

Dear New Patient,

Thank you for your interest in the Waller Wellness Center. In an effort to expedite your first visit with us we have enclosed our "Patient History Form" for you to fill out. This will give us valuable information about your past medical history, family history, dietary and lifestyle choices, which are of vital importance to your overall health goals.

To give you more specific information about our practice, we have also included one of our brochures, and our "Policies & Procedures" fact sheet.

In order to make it easier for you to find us, we have enclosed directions and a map. Feel free to call us if you have any questions about how to find us.

Your first visit will consist mostly of "data gathering". Please bring any test results that you have such as lab results, mammogram reports, bone density tests etc. It will also be helpful if you bring the bottles of any supplements you take regularly. You don't need to bring in your medication bottles, just fill out the "Medication" section of your Patient History Form and include the name of your medications, how often you take them, and their doses.

At your first visit we will also "prioritize" your major symptoms and health issues for future goal setting activities. As with any other area of your life, when there are numerous areas that require change, it can get overwhelming. Our role is to help you set attainable goals, and to make sure that you take "one step at a time" on your road to wellness and vitality. Your needs are very important in helping to set the pace of the process. If you are the kind of person that "needs to go slow" let us know. But if you want a more aggressive approach, we can do that too. This is going to be an exciting and invigorating process!

Looking forward to helping you on your way to wellness & vitality,

Dr. Catherine Waller



## How Can We Help You?

What are your concerns and current health goals? At the Waller Wellness Center we have only one mission—to help you reach your health-related goals. That may involve finding the cause of a symptom or illness and treating it, or it may mean helping you optimize your health in order to slow down and/or reverse the aging process. In today's world of integrative medicine there is an ever expanding list of options available to you, and it can get quite confusing. Our goal is to help guide you through the “maze” of possibilities, to find the therapies that are right for you.

Your health and wellness are precious. It's important that you put your trust in those medical practitioners that have the most expertise and training in both alternative and conventional therapies. Many conventional medical practitioners are “trying their hand” at some alternative medicine practices, but haven't had adequate training. Make sure that the physician you choose is Board Certified and Fellowship trained in Anti-aging and Functional Medicine.

### **Services We Offer:**

- Bio-identical hormone replacement therapy (men and women)
- Nutritional Counseling & Supplement Recommendations
- Age Management Medicine
- “Ultra prevention”
- Genetic Testing (to determine susceptibility to Specific Diseases including Cancer)
- Weight Loss Program
- Detoxification Protocol
- Psychotherapy Services:
  - EMDR, EFT(Emotional Freedom Technique), EmWave Personal Stress Reliever
- Full range of testing:
  - Salivary Hormone Levels
  - Detoxification Assessment
  - Hair Analysis
  - Heavy Metal Testing (mercury, lead, arsenic)
  - Urine Neurotransmitter Levels (ADHD, Depression, Anxiety, Insomnia, Weight Loss)
  - Oxidative Stress Analysis
  - Comprehensive Stool Digestive Analysis
  - “Leaky Gut” Assessment
  - Food Allergy Panel ( blood)
  - Infection Assessment ( Lyme's Disease, Candida, Epstein Barr)

### **We provide you with a road map to optimal health, and treat a variety of problems such as:**

- |                            |                     |                                   |
|----------------------------|---------------------|-----------------------------------|
| • High Blood Pressure      | • ADHD              | • Chronic Fatigue                 |
| • Digestive Disorders      | • Hormone Balancing | • Insomnia                        |
| • Irritable Bowel Syndrome | • Menopause (women) | • Allergies                       |
| • Autoimmune Disorders     | • Andropause (men)  | • Multiple Chemical Sensitivities |
| • Sexual Dysfunction       | • High Cholesterol  | • Fibromyalgia                    |
| • Joint Problems           | • Weight Loss       | • Osteoporosis                    |
| • Hair Loss                | • Thyroid Disorders | • Depression & Anxiety            |
| • Diabetes                 | • Adrenal Fatigue   | • Memory Loss & “Foggy” thinking  |



## **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 – 2<sup>nd</sup> 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)



## 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 either by Mary Wilson, our Nurse Practitioner, or by Pamela Thomas, our Physician Assistant. 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](mailto: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.

1854 West Auburn Road, Suite 400, Rochester Hills, MI 48309 Phone: 248-844-1414 Fax: 248-844-2670 (5/12)



# 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](mailto: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

# Health History Form

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) XXX - XX -- _____		Birthdate ____/____/____	
Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status M / S / D	Home Phone (____) _____--_____		Work Phone (____) _____--_____
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: _____					
<b>BEST WAY TO CONTACT YOU (Choose One):</b> <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> 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.					
<b><u>DO WE HAVE PERMISSION TO LEAVE THE FOLLOWING INFORMATION ON YOUR HOME ANSWERING MACHINE OR VOICE MAIL?</u></b>					
Appointment Information: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Medical Information: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Billing/Payment Information: <input type="checkbox"/> YES <input type="checkbox"/> NO					
<b><u>IF SOMEONE ANSWERS THE PHONE WHEN WE CALL, WHO CAN WE LEAVE THIS INFORMATION WITH?</u></b>					
<input type="checkbox"/> No One					
<input type="checkbox"/> Spouse _____ <input type="checkbox"/> Child(ren) _____					
<input type="checkbox"/> Friend _____ <input type="checkbox"/> Other _____					
<b><u>CAN WE CONTACT YOU AT WORK?</u></b> <input type="checkbox"/> YES <input type="checkbox"/> NO					
<b><u>CAN WE LEAVE THE ABOVE MENTIONED INFORMATION ON YOUR WORK VOICE MAIL?</u></b> <input type="checkbox"/> YES <input type="checkbox"/> 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				Previous Treatments / Approach	Results?		
							Excellent	Good	Fair
0. e.g. Headaches	6 / 2007	4 times / week	Mild	Moderate	Severe				
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)

<input type="checkbox"/> None	<input type="checkbox"/> Massage	<input type="checkbox"/> Yoga	<input type="checkbox"/> Environmental medicine
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Roling	<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Dietary Therapy
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Reiki	<input type="checkbox"/> Ayurveda	<input type="checkbox"/> Biological Dentistry
<input type="checkbox"/> Supplements	<input type="checkbox"/> Homeopathy	<input type="checkbox"/> Light therapy	<input type="checkbox"/> IV (intravenous) therapy
<input type="checkbox"/> Colonics	<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Meditation	<input type="checkbox"/> Naturopathic medicine
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____



## PAST MEDICAL HISTORY

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
		<b>GASTROINTESTINAL</b>				<b>HEENT / RESPIRATORY</b>	
		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:				<b>GENITAL AND URINARY</b>	
		<b>CARDIOVASCULAR</b>				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	
		<b>METABOLIC / ENDOCRINE</b>				BPH / Prostate Problems (Men)	
		Diabetes				Other:	
		Hypoglycemia				<b>INFLAMMATORY / AUTOIMMUNE</b>	
		Pre-Diabetes (Metabolic Syndrome)				Chronic Fatigue Syndrome	
		Hypothyroidism (Low Thyroid)				Fibromyalgia	
		Hyperthyroidism (Overactive Thyroid)				SLE (Systemic Lupus Erythematosus)	
		Polycystic Ovaries (PCOS)				Rheumatoid Arthritis	
		Eating Disorder (Anorexia/Bulimia)				Hashimoto's Thyroiditis	
		Obesity / Overweight				Immune Dysfunction (Frequent Infections)	
		Other:				Food Allergies	
		<b>SKIN &amp; NAILS</b>				Environmental Allergies	
		Acne				Multiple Chemical Sensitivities	
		Eczema / Psoriasis (Circle one)				<b>NEUROLOGIC / MOOD</b>	
		Rosacea/ Hives (Circle one)				Headaches - Migraines / Tension (Circle one)	
		Fungal Nails				Seizure Disorder	
		Other:				ADD / ADHD (Attention Deficit Disorder)	
		<b>MUSCULOSKELETAL / PAIN</b>				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:				<b>CANCER</b>	
		<b>HEMATOLOGICAL</b>				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**

**PAST SURGICAL HISTORY**



Normal	Abnormal	Check Box if test was performed. Indicate "Normal" or "Abnormal" and provide date.	Date	Check Box if surgery was performed and provide date.	Date
		Full Physical Exam		Appendectomy	
		Mammogram / Breast Ultrasound (Circle)		Tonsillectomy	
		Bone Density Test		Tubal Ligation/Vasectomy	
		Colonoscopy		Gall Bladder	
		Cardiac Stress Test		Joint Replacement – Knee / Hip (circle one)	
		EKG		Heart Surgery – Bypass / Valve (circle one)	
		Chest X-ray		Angioplasty or Stent	
		Upper GI / Gastroscopy		Vascular (Blood Vessel) Surgery	
		Carotid Artery Ultrasound		Pacemaker insertion	
		Pelvic Ultrasound		Hysterectomy – Why?	
		Abdominal Ultrasound		Ovary Surgery – Why?	
		Prostate Ultrasound		Breast Surgery – Why?	
		MRI / CT Scan		Prostate Surgery – Why?	
		Eye Exam		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 1<sup>st</sup> 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 2<sup>nd</sup> 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**

<b>Current Medications</b>			
----------------------------	--	--	--

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

<b>Check All Family Members that Apply</b> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Fast eater</li> <li><input type="checkbox"/> Erratic eating habits</li> <li><input type="checkbox"/> Eat too much</li> <li><input type="checkbox"/> Late night eater</li> <li><input type="checkbox"/> Dislike health food</li> <li><input type="checkbox"/> Time constraints</li> <li><input type="checkbox"/> Eat more than 50% of meals away from home</li> <li><input type="checkbox"/> Travel frequently</li> <li><input type="checkbox"/> Non-availability of healthy foods</li> <li><input type="checkbox"/> Do not plan meals or menus</li> <li><input type="checkbox"/> Reliance on convenience items</li> <li><input type="checkbox"/> Poor snack choices</li> <li><input type="checkbox"/> Significant other or family members don't like healthy foods</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Significant other or family members have special dietary needs or food preferences</li> <li><input type="checkbox"/> Love to eat</li> <li><input type="checkbox"/> Eat because I have to</li> <li><input type="checkbox"/> Have a negative relationship to food</li> <li><input type="checkbox"/> Struggle with eating issues</li> <li><input type="checkbox"/> Emotional eater (eat when sad, lonely, depressed, bored)</li> <li><input type="checkbox"/> Eat too much under stress</li> <li><input type="checkbox"/> Eat too little under stress</li> <li><input type="checkbox"/> Don't care to cook</li> <li><input type="checkbox"/> Eating in the middle of the night</li> <li><input type="checkbox"/> Confused about nutritional advice</li> <li><input type="checkbox"/> Diet often for weight control</li> </ul> |
|---|--|

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 2<sup>nd</sup> 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                          | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Take several nutritional supplements each day           | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Keep a record of everything you eat each day            | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Modify your lifestyle (e.g. work demands, sleep habits) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Practice relaxation techniques                          | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Engage in regular exercise                              | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Have periodic lab tests to assess progress              | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**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

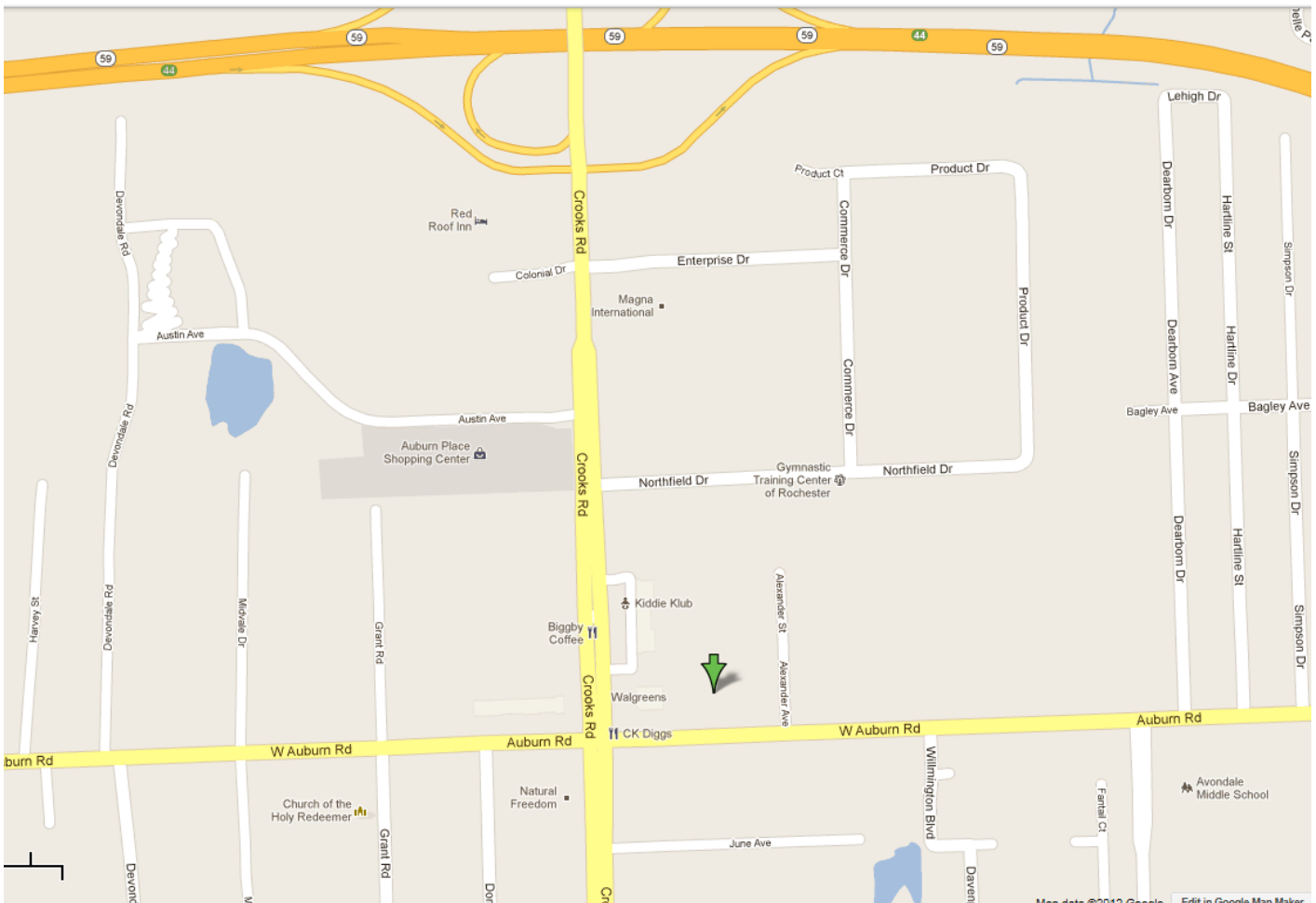
[www.wallerwellness.com](http://www.wallerwellness.com)

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](http://www.wallerwellness.com)



1854 W Auburn Rd #400, Rochester Hills, MI Phone: 248-844-1414 Fax: 248-844-2670 (6/12)



# Functional Medicine

*A new approach in treatment—bringing hope to patients with unexplained symptoms*

By Catherine A. Waller, M.D.

Countless patients go to the doctor every year with a multitude of symptoms ranging from fatigue, headache and joint pain, to muscle aches, insomnia and mood swings; only to be told that all of their tests are “normal.” They are declared “healthy” and sent on their way, or labeled as having a *functional illness*—a term used by some traditional medicine physicians meaning *the patient has a psychiatric illness such as stress or hypochondriasis causing their symptoms*. Frustrated, these patients are left with few options or suggestions as to how to help themselves feel better.

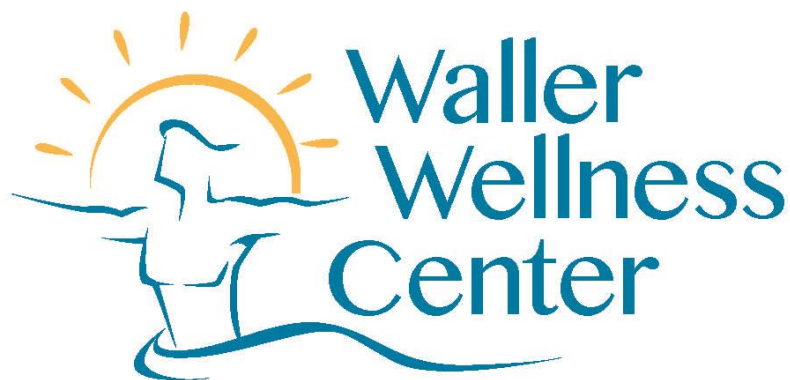
Some just accept their fate and suffer in silence, assuming that it is just *old age*. Others refuse to be placated and hit the Internet in search of answers. The lucky ones stumble upon a new paradigm shift in medicine called *Functional Medicine*. Its name is derived from the term *functional illness*—but instead of assuming there’s nothing wrong with the patient, Functional Medicine assumes that something was wrong with the diagnostic testing process, and most likely, there is a subtle malfunction in the biological processes of the patient, missed by traditional diagnostic testing.

The forefathers of traditional medicine created a



division of the human body into organ systems (... cardiovascular, neurological, pulmonary, urologic, endocrine, intestinal etc.). As our medical knowledge has broadened over the last 5-10 years, however, we have learned more about the biochemical processes that go on in the body, and it has become clear that the “organ system” classification is inadequate. It just does not represent how the body actually works.

The body is actually one large matrix of interconnected biochemical processes that affect *all* of the organ systems. When these processes are all working well, there is health



## The 8 Major Areas of Clinical Imbalance Addressed by Functional Medicine:

1. Immune & Inflammatory Balance
2. Energy Production (Mitochondrial Dysfunction) & Oxidative Stress (Free Radicals)
3. Gastrointestinal Imbalance
4. Detoxification & Biotransformation
5. Hormonal & Neurotransmitter Imbalance
6. Structural Imbalance (Musculoskeletal & Energy Flow)
7. Mind and Spirit (Stress Levels, Attitudes & Beliefs)
8. Environmental Inputs (Diet, Nutrition, Genetics, Exercise)

When the body's processes are all working well, there is health and vitality. If one of them is malfunctioning, the entire body is affected.

and vitality. If one of them is malfunctioning, the entire body is affected. If the malfunction goes on long enough symptoms will begin. If symptoms go on for any length of time, disease will usually occur.

Here is an example of how the malfunction of a biological process can affect every organ system: The immune system's job is to recognize *friend* from *foe* and to mount an attack against all *foes*. One of the ways it does this is by increasing inflammation, which calls into action a variety of cells and chemicals, whose job it is to destroy the "invader."

Inflammation is like a fire...if it gets out of control it can damage the entire body. Recent studies have shown that excess inflammation is a causative factor in *all* of our major chronic diseases...heart disease, hypertension, peripheral vascular disease, diabetes, obesity, osteoporosis, Alzheimer's and cancer. We can measure the level of inflammation in a patient's body with a simple blood test called a high sensitivity CRP (C-reactive protein), but that doesn't tell us the source of the inflammation. Excess inflammation has many

causes—including chronic infection, allergies (food or environmental), lack of oxygen to tissues, free radicals (oxidative stress), exposure to toxins, insulin resistance, and obesity.

We can separate the main biological processes into categories, but it is important not to lose sight of the fact that they are interdependent—they interact and affect each other continuously.

There are many diagnostic tools available to the functional medicine physician, to help him/her assess each of these areas of biological functioning. These tools are largely unknown to traditional physicians, but have been available for over 20 years.

The job of a Functional Medicine physician is to assess each of the 8 areas and make recommendations on how to repair and/or improve their functioning. Returning patients to health requires reversing or substantially improving the specific dysfunctions that have contributed to the disease state and symptoms. Those dysfunctions are, for each of us, the result of lifelong interactions among our environment, our lifestyle, and our genetic predisposition. Each patient, therefore, represents a unique, complex and interwoven set of influences that has set the stage for the development of disease or the maintenance of health.

Conventional medicine normally acts when a diagnosis can be made, or when signs and symptoms are severe enough (or the patient is persistent enough) to demand a clinical interven-

tion. Functional medicine physicians focus on restoring balance to the dysfunctional systems by strengthening the fundamental physiologic processes that underlie them and by adjusting the environmental inputs that nurture or impair them. This approach leads to therapies that focus on restoring health and function, rather than simply controlling signs and symptoms. With this new approach to medicine, patients with unexplained symptoms have hope again. Their *functional* illness is a perfect match for a Functional Medicine physician.

**Dr. Catherine A. Waller, M.D.**, is one of only 20 physicians in the world board-certified in anti-aging and functional medicine. She has been in practice for over 20 years, lectures regularly throughout Southeast Michigan and currently practices at the Waller Wellness Center, 1854 W. Auburn Road, Ste 400, Rochester Hills, MI 48309. For more information, call 248-844-1414.