgery		
Hysterectomy		
Other:		
Other:		

**Hospitalizations***Date**Reason*


## Diagnostic Studies

	<i>Date</i>	<i>Comments</i>
Bone Density		
CT Scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Other:		

## Family History

Please check below if any blood relatives have any of the following:

	<i>Relationship</i>		<i>Relationship</i>
<input type="checkbox"/> Cancer		<input type="checkbox"/> Depression	
<input type="checkbox"/> Heart disease		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Allergies	
<input type="checkbox"/> Obesity		<input type="checkbox"/> Eczema	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> ADHD	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Autism	
<input type="checkbox"/> Autoimmune disease		<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Dementia	
<input type="checkbox"/> Kidney disease		<input type="checkbox"/> Substance abuse	
<input type="checkbox"/> Thyroid problems		<input type="checkbox"/> Genetic disorders	
<input type="checkbox"/> Seizures/Epilepsy		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Psychiatric disorder		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Other: _____	

## History

### Patient's Birth/Childhood History:

You were born:  Term  Premature  Unknown

Were there any pregnancy or birth complications?  Yes  No  Unknown

If yes, explain: \_\_\_\_\_

You were:  Breast-fed/ How long? \_\_\_\_\_  Bottle-fed/type of formula? \_\_\_\_\_  Unknown

Age of introduction of: Solid food \_\_\_\_\_ Wheat \_\_\_\_\_ Dairy \_\_\_\_\_

Did you eat a lot of sugar or candy as a child?  Yes  No

As a child, were there any foods that were avoided because they gave you symptoms?  Yes  No  Unknown

If yes, what foods and what symptoms? (example: Milk - gas and diarrhea) \_\_\_\_\_

What were your eating habits like as a child? (List types of food) \_\_\_\_\_

### Dental History:

Check if you have any of the following, and provide number if applicable:

Silver mercury fillings \_\_\_\_\_  Gold fillings \_\_\_\_\_  Root Canals \_\_\_\_\_  Implants \_\_\_\_\_

Caps/Crowns \_\_\_\_\_  Tooth pain \_\_\_\_\_  Bleeding Gums \_\_\_\_\_  Gingivitis \_\_\_\_\_

Problems with chewing \_\_\_\_\_  Other dental concerns (explain): \_\_\_\_\_

Have you had any mercury fillings removed?  Yes  No

If yes, when and how many \_\_\_\_\_

How many fillings did you have as a kid? \_\_\_\_\_

Do you brush regularly?  Yes  No Do you floss regularly?  Yes  No

### Environmental/Detoxification History:

Do any of these significantly affect you?

Cigarette smoke  Perfume/Colognes  Auto exhaust fumes  Other \_\_\_\_\_

In your work or home environment are you regularly exposed to: (*Check all that apply*)

Mold  Water leaks  Renovations  Chemicals  Electromagnetic radiation  Damp environments

Carpets or rugs  Old paint  Stagnant or stuffy air  Smokers  Pesticides  Herbicides  Paint

Harsh chemicals (*solvents, glues, gas, acids, etc*)  Cleaning chemicals  Airplane Travel

Heavy metals (*lead, mercury, etc.*)  Plastic Food storage  Other \_\_\_\_\_

Have you had a significant exposure to any harmful chemicals?  Yes  No

If yes: Chemical name, length of exposure, date: \_\_\_\_\_

Do you have any pets or farm animals?  Yes  No

If yes, do they live:  Inside  Outside  Both inside and outside

Do you use cosmetics?  Yes  No

If yes, which types and brands: \_\_\_\_\_

Sex History: (complete applicable questions)

Age at first period \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_

Length of cycle \_\_\_\_\_ Time between cycles \_\_\_\_\_

Cramping?  Yes  No Pain?  Yes  No

Have you ever had premenstrual problems (*bloating, breast tenderness, irritability, etc.*)?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have other problems with your periods (*heavy, irregular, spotting, skipping, etc.*)?  Yes  No

If yes, please describe: \_\_\_\_\_

Use of hormonal birth control:  Birth Control Pills  Patch  Nuvaring  IUD

Other \_\_\_\_\_ How long? \_\_\_\_\_

Any problems with hormonal birth control?  Yes  No

If yes, explain \_\_\_\_\_

Use of other contraception?  Yes  No  Condoms  Diaphragm  Partner vasectomy  Other \_\_\_\_\_

Are you in menopause?  Yes  No If yes, age at last period \_\_\_\_\_

Was it surgical menopause?  Yes  No If yes, explain surgery \_\_\_\_\_

Do you currently have symptomatic problems with menopause? (*Check all that apply*)

Hot flashes  Mood swings  Concentration/memory problems  Headaches  Joint pain  Weight gain

Vaginal dryness  Decreased libido  Loss of control of urine  Palpitations

Are you on hormone replacement therapy?  Yes  No

If yes, for how long and for what reason (hot flashes, osteoporosis, prevention, etc.)? \_\_\_\_\_

Do you or have you ever had any sexually transmitted disease?  Yes  No

If yes, describe \_\_\_\_\_

Other Urogenital Symptoms: *(Check all that apply)*

- Endometriosis
- Infertility
- Fibrocystic breasts
- Vaginal infection
- Fibroids
- Ovarian cysts
- Pelvic inflammatory disease
- Reproductive Cancer
- Testicular Mass
- Testicular pain
- Prostate enlargement
- Prostate infection
- Change in sex drive
- Impotence
- Premature ejaculation
- Difficulty obtaining an erection
- Difficulty maintaining an erection
- Loss of control of urine
- Urinary urgency/hesitancy/change in stream
- Vasectomy
- Nocturia (urination at night) # of times per night \_\_\_\_\_

Screenings/Procedures *(If applicable, provide date)*

Last pap test: \_\_\_\_\_  Normal  Abnormal

Last mammogram: \_\_\_\_\_  Normal  Abnormal

Last bone density: \_\_\_\_\_ Results:  High  Low  With Normal Range

Last PSA test: \_\_\_\_\_ PSA Levels:  0-2  2-4  4-10  >10

Other tests/procedures (list type and date) \_\_\_\_\_

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## **Lifestyle Review**

### Sleep

How many hours of sleep do you get each night on average? \_\_\_\_\_

Do you have problems falling asleep?  Yes  No Staying asleep?  Yes  No

Do you have problems with insomnia?  Yes  No Do you snore?  Yes  No

Do you feel rested upon awakening?  Yes  No

Do you use sleeping aids?  Yes  No

If yes, explain: \_\_\_\_\_

Do you wake up during the night?  Yes  No

If yes, what time(s)? \_\_\_\_\_

What time do you go to bed? \_\_\_\_\_ What time do you typically wake-up? \_\_\_\_\_

### Exercise

Do you feel motivated to exercise?  Yes  A little  No

Are there any problems that limit exercise?  Yes  No

If yes, explain \_\_\_\_\_

Do you feel unusually fatigued or sore after exercise?  Yes  No

If yes, explain \_\_\_\_\_

### Current Exercise Program:

Cardio/Aerobic:

Type: \_\_\_\_\_

*(e.g walking, jogging, swimming)*

Frequency: \_\_\_\_\_  
(#of times per week)

Time/duration: \_\_\_\_\_  
(minutes each day)

- Intensity:  Low (able to talk and/or sing)  Moderate (able to talk but not sing)  
 Vigorous/hard (difficulty talking)

Strength/Resistance:

Type: \_\_\_\_\_  
(e.g walking, jogging, swimming)

Frequency: \_\_\_\_\_ Time/duration: \_\_\_\_\_  
(#of times per week) (minutes each day)

- Intensity:  Low (able to talk and/or sing)  Moderate (able to talk but not sing)  
 Vigorous/hard (difficulty talking)

Flexibility/Stretching:

Type: \_\_\_\_\_  
(e.g walking, jogging, swimming)

Frequency: \_\_\_\_\_ Time/duration: \_\_\_\_\_  
(#of times per week) (minutes each day)

- Intensity:  Low (able to talk and/or sing)  Moderate (able to talk but not sing)  
 Vigorous/hard (difficulty talking)

## Nutrition

Do you currently follow any of the following special diets or nutritional programs? (check all that apply)

- Vegetarian  Vegan  Allergy  Elimination  Low Fat  Low Carb  High Protein  No Dairy  
 Low Sodium  No Wheat  Gluten Free  Blood Type \_\_\_\_\_  Other: \_\_\_\_\_

Do you have sensitivities to certain foods?  Yes  No

If yes, list food and symptoms: \_\_\_\_\_

Do you have an aversion to certain foods or textures?  Yes  No

If yes, explain: \_\_\_\_\_

Do you adversely react to: (check all that apply)

- Monosodium glutamate (MSG)  Artificial sweeteners  Garlic/onion  Cheese  Citrus Foods  
 Chocolate  Alcohol  Red Wine  Sulfite-containing foods (wine, dried fruit, salad bars)  
 Preservatives  Food colorings  Other food substances \_\_\_\_\_

Are there any foods that you crave or binge on?  Yes  No

If yes, what foods? \_\_\_\_\_

Do you crave sugar?  Yes  No

Do you crave salt?  Yes  No

Do you eat 3 meals a day?  Yes  No

If no, how many: \_\_\_\_\_

Does skipping a meal greatly affect you?  Yes  No

How many meals do you eat out per week?  0-1  1-3  3-5  >5 meals per week

How many meals are home cooked per week?  0-1  1-3  3-5  >5 meals per week

What are the three worst foods you eat each week? \_\_\_\_\_

What are the three healthiest foods you eat each week? \_\_\_\_\_

Do you feel tired, bloated and/or gassy after meals?  Yes  No

If yes, please explain \_\_\_\_\_

Do you feel excessively hungry?  Yes  No

If yes, please explain \_\_\_\_\_

Do you have a poor appetite?  Yes  No

If yes, please explain \_\_\_\_\_

Check the factors that apply to your current lifestyle and eating habits:

- Fast eater  Eat too much  Late-night eating  Dislike healthy foods  Time constraints
- Travel frequently  Eat more than 50% of meals away from home  Poor snack choices
- Health foods not readily available  Significant other or family members don't like healthy foods
- Significant other or family members have special dietary needs  Eat because I have to  Love to eat
- Have a negative relationship to food  Struggle with eating issues  Don't care to cook
- Emotional eater (eat when sad, longley, bored, etc)  Confused about nutrition advice
- Eat too much under stress  Eat too little under stress  Multitask during meals

How many servings do you eat in a typical day of these foods:

Fruits (not juice) \_\_\_\_\_ Vegetables (not including white potatoes) \_\_\_\_\_

Red meat \_\_\_\_\_ Legumes (beans, peas, etc) \_\_\_\_\_

Nuts & Seeds \_\_\_\_\_ Dairy/Alternatives \_\_\_\_\_

Fish \_\_\_\_\_ Cans of soda (regular or diet) \_\_\_\_\_

Sweets (candy, cookies, cake, ice cream, etc) \_\_\_\_\_

How many ounces of water do you drink daily? \_\_\_\_\_ oz/day

Do you drink caffeinated beverages?  Yes  No If yes, check amounts:

Coffee (ounces per day) \_\_\_\_\_ oz/day Tea (ounces per day) \_\_\_\_\_ oz/day

Caffeinated sodas - regular or diet (cans per day)  1  2-4  >4

Do you have adverse reactions to caffeine?  Yes  No

If yes, explain: \_\_\_\_\_

When you drink caffeine do you feel :  Irritable  Wired  Aches or pains

### Tobacco Use

Do you smoke currently?  Yes  No # packs per day \_\_\_\_\_ # of years \_\_\_\_\_

What type?  Cigarettes  Smokeless  Pipe  Cigar  Vape

Have you attempted to quit?  Yes  No

If yes, using what methods: \_\_\_\_\_

If you smoked previously: # packs per day \_\_\_\_\_ # of years \_\_\_\_\_

Are you regularly exposed to second-hand smoke?  Yes  No

### Alcohol

How many alcoholic beverages do you drink in a week? (1 drink = 5 oz of wine, 12 oz of beer, 1.5 oz of spirits)

1-3  4-6  7-10  >10  None

Previous alcohol intake?  Yes ( Mild  Moderate  High)  None

Have you ever had a problem with alcohol?  Yes  No

If yes, please explain \_\_\_\_\_

Have you ever thought about getting help to control or stop your drinking?  Yes  No

### Other Substances

Are you currently using any recreational drugs?  Yes  No

If yes, type and frequency: \_\_\_\_\_

Have you ever used IV or inhaled recreational drugs?  Yes  No

### Stress

Do you feel you have an excessive amount of stress in your life?  Yes  No

Do you feel you can easily handle the stress in your life?  Yes  No

How much stress do each of the following cause on a daily basis (Rate on scale of 1-10, 10 being the highest)

Work \_\_\_\_\_ Family \_\_\_\_\_ Social \_\_\_\_\_ Finances \_\_\_\_\_ Health \_\_\_\_\_

Do you use relaxation techniques?  Yes  No If yes, how often? \_\_\_\_\_

Which techniques do you use? (check all that apply)

Meditation  Breathing  Tai Chi  Yoga  Prayer  Other: \_\_\_\_\_

Have you ever sought counseling?  Yes  No Are you currently in therapy?  Yes  No

If yes, describe: \_\_\_\_\_

Have you ever been abused, a victim of crime, or experienced significant trauma?  Yes  No

What lifts your spirits and gives you strength? \_\_\_\_\_

What is the most pleasing aspect of your life right now? \_\_\_\_\_

What is the most unsatisfactory part of your life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How much responsibility do you assume for the pleasing and unsatisfactory aspects of your life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the best thing that could happen to you as a result of our experience working together? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the worst thing that could happen? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you like most about your life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you like least about your life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do your health concerns make you feel imbalanced?

Mentally: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emotionally: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physically: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Spiritually: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Relationships**

Marital status:  Single  Married  Divorced  Long-Term Partner  Widow/er

With whom do you live? *(Include children, parents, relatives, friends, pets)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current occupation: \_\_\_\_\_

Previous occupation: \_\_\_\_\_

Do you have resources for emotional support?  Yes  No (Check all that apply)

Spouse/Partner  Family  Friends  Religious/Spiritual  Pets  Other \_\_\_\_\_

Do you have a religious or spiritual practice?  Yes  No

If yes, what kinds? \_\_\_\_\_

How important are spiritual matters to you? \_\_\_\_\_

Would you like your spiritual/religious beliefs to be included in our work? If yes, how much? \_\_\_\_\_

How well have things been going for you? (Mark on scale of 1-10, or N/A if not applicable)

	N/A	Poorly				Fine				Very Well	
Overall	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At school	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your spouse	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10

### Health Goals

What results or outcome do you hope to achieve from working together? \_\_\_\_\_

When was the last time you felt well? \_\_\_\_\_

Did something trigger your change in health? \_\_\_\_\_

What makes you feel better? \_\_\_\_\_

What makes you feel worse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does your condition affect you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you think is happening and why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**Readiness Assessment**

**Rate on a scale of 5 (very willing) to 1 (not willing):**

In order to improve your health, how willing are you to:

Significantly modify your diet	5	4	3	2	1
Take several nutritional supplements each day	5	4	3	2	1
Keep a record of every you eat each day	5	4	3	2	1
Modify your lifestyle (e.g., work demands, sleep habits)	5	4	3	2	1
Practice a relaxation technique	5	4	3	2	1

**Rate on a scale of 5 (very confident) to 1 (not confident at all):**

How confident are you of your ability to organize and follow through on the above health-related activities?

5      4      3      2      1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Rate on a scale of 5 (very supportive) to 1 (very unsupportive):**

At the present time, how supportive do you think the people in your household will be to you implementing the above changes?

5      4      3      2      1

**Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):**

How much ongoing support (e.g., telephone consults, email, correspondence) from our professional staff would be helpful to you as you implement your personal health program?

5      4      3      2      1

Comments \_\_\_\_\_  
\_\_\_\_\_

**\*\* Please include age/year of onset in space next to condition \*\***

**Medical History: Illnesses/Conditions**

**Check YES** = a condition you currently have, **Check PAST** = a condition you've had in the past.

<b>Gastrointestinal</b>	<b>Yes</b>	<b>Past</b>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
GERD (reflux)	<input type="checkbox"/>	<input type="checkbox"/>
Crohn’s disease/ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Urinary/Genital</b>		
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial cystitis	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine/Metabolic</b>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism (low thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism (overactive thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Ovarian Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Metabolic syndrome/insulin resistance	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Inflammatory/Immune</b>		
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
Multiple chemical sensitivities	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Musculoskeletal</b>	<b>Yes</b>	<b>Past</b>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin</b>		
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b>		
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High blood fats (cholesterol, triglycerides)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia (irregular heart rate)	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurologic/Emotional</b>		
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson’s disease	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cancer</b>		
Lung	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>
Colon	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

**\*\* If symptoms present longer than 6 months, please include age/year of onset in space next to condition \*\***

## Symptom Review

**Please check** if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't remember dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low body temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head, Eyes, and Ears			
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear ringing/buzzing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye crusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid margin redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to loud noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal			
Back muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calf cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle twitches:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal (cont.)	Mild	Moderate	Severe
Neck muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood/Nerves			
Agoraphobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auditory hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness (spinning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fearfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light-headedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor/trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			
Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaking/incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestion			
Anal spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canker sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cracking at corner of lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures w/poor chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Farting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foods "repeat" (reflux)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gluten (wheat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease/jaundice (yellow eyes or skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Digestion <i>(cont.)</i>	Mild	Moderate	Severe
Lower abdominal pain			
Mucus in stools			
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong stool odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undigested food in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating			
Binge eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't gain weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent dieting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad odor in nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough - dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough - productive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change of season	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

<b>Nails</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Bitten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Curve up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frayed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus - fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus - toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ragged cuticles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ridges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thickening of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toenails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White spots/lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lymph Nodes</b>			
Enlarged/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tender/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other enlarged/tender lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin, Dryness of</b>			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
And unmanageable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any dandruff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin Problems</b>			
Acne on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athlete's foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bumps on back of upper arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cellulite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears get red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Skin Problems <i>(cont.)</i></b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes - genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jock itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lackluster skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moles w color/size change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pale skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patchy dullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to poison ivy/oak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin darkening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong body odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thick calluses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Itching Skin</b>			
Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear canals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nipples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roof of mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Male Reproductive</b>			
Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ejaculation problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor libido (low sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive	Mild	Moderate	Severe
Breast cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor libido (sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premenstrual:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scanty periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spotting between	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Notification of Federal Health Care Privacy Rights

Please sign below indicating you have received this is notification of your Federal Health Care Privacy Rights:

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance portability and Accessibility Act (HIPAA), Atma Clinic can use your protected health information for treatment, payment and health care operations.

1. Treatment – we may use or disclose your health information to a physician or other health care provider providing treatment to you.
2. Payment – we may use and disclose your health information to obtain payment for services we provide you.
3. Healthcare Operations – we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Most uses and disclosures that do not fall under treatment, payment, healthcare operations will require your written authorization. Upon signing, you may revoke your authorization in writing through our practice at anytime.

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or other person responsible for your care, using your professional judgment. We will only disclose health information that is directly relevant to the person's involvement with your healthcare.

We will not use your health information for marketing communications without your written consent.

We may also use or disclose your health information when we are required to do so by law.

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health and safety.

We may disclose the health information of armed forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may

Notification of Federal Health Care Privacy Rights

disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.

You have the right to restrict the disclosure of your protected health information in writing. The request for restriction may be denied if the information is required for treatment, payment or healthcare operations.

You have the right to

- Receive confidential communications regarding your protected health information.
- Inspect a copy of your protected health information.
- Amend your protected health information.
- Receive an account of disclosures of your protected health information.
- A paper copy of this notice of privacy practices.

If you have any complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

For further information about Atma Clinic's privacy policies, please contact our office and at the following address or phone number:

1026 Westdale Rd  
Lawrence, KS 66049  
(785) 760-0695

Printed Name

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Signature

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Date

---

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it. At the bottom please record all bowel movements along with stool type.

<b>DATE:</b>	Beverages	Environment	Mood/Digestive Changes
Breakfast (Time: _____)			
Snack (Time: _____)			
Lunch (Time: _____)			
Snack (Time: _____)			
Dinner (Time: _____)			
Snack (Time: _____)			

**Bowel Movements (Time and Type)**

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it. At the bottom please record all bowel movements along with stool type.

DATE:	Beverages	Environment	Mood/Digestive Changes
Breakfast (Time: _____)			
Snack (Time: _____)			
Lunch (Time: _____)			
Snack (Time: _____)			
Dinner (Time: _____)			
Snack (Time: _____)			

**Bowel Movements (Time and Type)**

NAME: \_\_\_\_\_








DOB: \_\_\_\_\_

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it. At the bottom please record all bowel movements along with stool type.

<b>DATE:</b>	Beverages	Environment	Mood/Digestive Changes
Breakfast (Time: _____)			
Snack (Time: _____)			
Lunch (Time: _____)			
Snack (Time: _____)			
Dinner (Time: _____)			
Snack (Time: _____)			

**Bowel Movements (Time and Type)**

# Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. <b>Entirely Liquid</b>



# Medical Symptoms Questionnaire (MSQ)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for the **past 14 days.**

- Point Scale**
- 0 – *Never or almost never* have the symptom
  - 1 – *Occasionally* have it, effect is *not severe*
  - 2 – *Occasionally* have it, effect is *severe*
  - 3 – *Frequently* have it, effect is *not severe*
  - 4 – *Frequently* have it, effect is *severe*

<b>HEAD</b>	<input type="text"/> Headaches <input type="text"/> Faintness <input type="text"/> Dizziness <input type="text"/> Insomnia	<b>Total</b> _____
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<b>EYES</b>	<input type="text"/> Watery or itchy eyes <input type="text"/> Swollen, reddened or sticky eyelids <input type="text"/> Bags or dark circles under eyes <input type="text"/> Blurred or tunnel vision <i>(Does not include near or far-sightedness)</i>	<b>Total</b> _____
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<b>EARS</b>	<input type="text"/> Itchy ears <input type="text"/> Earaches, ear infections <input type="text"/> Drainage from ear <input type="text"/> Ringing in ears, hearing loss	<b>Total</b> _____
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<b>NOSE</b>	<input type="text"/> Stuffy nose <input type="text"/> Sinus problems <input type="text"/> Hay fever <input type="text"/> Sneezing attacks <input type="text"/> Excessive mucus formation	<b>Total</b> _____
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<b>MOUTH/THROAT</b>	<input type="text"/> Chronic coughing <input type="text"/> Gagging, frequent need to clear throat <input type="text"/> Sore throat, hoarseness, loss of voice <input type="text"/> Swollen or discolored tongue, gums, lips <input type="text"/> Canker sores	<b>Total</b> _____
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<b>SKIN</b>	<input type="text"/> Acne <input type="text"/> Hives, rashes, dry skin <input type="text"/> Hair loss <input type="text"/> Flushing, hot flashes <input type="text"/> Excessive sweating	<b>Total</b> _____
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<b>HEART</b>	<input type="text"/> Irregular or skipped heartbeat <input type="text"/> Rapid or pounding heartbeat <input type="text"/> Chest pain	<b>Total</b> _____
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## MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

### LUNGS

\_\_\_\_\_ Chest congestion  
\_\_\_\_\_ Asthma, bronchitis  
\_\_\_\_\_ Shortness of breath  
\_\_\_\_\_ Difficulty breathing

**Total** \_\_\_\_\_

### DIGESTIVE TRACT

\_\_\_\_\_ Nausea, vomiting  
\_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Constipation  
\_\_\_\_\_ Bloating feeling  
\_\_\_\_\_ Belching, passing gas  
\_\_\_\_\_ Heartburn  
\_\_\_\_\_ Intestinal/stomach pain

**Total** \_\_\_\_\_

### JOINTS/MUSCLE

\_\_\_\_\_ Pain or aches in joints  
\_\_\_\_\_ Arthritis  
\_\_\_\_\_ Stiffness or limitation of movement  
\_\_\_\_\_ Pain or aches in muscles  
\_\_\_\_\_ Feeling of weakness or tiredness

**Total** \_\_\_\_\_

### WEIGHT

\_\_\_\_\_ Binge eating/drinking  
\_\_\_\_\_ Craving certain foods  
\_\_\_\_\_ Excessive weight  
\_\_\_\_\_ Compulsive eating  
\_\_\_\_\_ Water retention  
\_\_\_\_\_ Underweight

**Total** \_\_\_\_\_

### ENERGY/ACTIVITY

\_\_\_\_\_ Fatigue, sluggishness  
\_\_\_\_\_ Apathy, lethargy  
\_\_\_\_\_ Hyperactivity  
\_\_\_\_\_ Restlessness

**Total** \_\_\_\_\_

### MIND

\_\_\_\_\_ Poor memory  
\_\_\_\_\_ Confusion, poor comprehension  
\_\_\_\_\_ Poor concentration  
\_\_\_\_\_ Poor physical coordination  
\_\_\_\_\_ Difficulty in making decisions  
\_\_\_\_\_ Stuttering or stammering  
\_\_\_\_\_ Slurred speech  
\_\_\_\_\_ Learning disabilities

**Total** \_\_\_\_\_

### EMOTIONS

\_\_\_\_\_ Mood swings  
\_\_\_\_\_ Anxiety, fear, nervousness  
\_\_\_\_\_ Anger, irritability, aggressiveness  
\_\_\_\_\_ Depression

**Total** \_\_\_\_\_

### OTHER

\_\_\_\_\_ Frequent illness  
\_\_\_\_\_ Frequent or urgent urination  
\_\_\_\_\_ Genital itch or discharge

**Total** \_\_\_\_\_

**Grand Total** \_\_\_\_\_



An Integrative approach to Personalized Medicine  
**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City, ST, Zip \_\_\_\_\_ Phone \_\_\_\_\_

I authorize to release medical records:

From: Dr's Name/Facility Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, ST, Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

To: Atma Clinic  
1011 Westdale Rd  
Lawrence, KS 66049  
Ph: 785-760-0695 Fax: 855-892-4307

I authorize the disclosure of the following:

- Progress Notes                       Lab  
 Radiology and Imaging reports    Immunizations  
 Entire records                       Records from (date) \_\_\_\_\_ to \_\_\_\_\_  
 Other \_\_\_\_\_

Purpose of Transfer \_\_\_\_\_

- I understand that the information in my health record may include that relation to alcohol or drug abuse, abortion, acquired immune deficiency syndrome (AIDS), developmental disabilities, human immunodeficiency virus ( HIV), behavioral or mental health services, or sexually transmitted infection.
- I understand that I have the right to inspect or copy the information I have authorized to be used or disclosed by tis form.
- I understand that if the parties listed above are not health care providers, health plans or health care clearinghouses who must follow the federal standards and may be redisclosed without obtaining my authorization.
- I understand that I have the right to revoke this authorization at any time. Such revocation must be in writing and presented to address above. Such revocation will not apply to information that has already been released per this authorization.
- I understand that authorizing the disclosure of this information is voluntary. Refusing to sign this authorization will not affect my receiving treatment. It is expressly agreed that a photocopy of this authorization is as valid as the original

Signature of Patient or Legal Guardian \_\_\_\_\_

Today's Date \_\_\_\_\_ Expiration Date \_\_\_\_\_



## HIPAA RELEASE FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name. (Including a spouse or significant other).

Please print name, relationship, and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

\_\_\_\_\_  
Name Relationship Phone #

\_\_\_\_\_  
Name Relationship Phone #

\_\_\_\_\_  
Name Relationship Phone #

\_\_\_\_\_  
Name Relationship Phone #

\_\_\_\_\_  
Patient printed name

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

# NUTRITIONAL THERAPY

## INFORMED CONSENT AND DISCLAIMER

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Before you choose to use the services of a Nutritional Therapist, please read the following information **FULLY AND CAREFULLY.**

**GOAL:** Our basic goal is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimum level. Nutritional therapy is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the goal of optimum health, absent other non-nutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A Nutritional Therapist is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. A Nutritional Therapist is not trained to provide medical diagnoses, and no comment or recommendation should be construed as being a medical diagnosis. Since every human being is unique, we cannot guarantee any specific result from our programs.

**HEALTH CONCERNS:** If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A Nutritional Therapist is not a substitute for your family physician or other appropriate healthcare provider. A Nutritional Therapist is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases.

If you are under the care of another healthcare provider, it is important that you contact your other healthcare providers and alert them to your use of nutritional supplements. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.

If you are using medications of any kind, you are required to alert the Nutritional Therapist to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

If you have any physical or emotional reaction to nutritional therapy, discontinue their use immediately, and contact your Nutritional Therapist to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

**COMMUNICATION:** Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to do your part by using your nutrition guidelines, exercise your body and mind sufficiently to bring your emotions into a positive balance, eat a proper diet, get plenty of rest, and learn about nutrition. You must stay in contact with the Nutritional Therapist so we can let you know what is happening and the best course of action.

You should request your other healthcare provider, if any, to feel free to contact the Nutritional Therapist for answers to any questions they may have regarding nutritional therapy.

**LICENSURE:** A Nutritional Therapist is not licensed or certified by any state. However, a Nutritional Therapy Practitioner™ is trained by the Nutritional Therapy Association, Inc.® which provides a certificate of completion to students who have successfully met all course requirements, including a written and practical exam. A license to practice Nutritional Therapy is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.

**FEES:** This coaching agreement is valid as of date of signing. Client agrees to pay all fees at time of visit. Fees are per visit, in accordance with fee schedule. The fee schedule is subject to change upon notice from Atma Clinic to Client.

**CANCELLATION POLICY:** Client agrees that it is the Client's responsibility to notify the Nutrition Therapist 24 hours in advance of the scheduled calls/meetings. Nutrition Therapist reserves the right to bill Client for a missed meeting. Nutrition Therapist will attempt in good faith to reschedule the missed meeting.

By my/our signature(s) below, I/we acknowledge and agree that the Nutritional Therapist is not responsible for any resulting sickness or ailment from any dietary change and/or consuming nutritional supplements. I/we fully understand and accept the risks associated with implementing new dietary changes and consuming nutritional supplements. I/we understand and agree on behalf of myself, my dependents, heirs, administrators, legal representatives, and assigns, to release and hold harmless the Nutritional Therapist, Atma Clinic, LLC and any and all members, employees, agents and representatives thereof, from any and all liability for illness, injuries, or death, and for any losses or damages relating thereto, however occurring, in relation to my use of the services of the Nutritional Therapist. Without limitation, I understand and agree that neither the Nutritional Therapist, Atma Clinic, LLC, nor any members, employees, agents or representatives thereof, is liable for any direct, indirect, consequential, or incidental damage, injury, death, loss, delay, or inconvenience of any kind which may be occasioned by reason of any act or omission, including, without limitation, any willful or negligent act or failure to act, or breach of contract. I/we confirm that I/we have read and fully understand the above disclaimer and waiver of liability are in complete agreement thereto and do freely and without duress sign and consent to all terms contained herein.

CLIENT NAME (PLEASE PRINT) \_\_\_\_\_

ADDRESS \_\_\_\_\_

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

PHONE (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_ (OTHER) \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE FOR CLIENT \_\_\_\_\_

RELATIONSHIP TO CLIENT \_\_\_\_\_ DATE \_\_\_\_\_

NUTRITIONAL THERAPY MAY NOT BE COVERED BY INSURANCE AND ALL COSTS ARE THE SOLE RESPONSIBILITY OF THE CLIENT.