Policies & Procedures

(Please Read & Sign Below)

The Waller Wellness Center does not bill insurance providers. Payment is expected at the time of service, and an itemized receipt with appropriate diagnostic and billing codes will be provided on the day of your visit. Most insurance companies will reimburse patients for a portion of the visit, but the amount of reimbursement varies depending on the insurance provider and the individual policy. It is your responsibility to submit the receipt to your insurance company for reimbursement. If additional WWC staff time is required to facilitate the processing of your claim, a charge may apply. **Please keep all of your receipts for insurance and tax purposes**.

Initial consultations are 60 minutes and cost $425. (A $100 non-refundable deposit is required to reserve the appointment time.) The visit includes a thorough assessment of family history, past medical history, current medical problems, risk factors for preventable diseases, nutritional history, toxic substance exposure history, and history of current symptoms. Recommendations for a comprehensive individualized evaluation are made. Most often testing includes salivary hormone levels, and blood tests for early detection of thyroid disorders, diabetes, and heart disease risk. Other specialized tests may be ordered, such as vitamin & nutritional assessments, stool analysis, hair analysis & detoxification profiles. Most blood work is covered by insurance, but reimbursement for specialized testing varies by insurance carrier.

The second visit (approximately 1 to 2 months after the initial consultation) is 60 minutes and the cost is $325. It includes a detailed review of test results and formulation of an individualized treatment plan, which typically includes hormone supplementation, lifestyle modification, vitamin and herbal supplement suggestions. **You are encouraged to bring a recording device to help you capture as much information as possible at the visit (a lot of information is covered).** Subsequent follow-up visits are 30 minutes and cost $185.

One to three months after the treatment plan is implemented, follow up testing will be necessary to evaluate the effectiveness of the therapy. It takes 3 to 4 weeks for the physician to receive saliva results; therefore the **testing must be completed in a timely fashion to insure a productive visit**. Depending on how well the patient responds to therapy, subsequent visits can be anywhere from 2 to 6 months apart.

Bringing children to a visit is not recommended. Childcare is not available and distractions decrease your ability to get important information from your visit.

New Patient Deposit, "No Show" and "Short-Notice Cancellation" Policy:
There is a $100 Non-refundable Deposit required for Initial Consultations. There is a "No Show/ Late Cancellation" fee equal to the entire visit fee ($325 – 2nd Visits, $185 – Follow-up visits) for cancellations with less than 48 hours notice. If two or more "No Show" visits occur, visits must be prepaid with credit card, before they can be rescheduled. Medication refills will be denied if follow-up visits are missed or repeatedly rescheduled.

Dr. Waller Does NOT Replace Your Primary Care Physician (PCP):
We do not replace (or function as) your primary care physician. We provide comprehensive health assessments and make recommendations which emphasize healthy lifestyles, risk factor management, and changing personal behavior. Each person receives an individualized treatment plan to address specific concerns, but this does not take the place of the regular medical care provided by your primary care physician. You should maintain your relationship with your PCP, or if you do not have a PCP, we ask that you obtain one.

Please sign below, acknowledging that you understand and accept the conditions above:

_____ _____ _____/_____/_____

Patient Name (Printed) Patient Signature Date:

(A copy of this document will be provided upon your request)

Revised 9-10-12

New Patient Deposit Notice

Waller Wellness Center (WWC) requires a $100 non-refundable deposit prior to making a new patient appointment. This is done for two reasons:

1. We have a large number of new patients who would like to be seen by our medical providers, and we make every effort to see them as soon as possible. When someone does not keep a new patient appointment, or reschedules within 48 hours of the appointment, we are often unable to fill that time slot.
2. Prior to the first visit, our staff takes time to register you as a patient, and your provider must review your history form along with any medical records you may provide. In the event of a cancellation or missed appointment, the non-refundable deposit helps offset these costs.

The cost of the Initial Consultation is $425, and will be completed by our Nurse Practitioner, Mary Wilson NP. The initial deposit of $100 will be applied to your visit. The balance of $325 will be payable at our office on the day of your appointment.

If you fail to keep your Initial Consultation, choose not to use the services of WWC or either of our medical providers, or reschedule your appointment with less than 48 hours notice, you will forfeit your $100 deposit **.(To verify the date and time of your reschedule request, we must receive an email sent to support@WallerWellness.com at least 48 hours in advance of the appointment.)**

There are several payment options to choose from:

- Enclose a check or money order with the ***Personal Health History*** form when you return it.
- Provide a credit card number when we call to schedule your Initial Consultation.
- Provide credit card information with the enclosed "***New Patient Deposit Authorization"*** form.

Whichever option you chose, we request that you sign the "***New Patient Deposit Authorization"*** form acknowledging your understanding of this policy, and return it to us with your completed "***Personal Health History"*** form. After we receive your deposit, "***New Patient Deposit Authorization"*** and "***Personal Health History"*** form, we will contact you to schedule your appointment.

New Patient Deposit Authorization

Patient Name_____

Address_____

City_____State_____ Zip_____

Form of payment (choose one):

_____**Check:** Please make payable to ***Catherine Waller MD PC*** in the amount of $100. Sign and mail this form to us along with the completed *Personal Health History*. When we receive it we will call to schedule your appointment.

_____ **Credit card provided by phone:** Sign and mail this form to us with the completed *Personal Health History*. When we call to make your appointment we will take your credit card information and process the payment at that time.

_____ **Credit card provided by mail:** Please provide the following information so we may process the $100 prepayment:

Amount: $ 100.00 USD.

Credit card type: ____Visa _____Master Charge _____ Discover

Credit card number: _____-_____-_____-_____

Credit card CV2 number (3 digit number located on back of card): _____

Expiration date: _____/_____/_____

Name as it appears on the card: _____

Billing address: _____

City_____ State_____ Zip_____

Confirmation and Authorization:
I understand and agree to the following:

- I have been provided a copy of the ***New Patient Deposit*** form and have read and understood the contents of this form.
- My New Patient Deposit is **non-refundable and will be forfeited** in the event that I :
  a) Do not show up for my appointment, or
  b) Decide not to use the services of Dr. Catherine Waller MD, or other WWC staff (Nurse Practitioners/Physician assistants)
  c) Provide less than 48 hours notice of a need to reschedule my appointment.
- **To verify the date and time of my reschedule request, I must send an email to scheduling@wallerwellness.com at least 48 hours in advance of the appointment, or send a letter post marked at least 3 days before the visit to: Waller Wellness Center, 1854 West Auburn Road Suite 400, Rochester Hills, MI, 48309**
- I understand I will have to pay an additional $100 deposit before I can reschedule my appointment in the event of forfeit.
- If credit card information is provided above, I authorize ***Catherine Waller MD PC*** to process a non-refundable $100 charge to my credit card.
- **For Initial Consultation:** I understand that the $100 non-refundable deposit will be applied to the Initial Consultation charge of $425, with the balance of $325 due at the time of service. (All Initial Consultations are completed by the Nurse Practitioner)

_____ ____/_____/_____ _____

Patient Name (printed) **Date** **Patient Signature**

Revised 05-2-12

Waller Wellness Center

1854 West Auburn Road Suite 400, Rochester Hills, MI 48309
248-844-1414 Fax: 248-844-2670

Today's Date: _____/_____/_____

Name (First, MI, Last)	Social Security No.(last 4 digits only)	Birthdate
	XXX – XX -- _____	_____/_____/_____

Age	Sex	Marital Status	Home Phone	Work Phone
	☐ M ☐ F	M / S / D	(_____) _____--_____	(_____) _____--_____

Home Address (street, city, state and zip code)	Cell Phone
_____	(_____) _____--_____
_____	Email Address
_____	

Employer	Job Title /Occupation

Emergency Contact (Name)	Contact (Phone)	Who referred you?
	(_____) _____--_____	

Personal Physician (Name and Address)	Preferred Pharmacy Name/Phone
_____	_____
_____	_____
_____	_____
_____	_____
Office Phone:	

BEST WAY TO CONTACT YOU (Choose One): ☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone** ☐ **Email**

From time to time we may need to contact you by phone. Sometimes we need to leave a detailed message, with information that answers questions you asked of us. It would save time and prevent "phone tag" if we had your permission to leave specific information for you on your home (or work) answering machine, voice mail or cell phone.

DO WE HAVE PERMISSION TO LEAVE THE FOLLOWING INFORMATION ON YOUR HOME ANSWERING MACHINE OR VOICE MAIL?

Appointment Information: ☐ **YES** ☐ **NO**
Medical Information: ☐ **YES** ☐ **NO**
Billing/Payment Information: ☐ **YES** ☐ **NO**

IF SOMEONE ANSWERS THE PHONE WHEN WE CALL, WHO CAN WE LEAVE THIS INFORMATION WITH?

☐ No One
☐ Spouse _____ ☐ Child(ren)_____
☐ Friend_____ ☐ Other _____

CAN WE CONTACT YOU AT WORK? ☐ **YES** ☐ **NO**
CAN WE LEAVE THE ABOVE MENTIONED INFORMATION ON YOUR WORK VOICE MAIL? ☐ **YES** ☐ **NO**

_____ _____ _____/_____/_____

Patient Signature: **Print Name:** **Date:**

COMPLAINTS/CONCERNS

Please list ***in order of importance*****, the five (5) main concerns you have (starting with the most important one**).
Please note how long each symptoms has been present.

Problem	Onset	Frequency	Mild	Moderate	Severe	Previous Treatments / Approach	Results? Excellent	Good	Fair
0. e.g. Headaches	6 / 2007	4 times / week							
1.									
2.									
3.									
4.									
5.									

What do you hope to achieve in your visits with us? _____
_____

_____

If you had a magic wand and could erase three health problems or symptoms, which would they be, and why?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel **worse**? _____
_____

What makes you feel **better**? _____
_____

Please list all physicians you have seen for the above health conditions:

1.	4.
2.	5.
3.	6.

Please check all the Alternative Treatments you have tried for your condition(s)

☐ None	☐ Massage	☐ Yoga	☐ Environmental medicine
☐ Chiropractic	☐ Rolfing	☐ Hypnosis	☐ Dietary Therapy
☐ Acupuncture	☐ Reiki	☐ Ayurveda	☐ Biological Dentistry
☐ Supplements	☐ Homeopathy	☐ Light therapy	☐ IV (intravenous) therapy
☐ Colonics	☐ Biofeedback	☐ Meditation	☐ Naturopathic medicine
☐ _____	☐ _____	☐ _____	☐ _____

PAST MEDICAL HISTORY

Current	Past	Disease/Diagnosis/Condition (Check appropriate box and give date of onset)	Date	Current	Past	Disease/Diagnosis/Condition (Check appropriate box and give date of onset)	Date
		GASTROINTESTINAL				**HEENT / RESPIRATORY**	
		Irritable Bowel Syndrome				Asthma	
		Crohn's or Ulcerative Colitis				Bronchitis – Chronic or Recurrent	
		Constipation / Diarrhea – Recurrent (Circle one)				Emphysema	
		Gastritis or Ulcer Disease				Pneumonia - Recurrent	
		GERD or Reflux Disease				Sleep Apnea	
		Colon Polyps				Sinusitis – Chronic or Recurrent	
		Hepatitis / Liver Disease				Recurrent Ear Infections	
		Gallstones / Gall Bladder Problems				Macular Degeneration / Eye Disorder _____	
		Other:				**GENITAL AND URINARY**	
		CARDIOVASCULAR				Kidney Disease / Stones / Infection (Pyelonephritis)	
		Heart Attack or Stent Placement				Interstitial Cystitis	
		Valvular Disease (Mitral Valve Prolapse etc.)				Urinary Incontinence	
		Stroke or TIA (Transient Ischemic Attack)				Frequent Urinary Tract (Bladder) Infections	
		High Cholesterol (Hyperlipidemia)				Sexually Transmitted infection (Herpes etc.)	
		Irregular Heart Rhythm (Palpitations)				Sexual / Reproductive Problems	
		High Blood Pressure (Hypertension)				Recurrent Yeast Infections	
		Chest Pain / Angina				Uterine Fibroids / Ovarian Cysts (Women)	
		Other:				Menstrual Disorders	
		METABOLIC / ENDOCRINE				BPH / Prostate Problems (Men)	
		Diabetes				Other:	
		Hypoglycemia				**INFLAMMATORY / AUTOIMMUNE**	
		Pre-Diabetes (Metabolic Syndrome)				Chronic Fatigue Syndrome	
		Hypothyroidism (Low Thyroid)				Fibromyalgia	
		Hyperthyroidism (Overactive Thyroid)				SLE (Systemic Lupus Erythematosis)	
		Polycystic Ovaries (PCOS)				Rheumatoid Arthritis	
		Eating Disorder (Anorexia/Bulimia)				Hashimoto's Thyroiditis	
		Obesity / Overweight				Immune Dysfunction (Frequent Infections)	
		Other:				Food Allergies	
		SKIN & NAILS				Environmental Allergies	
		Acne				Multiple Chemical Sensitivities	
		Eczema / Psoriasis (Circle one)				**NEUROLOGIC / MOOD**	
		Rosacae/ Hives (Circle one)				Headaches - Migraines / Tension (Circle one)	
		Fungal Nails				Seizure Disorder	
		Other:				ADD / ADHD (Attention Deficit Disorder)	
		MUSCULOSKELETAL / PAIN				Memory Problems	
		Osteoarthritis – Where?				Mild Cognitive Impairment	
		Osteoporosis / Osteopenia (Circle one)				Parkinson's	
		Gout				ALS / Multiple Sclerosis (Circle One)	
		Neck Pain – Why?				Depression	
		Back Pain – Why?				Anxiety Disorder	
		Herniated Disc – Where?				Bipolar Disorder	
		Carpal Tunnel Syndrome				Schizophrenia	
		Tendinitis – Where?				Other:	
		Other:				**CANCER**	
		HEMATOLOGICAL				Breast Cancer / Prostate Cancer (Circle one)	
		Anemia				Colon Cancer / Lung Cancer (Circle one)	
		Blood Clots / Bleeding Disorder				Leukemia / Lymphoma (Circle one)	
		Abnormal Blood Cells				Skin Cancer – Type?	
		Other:				Other:	

DIAGNOSTIC STUDIES

Normal	Abnormal	Check Box if test was performed. Indicate "Normal" or "Abnormal" and provide date.	Date
		Full Physical Exam	
		Mammogram / Breast Ultrasound (Circle)	
		Bone Density Test	
		Colonoscopy	
		Cardiac Stress Test	
		EKG	
		Chest X-ray	
		Upper GI / Gastroscopy	
		Carotid Artery Ultrasound	
		Pelvic Ultrasound	
		Abdominal Ultrasound	
		Prostate Ultrasound	
		MRI / CT Scan	
		Eye Exam	

PAST SURGICAL HISTORY

	Check Box if surgery was performed and provide date.	Date
	Appendectomy	
	Tonsillectomy	
	Tubal Ligation/Vasectomy	
	Gall Bladder	
	Joint Replacement – Knee / Hip (circle one)	
	Heart Surgery – Bypass / Valve (circle one)	
	Angioplasty or Stent	
	Vascular (Blood Vessel) Surgery	
	Pacemaker insertion	
	Hysterectomy – Why?	
	Ovary Surgery – Why?	
	Breast Surgery – Why?	
	Prostate Surgery – Why?	
	Other:	

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

INJURIES

Type of Injury	How did it occur?	Date

Comments or Additional Medical History: _____

FEMALE MEDICAL HISTORY (for Women only)

OBSTETRICS HISTORY *Check box if yes and provide appropriate information in the blanks*

❑ # of Pregnancies _____ ❑ # of Caesarean _____ ❑ # of Vaginal births_____ ❑ Pre-term Labor

❑ # of Miscarriages _____ ❑ # of Abortions _____ ❑ # of Living Children____ ❑ Other:_____

❑ Post partum depression ❑ Toxemia ❑ Gestational diabetes ❑ Baby over 8 pounds

❑ Breast feeding For how long? _____ ☐ Infertility Treatments:_____ ☐ Fibroids ☐ Endometriosis

MENSTRUAL HISTORY

Age at 1st period: ____ Menses Frequency: ____Days Length: ___ Days Pain: ☐ Yes ☐ No Clotting: ☐ Yes ☐ No

Last Menstrual Period: ___/___/____ Has your period skipped: ☐ Yes ☐ No Heavy Bleeding: ☐ Yes ☐ No

Do you currently use contraception? ☐ Yes ☐ No If yes, what type do you use? ☐ Other:_____

☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Have you ever used hormonal contraception? Yes ____ No_____ If yes, when _____

Use of hormonal contraception: ❑ Birth control pills ❑ Patch ❑ Nuva Ring How long? _____

Are you using the pill now? ☐ Yes ☐ No Did taking the pill agree with you? ☐ Yes ☐ No

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ❑ Yes ❑ No

RECENT SCREENING TESTS & RESULTS

Date of Last PAP Test: ____/____/_____ ☐ Normal ☐ Abnormal (Results:_____)

Date of Last Mammogram ____/____/_____ ☐ Normal ☐ Abnormal (Results:_____)

Date of Breast Biopsy(if applicable) ___/____/____ ☐ Normal ☐ Abnormal (Results:_____)

Date of last Bone Density: ____/_____/____ Results: ❑ High ❑ Low ❑ Within normal range

HORMONAL IMBALANCE ISSUES

Are you in menopause? ☐ Yes ☐ No Age at Menopause _____ *(Check all applicable symptoms below)*

☐ Hot Flashes ☐ Night Sweats ☐ Mood Swings ☐ Concentration/ Memory Problems ☐ Vaginal Dryness

☐ Decreased Libido ☐ Weight Gain ☐ Headaches ☐ Palpitations ☐ Urine Leaking/Bladder Problems

Are you on hormone replacement? ☐ Yes ☐ No How Long? _____

Other Issues:_____

_____

_____

MEN'S HISTORY (for Men only)

Have you had a PSA done? ☐ Yes ☐ No PSA Level: ☐ 0–2 ☐ 2–4 ☐ 4–10 ☐ > 10

☐ Prostate Enlarged ☐ Prostate Infections ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Nocturia (getting up to urinate at night) How many times per night ? _____

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

Other Issues:_____

_____

_____

_____

MEDICATIONS

Current Medications

Medication Name	Dose	# Times per day	Start Date (month/year)	Reason for Use

PREVIOUS MEDICATIONS *(Last 10 Years)*

Medication Name	Dose	# Times per day	Start Date (month/year)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement Name/Brand	Dose	Frequency	Start Date (month/year)	Reason for use

ALLERGIES (or Adverse Reactions)

Medication / Supplement / Food	Reaction

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.? ☐ Yes ☐ No
If yes, please explain:_____
If yes, are these symptoms associated with a particular food or supplement? ☐ Yes ☐ No
Which food or supplement?_____

Have you had?

Prolonged or regular use of NSAIDs (Advil, Aleve, Motrin etc.) ……..☐ Yes ☐ No
Prolonged or regular use of Tylenol ……☐ Yes ☐ No
Prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, Nexium, etc.)……☐ Yes ☐ No
Frequent antibiotics (greater than 3 times per year)……☐ Yes ☐ No
Long Term antibiotics (longer than 1 month at a time)……☐ Yes ☐ No
Use of Steroids (Prednisone, Medrol Dose Pack, Nasal Allergy Sprays) ……☐ Yes ☐ No
Use of Oral Contraceptives ……..☐ Yes ☐ No

FAMILY HISTORY

Check All Family Members that Apply **Place an "X" by any health problem(s) your family members have suffered with either now or in the past.**	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Aunts**	**Uncles**	**Other**
Age (if still alive)												
Age at death (if deceased)												
ADD/ADHD (Attention Deficit Disorder)												
Alzheimer's												
Anxiety												
Arthritis												
Asthma												
Autoimmune Diseases (Lupus, Hashimoto's, Rheumatoid Arthritis)												
Bipolar Disease												
Blood clotting problems												
Cancer - Colon												
Cancer - Breast												
Cancer - Uterine / Ovarian (circle one)												
Cancer – Skin: Melanoma / Squamous / Basal Cell (circle one)												
Cancer - Prostate / Bladder (circle one)												
Cancer – Other:												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema / Psoriasis (circle one)												
Emphysema / Chronic Bronchitis												
Epilepsy (Seizure Disorder)												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Heart Disease: Heart Attack / Bypass / Valve Disease (circle one)												
Heart Problem: Irregular Rhythm / Pacemaker (circle one)												
High Blood Pressure (Hypertension)												
High Cholesterol (Hyperlipidemia)												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)												
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)												
Irritable Bowel Syndrome												
Kidney disease												
Migraine Headaches												
Multiple Sclerosis / ALS (circle one)												
Obesity												
Osteoporosis												
Parkinson's												
Schizophrenia												
Sleep Apnea												
Stroke												
Substance abuse (alcoholism, etc.)												
Thyroid Disorder												
Other:												
Other:												
Other:												

Number of Sisters: ____ (# deceased: ____) # of Brothers: ____ (# deceased: ____) Birth Order: ____

NUTRITION & LIFESTYLE HISTORY

Have you ever had a nutrition consultation? Yes ☐ No ☐

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ **Low Fat** ☐ **Low Carbohydrate** ☐ **High Protein** ☐ **Low Sodium** ☐ **Diabetic** ☐ **No Dairy** ☐ **No Wheat**

☐ **Gluten Restricted** ☐ **Vegetarian** ☐ **Vegan** ☐ **Blood Type Diet** ☐ **Zone Diet**

☐ **Specific Program for Weight Loss / Maintenance – Type:**_____

Height (feet/inches)_____	Current Weight_____
Usual weight range +/- 5 lbs_____	Desired Weight range +/- 5 lbs_____
Highest adult weight _____	Lowest adult weight _____
Weight fluctuations (>10lbs) ☐ Yes ☐ No	Body Fat % (if known)_____%

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Are there any foods that you avoid because they give you symptoms? ☐ Yes ☐ No

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? _____

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No If no, who does the cooking? _____

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

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

- ❑ Fast eater
- ❑ Erratic eating habits
- ❑ Eat too much
- ❑ Late night eater
- ❑ Dislike health food
- ❑ Time constraints
- ❑ Eat more than 50% of meals away from home
- ❑ Travel frequently
- ❑ Non-availability of healthy foods
- ❑ Do not plan meals or menus
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Significant other or family members don't like healthy foods
- ❑ Significant other or family members have special dietary needs of food preferences
- ❑ Love to eat
- ❑ Eat because I have to
- ❑ Have a negative relationship to food
- ❑ Struggle with eating issues
- ❑ Emotional eater (eat when sad, lonely, depressed, bored)
- ❑ Eat too much under stress
- ❑ Eat too little under stress
- ❑ Don't care to cook
- ❑ Eating in the middle of the night
- ❑ Confused about nutritional advise
- ❑ Diet often for weight control

The most important thing I should change about my diet to improve my health is: _____

_____

_____

_____

SMOKING

Currently Smoking? ☐ Yes ☐ No How many years? _____ Packs per day: _____

If yes, what type? ☐ Cigarette ☐ Smokeless Cigarettes ☐ Cigar ☐ Pipe

How many attempts to quit: _____ How: ☐ Patch/Gum ☐ Medication ☐ Acupuncture ☐ Hypnosis

Previous Smoking: How many years? _____ Packs per day: _____When did you quit? _____How? _____

Are you exposed to 2nd hand smoke now? If yes, please explain: _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 _____ *If none skip to "Other Substances"*

Previous alcohol intake? ☐ Yes (☐ Mild 0-4/week ☐ Moderate 5-10/week ☐ High > 10/week)

Have you ever been told to cut down your alcohol intake? ☐ Yes ☐ No

Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you ever take an eye-opener? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (can you "hold" more than others?) ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

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

OTHER SUBSTANCES

Caffeine Intake: ☐ Yes ☐ No ☐ Coffee/ ☐ Tea How Many Cups/ Day: ☐ 1 ☐ 2-4 ☐ >4 a day

☐ Caffeinated Soda / ☐ Diet Soda Intake: ☐ Yes ☐ No How Many Cans or Bottles/Day: ☐ 1 ☐ 2-4 ☐ >4 a day

Are you currently using recreational drugs? ☐ Yes ☐ No If yes, what types?:_____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No If yes, what types?:_____

EXERCISE

Current Exercise program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Other (Pilates, yoga, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading etc.)			

Rate your level of motivation for including exercise in your life? ❑ Low ❑ Medium ❑ High

List problems that limit activity: _____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe:_____

_____

Do you usually sweat when exercising? ☐ Yes ☐ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No
Are you happy? ☐ Yes ☐ No
Do you feel your life has meaning and purpose? ☐ Yes ☐ No
Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No
Do you like the work you do? ☐ Yes ☐ No
Have you experienced major losses in your life? ☐ Yes ☐ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No
Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

STRESS/COPING

Have you ever sought counseling? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No Previously? ☐ Yes ☐ No If previously, from _____ to _____

Comments:_____

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

Daily stressors: *Rate on a scale of 1 – 10 (1= not stressful – 10 = very stressful)*

Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No How often? _____

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

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

Occupation _____# Hours worked per week _____ ☐ Retired

How many days have you lost from work or school in the past year? ☐ 0 - 2 ☐ 3 – 7 ☐ 7 - 14 ☐ > 15 days

How many vacation days do you take each year : ☐ None ☐ 1- 7 ☐ 7-14 ☐ 14-21 ☐ > 21

SLEEP/REST

Average number of hours you sleep ❑ <6 ❑ 6 – 8 ❑ 8 – 10 ❑ > 10

Average number of times you wake up each night ❑ 1 ❑ 2 ❑ 3 ❑ 4+

Do you have trouble falling asleep? ☐ Yes ☐ No Do you feel rested upon awakening? ☐ Yes ☐ No

If you wake up, how long does it take you to fall back asleep? ☐ 0 -15 Min ☐ 15 - 30 Min ☐ 30 – 60 Min ☐ > 60 Min

Do you snore? ☐ Yes ☐ No Do you stop breathing or gasp/choke while sleeping? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No What time do you go to bed?_____ What time do you get up?_____

Rate your energy level throughout the day: *(0 = SLEEPING, 1= exhausted, 2 = somewhat tired, 3 = OK, 4 = somewhat energetic, 5 = great)*

Wake up: ____ 10 -11 AM:____ 12 Noon:____ 2-3 PM:____ 5-6 PM:____ 8-9 PM:____ 11-12PM:____ 2-3 AM:_____

ROLES/RELATIONSHIPS

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership

Children: (Please List Names, Age, & Gender)_____

_____

Resources for emotional support? ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other _____

What is the attitude of those close to you about your illness? ❑ Supportive ❑ Non-supportive

How Well Have Things Been Going for You? :	Very well	Fine	Poorly	Very poorly	Does not apply	Comments
At school						
In your job						
In your social life						
With close friends						
With sex						
With your attitude						
With your boyfriend/girlfriend						
With your children						
With your parents						
With your spouse						

REVIEW OF SYSTEMS

Check only those items with which you identify, ***past or present***. Ignore anything that does not apply to you.

GENERAL

- ❑ Cold Hands & Feet
- ❑ Cold Intolerance
- ❑ Daytime Sleepiness
- ❑ Difficulty Falling Asleep
- ❑ Difficulty Staying Asleep
- ❑ Fatigue
- ❑ Fever
- ❑ Heat Intolerance
- ❑ Sweating - Excessive
- ❑ Swollen Glands
- ❑ Weakness - Generalized
- ❑ Weight Gain

SKIN:

- ❑ Acne / Oily / Boils (circle one)
- ❑ Athletes Foot
- ❑ Bruise Easily
- ❑ Bumps on Back of Upper Arms
- ❑ Burning on Bottom of Feet
- ❑ Changing Moles
- ❑ Crawling Sensation
- ❑ Cuts Heal slowly
- ❑ Dryness
- ❑ Hives
- ❑ Itching
- ❑ Peeling/Cracking Skin
- ❑ Pigmentation Changes
- ❑ Rash
- ❑ Strong Body Odor

Is your skin sensitive to?

- ❑ Sun
- ❑ Fabrics _____
- ❑ Detergents_____
- ❑ Latex
- ❑ Metals_____

HAIR

- ❑ Hair Growth - Excessive (Where:_____)
- ❑ Hair Loss / Thinning
  - ❑ Head
    - ❑ Crown
    - ❑ Temples
    - ❑ All Over
  - ❑ Eyebrows/Lashes
  - ❑ Legs / Underarms
  - ❑ Bald Spots- Scalp

NAILS

- ❑ Brittle
- ❑ Fungal Nails
- ❑ Splitting & Peeling
- ❑ Pitted / Ridges (circle one)
- ❑ Thickened
- ❑ White Spots/Lines on Nails

HEAD:

- ❑ Balance Problems
- ❑ Confusion
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Forgetfulness/ Poor Memory
- ❑ Mental Sluggishness
- ❑ Poor Focus & Concentration
- ❑ **Headaches:**
  - ❑ **Location:**
    - ❑ Frontal
    - ❑ Back of Head / Neck
    - ❑ Behind Eyes
    - ❑ Temples
    - ❑ Sinuses
  - ❑ After Meals
  - ❑ After Not Eating (too long)
  - ❑ **Migraines**
    - ❑ Triggered by:
      - ❑ Menstrual Cycles
      - ❑ Stress
      - ❑ Sleep Changes
      - ❑ Caffeine Changes
    - ❑ Relieved by:
      - ❑ Eating
      - ❑ Dark Quiet Room

EYES:

- ❑ Irritation / Inflammation
- ❑ Double / Blurred Vision
- ❑ Puffy Eyes / Eyelids
- ❑ Decreasing Vision
- ❑ Bright Flashes
- ❑ Eye Pain
- ❑ Dark Circles Under Eyes
- ❑ Sensitivity to Light
- ❑ "Floaters" in Vision

EARS:

- ❑ Aches/Pain/Pressure
- ❑ Discharge
- ❑ Frequent Infections
- ❑ Hearing Loss
- ❑ Itching
- ❑ Ringing / Buzzing
- ❑ Sensitive to Loud Noises

NOSE / SINUSES:

- ❑ Decreased Sense of Smell
- ❑ Nasal Congestion
- ❑ Nasal Drainage
- ❑ Nasal Polyps
- ❑ Nose Bleeds
- ❑ Post Nasal Drip
- ❑ Recurrent Sinus Infections
- ❑ Sneezing Spells

NOSE / SINUSES (cont.)

- ❑ Symptoms worse in the:
  - ❑ Spring
  - ❑ Summer
  - ❑ Fall
  - ❑ Winter

MOUTH:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Canker Sores
- ❑ Coated Tongue
- ❑ Cracking at Corners of Lips
- ❑ Dental Problems
- ❑ Dry Mouth
- ❑ Fever Blisters
- ❑ Grind Teeth When Sleeping
- ❑ Lips Swell - Angioedema
- ❑ Sore Tongue
- ❑ TMJ
- ❑ Wear Dentures

THROAT:

- ❑ Constant Clearing of Throat
- ❑ Difficulty Swallowing
- ❑ Frequent Hoarseness
- ❑ Frequent Sore Throat
- ❑ Throat Closes Up

NECK:

- ❑ Stiffness / Pain
- ❑ Lumps / Swollen Glands
- ❑ Goiter

CARDIOVASCULAR / CIRCULATION:

- ❑ Cold or Clammy Extremities
- ❑ Dizziness Upon Standing
- ❑ Heavy/Tight Chest
- ❑ Irregular Heartbeat
- ❑ Low Exercise Tolerance
- ❑ Numbness - Hands/Feet
- ❑ Palpitations
- ❑ Phlebitis
- ❑ Raynaud's Syndrome
- ❑ Shortness of Breath
- ❑ Spider Veins
- ❑ Swollen Ankles
- ❑ Varicose Veins

RESPIRATION:

- ❑ Frequent Colds / Bronchitis
- ❑ Frequent Coughing
- ❑ Frequently Sighing
- ❑ Wheezing
- ❑

DIGESTION

- ❑ Abdominal Pain
  - ❑ Upper
  - ❑ Lower
- ❑ Anal Fissures
- ❑ Anal Itching
- ❑ Belching Frequently
- ❑ Black/Tarry Stools
- ❑ Bloating
- ❑ Blood in Stools
- ❑ Changes in Bowels
- ❑ Constipation - Recurrent
- ❑ Cramping
- ❑ Diarrhea - Recurrent
- ❑ Excessive Flatulence (Gas)
- ❑ Excessive Fullness After Meal
- ❑ Gallbladder Pain
- ❑ Gallstones
- ❑ Heartburn / Acid Reflux
- ❑ Hemorrhoids
- ❑ Hepatitis - Type:_____
- ❑ Hiatal Hernia
- ❑ Indigestion
- ❑ Laxative Use
- ❑ Liver Disease
- ❑ Nausea
- ❑ Nervous Stomach
- ❑ Peptic/Duodenal Ulcer
- ❑ Poor Appetite
- ❑ Rectal Itching
- ❑ Strong Stool Odor
- ❑ Undigested Food in Stools
- ❑ Vomiting

EATING:

- ❑ Anorexia / Bulimia
- ❑ Binge Eating
- ❑ Caffeine Dependant
- ❑ Can't Gain Weight
- ❑ Can't Lose Weight
- ❑ Can't Maintain Healthy Weight
- ❑ Carbohydrate Cravings
- ❑ Chocolate Cravings
- ❑ Frequent Dieting
- ❑ Hypoglycemia
- ❑ Salt Cravings
- ❑ Sweets / Sugar Cravings

KIDNEY/URINARY TRACT:

- ❑ Burning / Pain with Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Night time Urination
- ❑ Problem Passing Urine

WOMEN'S HISTORY (women only)

- ❑ Breast Tenderness
- ❑ Change in Periods
- ❑ Decreased Libido
- ❑ Heavy Periods
- ❑ Hot Flashes
- ❑ Loss of Control of Urine
- ❑ Mood Swings
- ❑ Night Sweats
- ❑ Ovarian Cysts
- ❑ Painful Periods
- ❑ Pain With Intercourse
- ❑ Palpitations
- ❑ Spotting / Irregular Menses
- ❑ Vaginal Discharge
- ❑ Vaginal Dryness
- ❑ Weight Gain

MEN'S HISTORY (for men only)

- ❑ Decreased Libido
- ❑ Decreased Muscle Strength
- ❑ Diminished Urinary Stream
- ❑ Erectile Dysfunction
- ❑ Genital pain
- ❑ Hernia
- ❑ Infertility / Low sperm count
- ❑ Lumps in Testicles
- ❑ Prostate enlargement
- ❑ Prostate infections
- ❑ Sore on penis

MUSCULOSKELETAL

- ❑ Back Pain - _____
- ❑ Joint Pain /Stiffness
- ❑ Joint Swelling or Warmth
- ❑ Muscle Cramps – Legs / Feet
- ❑ Muscle Stiffness in Morning
- ❑ Muscle Twitches -_____
- ❑ Pain Wakes Me Up
- ❑ Restless Leg Syndrome
- ❑ Weakness in Legs and Arms
- ❑ Damp Weather Bothers Me

EMOTIONAL:

- ❑ ADD / Short Attention Span
- ❑ Aggressive / Anger Issues
- ❑ Agitated / Irritable
- ❑ Anxiety
- ❑ Burned Out
- ❑ Considered a Nervous Person
- ❑ Cry Often
- ❑ Depressed
- ❑ Difficulty Coping With Stress
- ❑ Easily Flare in Anger
- ❑ Extremely Shy
- ❑ Feel Insecure
- ❑ Frequently Keyed Up and Jittery
- ❑ Frustration
- ❑ Had Nervous Breakdown
- ❑ Have Considered Suicide
- ❑ Have Overused Alcohol
- ❑ Have Overused Drugs
- ❑ Hyperactive / Restless
- ❑ Listless / Withdrawn feeling
- ❑ Misunderstood by Others
- ❑ Nightmares
- ❑ Often Break Out in Cold Sweats
- ❑ Often Feel Suddenly Scared
- ❑ Panic Attacks
- ❑ Profuse sweating
- ❑ Startle Easily
- ❑ Tremors / Shaky Inside
- ❑ Use Tranquilizers
- ❑ Workaholic
- ❑ Worried Over Little Things

DENTAL HISTORY

Have you had sore gums (gingivitis) often over the years? ……☐ Yes ☐ No
Have TMJ (temporal mandibular joint) problems been a concern? ……☐ Yes ☐ No
Do you often have a 'metallic' taste in your mouth? ……☐ Yes ☐ No
Do you have a lot of bad breath (halitosis) or white tongue (thrush)?……☐ Yes ☐ No
Have you worn or do you presently wear braces?……☐ Yes ☐ No
Do you have problems chewing? ……☐ Yes ☐ No
Do you floss daily?…… ☐ Yes ☐ No
How many amalgam fillings do you have now? _____ How many Root Canals?_____
Did you play with mercury as a child or adult?……☐ Yes ☐ No
Have you eaten a lot of fish in your life? ……☐ Yes ☐ No

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 everything you eat each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (e.g. work demands, sleep habits)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice relaxation techniques	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Have periodic lab tests to assess progress	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Comments _____

_____

_____

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 fully engage in the above activities?_____

_____

_____

Rate on a scale of: 5 (very supportive) to 1 (not supportive at all).

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments_____

_____

_____

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

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

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments_____

_____

_____

Notes:

NAME:_____**DATE:**____/____/_____

3 DAY FOOD DIARY *(Please Print)*

Instructions for Completing the Diet Diary

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for three consecutive days including one weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
- Describe the food or beverage consumed. e.g., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
- Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.
- Please record all beverages, including water. List them in the "Beverage" category.
- Please record all bowel movements and their consistency (regular, loose, firm, etc.).

DIET DIARY – DAY ONE :

Time	Food / Beverage / Amount	Comment

Bowel Movements (Number per day, form, color): _____
Stress / Mood / Emotions:____ _____
Other Comments:_____
Water: Glasses/day_____ **Type**: ☐ Tap ☐ Distilled ☐ Spring ☐ Well ☐ Reverse Osmosis

DAY TWO :_____**Date:**____/____/_____

Time	Food / Beverage / Amount	Comment

Bowel Movements (Number per day, form, color):_____
Stress / Mood / Emotions:_____
Other Comments:_____
Water: Glasses/day_____ **Type**: ☐ Tap ☐ Distilled ☐ Spring ☐ Well ☐ Reverse Osmosis

DAY THREE:_____**Date:**____/____/_____

Time	Food / Beverage / Amount	Comment

Bowel Movements (Number per day , form, color): _____
Stress / Mood / Emotions:____ _____
Other Comments:_____
Water: Glasses/day_____ **Type**: ☐ Tap ☐ Distilled ☐ Spring ☐ Well ☐ Reverse Osmosis

Waller Wellness Center

1854 West Auburn Road Suite 400
Rochester Hills, MI 48309
Phone: 248-844-1414 Fax: 248-844-2670
www.wallerwellness.com

The office is open Monday, Tuesday, Wednesday & Friday from 9 AM to 5 PM. Thursdays 9AM to 7 PM

Directions from South: Take I-75 NORTH to Rochester Road NORTH. Go about 4 miles to Auburn Road and Turn LEFT (West). Go about 2 miles and we're on your RIGHT just before Crooks Road . The building complex is called the "Campus at Auburn & Crooks". (You will see the "**Waller Wellness Center**" sign on your RIGHT).

Directions from North: Take I-75 SOUTH to M-59 EAST (or I-94 WEST to M-59 WEST.) Get off at the Crooks Road exit and go SOUTH 1/2 mile. Make a "Legal LEFT turn" just before the traffic light at Auburn & Crooks (you will see Walgreen's on your LEFT). Turn RIGHT into the first entrance and go past Walgreen's into the Medical Building parking lot. We are in the building that is facing Auburn Road.

For more directions visit our website at: www.wallerwellness.com