Appointment Instructions

1. **Please arrive 15 minutes early for your appointment to complete all additional paperwork.**

2. In your initial appointment you will be given preliminary tests that will help determine if you are in a state of inflammation. The test performed will determine by the practitioner base off of your intake paperwork. Examples of these preliminary tests are:
   - Body Composition
   - Meta Oxy Urine Analysis
   - Nerve-Express Health
   - NES Quantum Scan
   - Orthostatic BP Test.

   These are all non-invasive and done in-office.

3. During the Body Composition Test a team member will be asking you to take your shoes and socks off. Please make sure they are easy to access.

   To prepare for this test, please **refrain from any alcohol intake for 12 hours prior to the test. In addition avoid exercise and sauna within 8 hours of this test. Please come prepared to use the bathroom.**

   Meta oxy Test
   - You will need to give a very small sample of urine, so please try to come prepared to urinate.
     ***Please avoid natural diuretics such as: coffee or tea the day of your visit.**
   - **If possible, do not drink fluids 1 hour prior to you appointment.**
   - Do not take any natural supplements the day of your initial visit.

     ***Please take any medication or products your medical doctor has directed you to consume**.

4. **What do you need to bring?**
   - **We highly encourage you to bring your spouse to this appointment.** We have found that if you live with anyone in your household it helps them understand how we can help you get your health back.
   - If you wear glasses or contacts at all, make sure you have them with you.
   - If you have any labs work that has been done in the past year, please bring copies of your test results to this appointment.

5. **What is the policy on rescheduling this appointment?**
   - You may reschedule your initial appointment up to 1 week in advance of your scheduled appointment.
   - **Our team needs time to review your case. In order to serve you to the best of our ability, we do require your paperwork to have been received by us at least one week prior to your initial appointment. Please understand your appointment will be cancelled if we do not receive your paperwork to review by the given date.**
   - **If you are more than 15 min late for your initial appointment, the appointment is considered cancelled and no refund will be given.** Outside of a catastrophic occurrence, you will be charged for any less than a 24 hour cancelation, 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

TotalHealth
NUTRITION CENTER

N82W15485 Appleton Ave. Menomonee Falls, WI 53051
3800 S. Moorland Road New Berlin, WI 53151
www.totalhealthinc.com 262-251-2929

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

Date of Birth:		Gender: □ Male□ Female

Age:		Height:		Weight:	

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

Status:
☐Married
☐Separated
☐Divorced
☐Widowed
☐Single
☐Partnership

Live with:
☐Spouse
☐Partner
☐Parents
☐Children
☐Friends
☐Alone

Education:

Occupation: Hours per week: ☐Retired

Employer	Work Address

In case of emergency, whom should we contact?

Name	Relationship	Address	Phone

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?
		Page 2 ☐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, on or by 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 every day?
☐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 freshener 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 bottle 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 after 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 similar symptoms 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 with 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 or often as a child or adult?
☐Yes	☐No	Were you caesarian delivered?
☐Yes	☐No	Were you breast fed? If so, How long _____

☐Yes ☐No Do you have a daily bowel movement? If so how many times per day? _____

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		Column #2	
	Anxiety		Sensitivity to light
	Mood swings		Fatigue after exercise (feeling worse)
	Enraged behavior or anger for no reason		Poor night vision or seeing halos around lights
	Excessive shyness, timidity, social phobia (not typical to your personality)		Shortness of breath, with very little effort
	Irritability (not typical to your personality)		Excessive thirst and/or frequent urination
	Low body temperature (below 97.5°)		Red eyes or tearing
	Insomnia (can't get to sleep or return to sleep		Blurred vision at times
	Dizziness		Morning stiffness
	Sound in ears (ringing or hearing your heart beat)		Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Psychological symptoms, even thoughts of suicide		Chronic fatigue or weakness
	Sensitivity to sound		Non-restful sleep
	Indecisiveness		Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Feeling of being overwhelmed or fearful		Trouble processing new information
	Metallic taste in your mouth		Word reversal or trouble finding words
	Bad breath		Sensitivity to touch
	Bleeding gums		Short-term memory loss
	Sensitive teeth		Chronic sinus congestion
	Canker sores or other sores in the mouth		Dry non-productive cough
	Floaters, shadows or swimmers when you read or look into the sky		Muscle twitching
	Dyslexia or loss of place while reading, even as a child		Excessive sweating, especially at night
	Swelling eyelids		Joint pain-not necessarily true arthritis-can move from joint to joint
	Peeling of top layer of skin (hands, feet)		Difficulty losing weight regardless of diet or exercise
	Dry skin		Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Heart pain (angina) and you are under 45 years old		Frequent illness, prolonged illness or sick days
	Depression		Numbness or weakness in arms and legs
	Gout (arthritic pain, especially in big toes)		Headaches
	Pain in shoulders or upper back		Trouble adding or dividing numbers in your head
	Twitching eyelids		Fluctuating constipation and diarrhea
	Anemia (low iron/hemoglobin on blood test)		Stomach pain for no apparent reason
	Wrist/ankle drop or weak extensor muscles		Appetite swings
	Hairloss (not normal male pattern baldness)		Frequent muscle aches, cramps, unusual sharp sudden pains
			Rashes or rosacea
			Cold extremities (hands and feet)

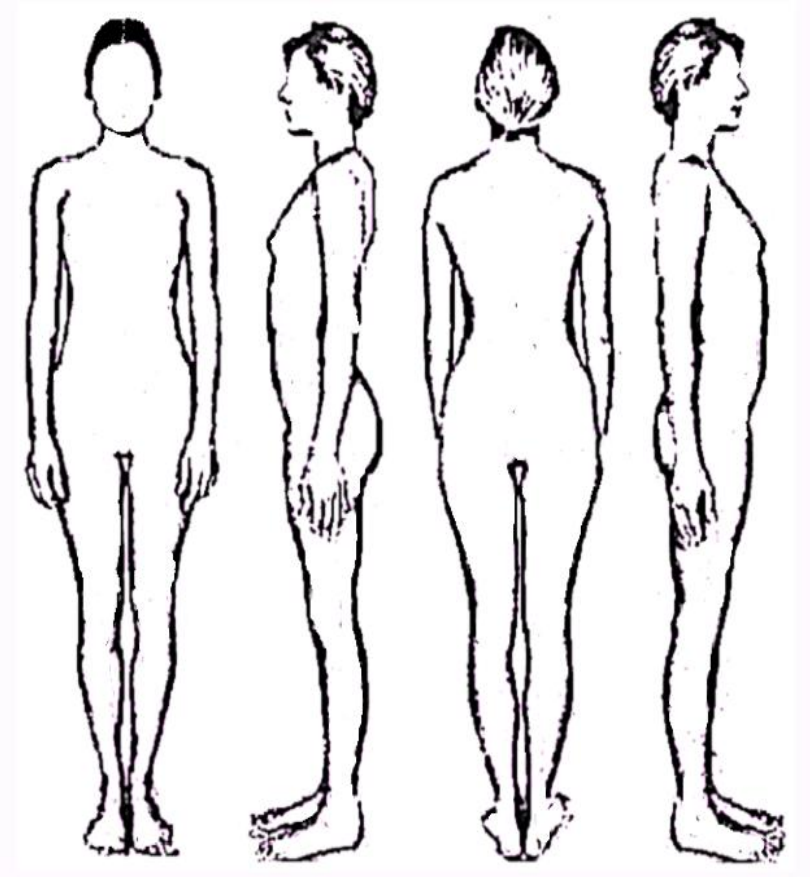
	Total Columns 1 & 2

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

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Name: _____ Date: _____

	DAY ONE	DAY TWO	DAY THREE
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			

Please keep an accurate three day food and drink diary.

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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 documentary's on how food is processed? (Exp- Food Inc., King Corn, Food Matters)_____