Rejuvenate Wellness Center
6940 South Holly Circle
Centennial, CO 80112
303-850-0880

Dear friend,

Welcome to Rejuvenate Wellness Center!

Thank you and congratulations on making the choice to come see us!

You have scheduled an appointment with Dr. Peter M. Petropulos on _____, _____ (day/date) at _____ (time) at our Rejuvenate Wellness Center office.

Please complete all paperwork prior to arriving at the office and **arrive 15 minutes BEFORE your appointment time (which is listed above).**

You have taken an important step and made the choice to turn either your own and/or your family member's health around. We understand that this process will involve some challenging lifestyle changes, and we are here to work together as partners with you to help you reach your optimum health.

Many of our patients have previously consulted with numerous other health practitioners. Your decision to partner with us in a quest to improve your health will result in identifying the cause(s) of your illness, and eliminate the use of "Band-Aid" treatments for your symptoms. Answers to some of the common questions/concerns by our patients are listed below.

What Should I Do Prior to My Visit?
In this packet, you have received a health questionnaire. Take the time to answer the questions with as much detail as possible. **Please try to assemble any of your medical information that may be helpful (tests, consultations with other physicians, list of current medications and supplements).** If you have had tests, lab studies, surgeries, and/or consultations but don't have the records, please ask the appropriate physicians and/or hospitals to give them to you or have them sent directly to us. Bring the completed questionnaire and any additional information with you to your appointment.

What If I Am on Any Medications or Supplements?
Please stay on them until we have an opportunity to review your complete history. Most of our patients are able to eventually stop or reduce many of the medications that other doctors have put them on after they have been on our program for awhile. At your initial appointment, you will receive nutritional supplement recommendations. We carry an extensive line of the finest supplements available to physicians anywhere. They are specifically designed to complement the other lifestyle recommendations of our program. Although you may be able to purchase similar products at local health food

stores, the potential quality of these supplements may compromise our treatment and therefore hinder your progress.

What Happens at My First Appointment?
Dr. Petropulos will thoroughly review your medical history and symptom survey that you completed prior to your visit and also review medical records including recent lab results which you will have provided. He will do a complete physical examination, muscle testing for food and environmental intolerances as well as bio-diagnostic testing utilizing the latest in BAX Aura testing. If, after your examination, further laboratory analysis is required, we also have a full range of laboratory services and a wide variety of cutting-edge testing available in-house including blood, saliva, hair, urine, and stool analyses. After reviewing all the information, he will make recommendations for an individualized program of nutritional and lifestyle augmentation. This can also include Chiropractic care, acupuncture and further BAX therapies if you wish.

How Long Will It Take Before I Feel Better?
You should notice your health beginning to improve within a few weeks. Some people notice the difference in only a few days. However, it can take a bit longer, especially if significant psychological trauma is involved or if you are slow in adopting the lifestyle changes we recommend.

What Will Be The Cost For My First Visit?
The time spent with you on the first visit is approximately 1 hour, 45 minutes. An initial appointment is $345 (which does not include any lab work, testing, or supplements).

Follow-Up Appointments
Follow-up appointments are typically 15 minutes with the doctor and cost $95. You may be in the room 15 to 30 minutes longer depending on individual therapies (i.e., acupuncture, electrical stimulation, laser treatment, etc.) needed for your treatment; however, no additional cost will be assessed. If you require or desire more than the standard 15-minute appointment with the doctor, the fee will be an additional $95 per 15 minutes.

Will My Insurance Cover The Visit?
Most insurance companies do not cover the alternative therapies we offer to our patients, so we do not work with insurance companies. We do not typically provide any paperwork (superbills), diagnosis codes, or information for insurance companies.

Do We See Patients From Out of State?
We do have out-of-town and international patients. In these cases, we try to do most of the follow-up via telephone and the Internet; but a personal visit is generally preferred, but not mandatory, for the initial consultation. If you are coming from out of state, we will try to accommodate you so we are able to complete as many tests as possible when you are here and will use your time with us as effectively as possible.

What If I Want to Send a Friend or Family Member to See You?
We would be delighted and deeply honored to work with your loved ones. However, it is vital that this friend or family member is ready to commit to a change in diet, nutrition, and lifestyle in order to meet his/her own health goals.

What Happens If I Need to Cancel My Appointment?
Please call us as soon as you know that you need to cancel but no later than **48 hours prior to your appointment time** (except for cancellations due to inclement weather). **Voice mail messages are acceptable.** Keep in mind that there is a waiting list of patients desiring these appointments. These patients may have their treatments delayed if you do not call in a timely manner. Alternative medicine emphasizes very thorough personalized care; therefore, we do not 'double book' appointments. As a result, our policy is to charge $345 for initial visits not cancelled with a 48-hour notice; and $95 will be charged for follow-up appointments not cancelled with a 24-hour notice.

Driving Directions:
Rejuvenate Inc is located at **6940 South Holly Circle Suite 201** in the southern Denver suburb of Centennial; the closest major cross streets are Arapahoe and Dry Creek. Driving directions from I-25 and C-470 are as follows:

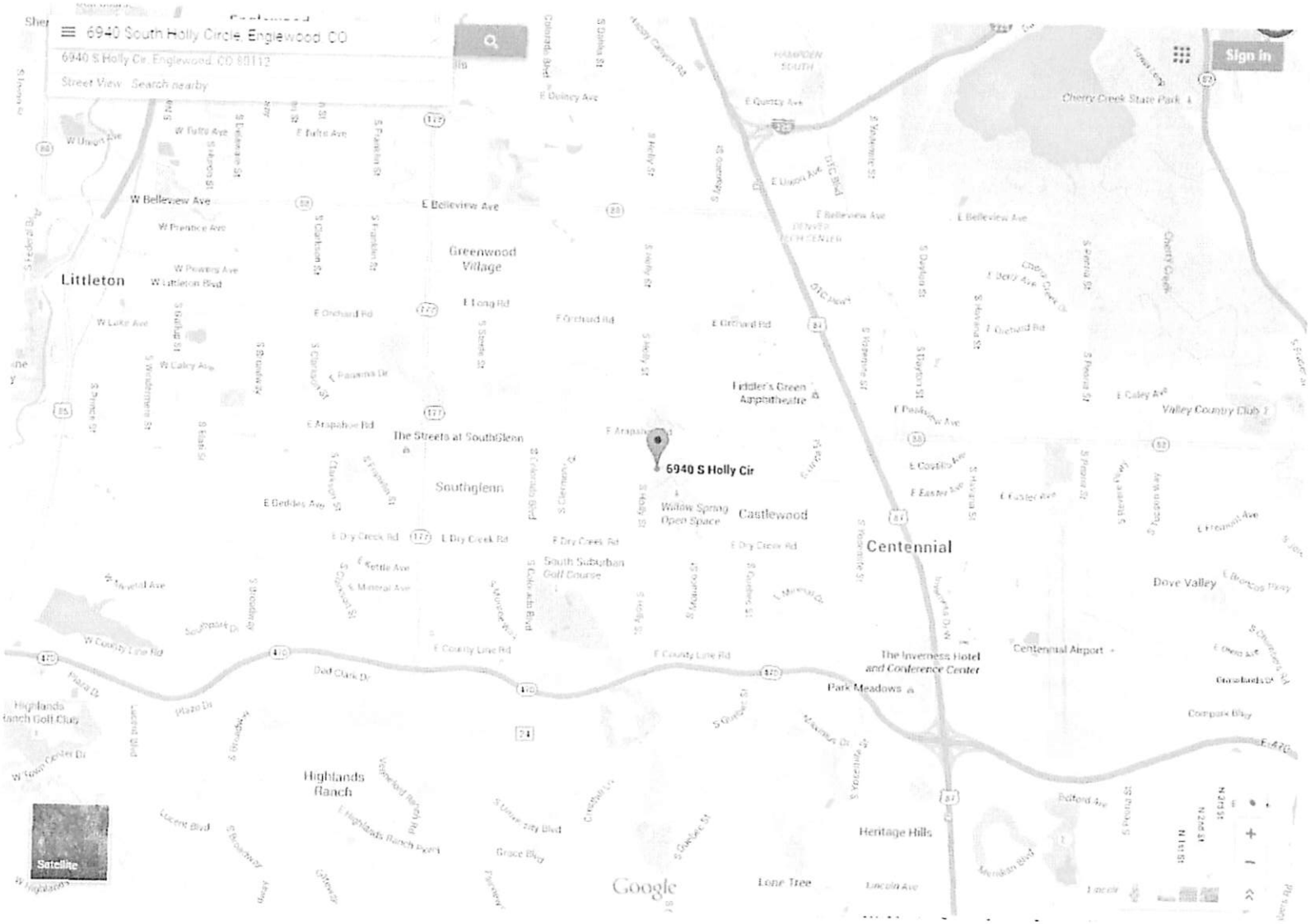
South Denver: Take I-25 N to Dry Creek Road, head West, then turn right (North) onto S. Holly Street, and then right (East) onto South Holly Circle, when you see a cul-de-sac and a sign for the Centennial Montessori turn right, head East. You will see a sign with our address on the right and a sign for the Joyous Chinese Cultural Center on the left, there is where our parking and entrance will be. We are located on the 2nd floor inside the Joyous Chinese Cultural Center.

North Denver: Take I-25 south to Arapahoe Road turn right (West), then turn left onto S. Holly Street (South), and then left onto South Holly Circle (East), when you see a cul-de-sac and a sign for the Centennial Montessori turn left, head East. You will see a sign with our address on the right and a sign for the Joyous Chinese Cultural Center on the left, there is where our parking and entrance will be. We are located on the 2nd floor inside the Joyous Chinese Cultural Center.

West Denver: From C-470 exit Quebec (North) to County Line (West), turn right (North) on S. Holly Street turn Right (East) onto South Holly Circle, when you see a cul-de-sac and a sign for the Centennial Montessori turn right, head East. You will see a sign with our address on the right and a sign for the Joyous Chinese Cultural Center on the left, there is where our parking and entrance will be. We are located on the 2nd floor inside the Joyous Chinese Cultural Center.

On behalf of Dr. Petropulos and Rejuvenate Wellness Center staff, we sincerely welcome you and look forward to helping you regain and maintain optimal health for many years to come.
We hope this information has answered your questions; however, if you still have questions, please feel free to call our office. We are open on Tuesdays and Thursdays, from 8am to 1pm and 3pm to 7pm; Fridays, 8am to 1pm and 3pm to 5pm; Saturdays from 8am to 2pm.

An aerial map showing I-25 and E-470 in relation to our office is attached.


6940 South Holly Circle, Englewood, CO
6940 S Holly Cir, Englewood, CO 80112
Street View - Search nearby
Sign In
6940 S Holly Cir
Littleton
Greenwood Village
Englewood
Southglenn
Castlewood
Centennial
Fiddler's Green Amphitheatre
The Streets at SouthGlenn
Willow Spring Open Space
South Suburban Golf Course
Cherry Creek State Park
Valley Country Club
Dove Valley
Centennial Airport
The Inverness Hotel and Conference Center
Park Meadows
Highlands Ranch
Highlands Ranch Golf Club
Heritage Hills
Lone Tree
Satellite
Google

REQUIRED INFORMATION for your Case History File—PLEASE PRINT

Name: _____ E-Mail Address_____

Address _____
City _____ State ____ Zip _____

Phone: H _____ C _____ W _____

Age _____ Birth Date _____ Sex ____ Marital Status: M S W D Civil Union

Employer _____ Occupation _____

Spouse/Partner's Name _____ Occupation _____

No. of Children _____ Names, in birth order _____

Person responsible for this account _____

Referred by _____

How long has it been since you really felt good? _____

List medications (over-the-counter and prescription) you are currently taking with dosage and frequency:

_____
_____
_____

Allergies to medications:

_____
_____

List any surgeries with dates:

_____
_____

List supplements, vitamins or herbs you are currently taking with dosage and frequency:

_____
_____
_____

Have you had a personal injury or accident? [□ Yes □ Past year □ Past 5 years □ Over 5 years]
If you answered 'yes,' describe:

_____
_____

Please list your 5 major health concerns in order of importance:

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

Please list any doctors who have treated these conditions:

_____
_____
_____

For each of your previously stated 5 major health concerns, Please indicate the following if they apply:

Major Health Concern 1:

Onset: What caused it and when did it begin?

Provoke: What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

Palliative: What makes it better – ice, over-the-counter medications, massage, position, etc.?

Quality: Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

Radiation: Does the pain (or symptoms) travel from one area to another?

Timing: Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

Severity:
*At its worst – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____
*At its best – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____

Major Health Concern 2:

Onset: What caused it and when did it begin?

Provoke: What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

Palliative: What makes it better – ice, over-the-counter medications, massage, position, etc.?

Quality: Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

Radiation: Does the pain (or symptoms) travel from one area to another?

Timing: Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

Severity:
*At its worst – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____
*At its best – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____

Major Health Concern 3:

Onset: What caused it and when did it begin?

Provoke: What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

Palliative: What makes it better – ice, over-the-counter medications, massage, position, etc.?

Quality: Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

Radiation: Does the pain (or symptoms) travel from one area to another?

Timing: Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

Severity:
*At its worst – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____
*At its best – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____

Major Health Concern 4:

Onset: What caused it and when did it begin?

Provoke: What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

Palliative: What makes it better – ice, over-the-counter medications, massage, position, etc.?

Quality: Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

Radiation: Does the pain (or symptoms) travel from one area to another?

Timing: Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

Severity:
*At its worst – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____
*At its best – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____

Major Health Concern 5:

Onset: What caused it and when did it begin?

Provoke: What worsens the complaint – position, activity, stress, food/drink, motion, etc.?

Palliative: What makes it better – ice, over-the-counter medications, massage, position, etc.?

Quality: Describe what you feel – is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, etc?

Radiation: Does the pain (or symptoms) travel from one area to another?

Timing: Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

Severity:
*At its worst – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____

Percent of the time _____
*At its best – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____

++Dr. Findings++

Complaint:

Onset:

Provoke:

Palliative:

Quality:

Radiation:

Timing:

Severity:
*At its worst – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____
*At its best – rate 1-10 (1 being no pain and 10 being the worst pain imaginable) _____
Percent of the time _____

Healthcare: Therapies: Past (P) and/or Current (C) and date

___Chiropractic _____	___Naturopathic _____	___Specialist_____
___Chiro for pets_____	___Oriental Medicine_____	___Natural Healer_____
___Acupuncture_____	___Nutritional Consult_____	___Spiritual Healer_____
___Therapeutic Massage_____	___Medical Treatment_____	___Energy Work_____

Diagnostic or Routine Exams: Check all that apply and list date

___X-Rays_____ ___Upper/Lower GI_____ ___Dental Exam_____
___MRI_____ ___DEXA Scan_____ ___Colonoscopy_____
___CAT Scan_____ ___Breast Exam_____ ___Other_____Date_____
___Blood Draw_____ ___Prostate Exam_____ ___Other_____Date_____
___Ultrasound_____ ___Eye Exam_____ ___Other_____Date_____

Medical History: Current = C Past = P (greater than 6 months) include dates if possible

Childhood: List Dates/Ages

___Chronic Strep Throat____ ___Chronic Ear infections____ ___Traumatic events _____
___Illnesses_____ ___Allergies_____ _____
___Chronic Antibiotic Use?_ ___Injuries_____ ___Other_____

Significant Illnesses: List Dates

___ Allergies_____ Hepatitis A / B / C_____ ___ Psychological_____
___ Arthritis _____ ___ Heart disease _____ ___ Rheumatic Fever_____
___ Asthma_____ ___ High blood pressure_____ ___ Seizures_____
___ Cancer _____ ___ Low blood pressure _____ ___ Thyroid disease_____
___ Depression_____ ___ Lung disease _____ ___ Vascular disease_____
___ Diabetes _____ ___ Neurological _____ ___ Other _____

Illness/Injuries/Surgeries/Hospitalizations: List Dates

___ Broken bones_____ ___ Burns_____ ___ Car accidents_____
___ Concussion _____ ___ Fallen down/upstairs_____ ___ Fallen from any height_____
___ Fallen on ice _____ ___ Feeling un-coordinated_____ ___ Fevers_____
___ Flu/colds _____ ___ Frequent accidents_____ ___ Frequent Illness_____
___ Frequent Infections _____ ___ Head trauma_____ ___ Hospitalizations _____
___ Infected wounds _____ ___ Loss of consciousness_____ ___ Psychological Hosp_____
___ Recreational Injuries_____ ___ Serious cuts_____ ___ Serious Depression_____
___ Significant trauma_____ ___ Surgeries _____ ___ Transfusions_____
___ Transplants _____ ___ Tripping/Stumbling_____ ___ Wounds slow to heal_____

Appliances or Aides:

___ Glasses/Prisms ___ Contacts ___ Orthotics
___ Joint replacement ___ Prosthetics ___ Implants of any kind
___ Braces ___ Splints ___ Pace Maker
___ Hearing Aids ___ Other ___ Other

Skin and Hair: List Dates

___ Rashes_____ ___ Eczema_____ ___ Hair/skin texture change____
___ Ulcerations_____ ___ Pimples_____ ___ Purpura_____
___ Hives_____ ___ Dandruff_____ ___ Itching_____
___ Loss of hair_____ ___ New moles/growth_____ ___ Other _____

_____
_____

General: List times of day or any correlating factors

___ Poor appetite_____ ___ Heavy appetite_____ ___ Change in appetite_____
___ Weight gain_____ ___ Weight loss_____ ___ Cravings salt/sweet/fats_____
___ Poor sleep_____ ___ Can't fall asleep easily_____ ___ Wake feeling rested_____
___ Decreased sleep_____ ___ Heavy sleep_____ ___ Insomnia_____
___ Apnea/Narcolepsy_____ ___ Night sweats_____ ___ Hours of sleep/night_____
___ Day napping _____ ___ Strong thirst hot/cold_____ ___ Cold hands/feet_____
___ Sudden energy drop_____ ___ Sudden temp changes_____ ___ Fatigue_____
___ Chills_____ ___ Poor circulation_____ ___ Localized weakness_____
___ Tremors_____ ___ Bowel/bladder changes_____ ___ Peculiar tastes/smells_____
___ Night pain _____ ___ Radiating pain_____ ___ Numbness/tingling _____
___ Pins and needles_____ ___ Sweats easily_____ ___ Excessive sweating_____
___ Body odor change_____ ___ Stress_____ ___ Bleed/bruise easily (where?)____
___ Sudden awakening at night_____

_____
_____
_____

Head, Eyes, Ears Nose and Throat: List any noticeable correlation and frequency

___Dizziness_____ ___Migraines_____ ___Auras, Sounds, Smells_____
___Headaches_____ ___Vision problems_____ ___Near/Far sighted_____
___Blurry vision_____ ___Night Blindness_____ ___Eye strain/pain_____
___Color blindness_____ ___Cataracts_____ ___Glaucoma_____
___Spots in eyes_____ ___Ringing in ears_____ ___Poor hearing_____
___Earaches_____ ___Ear Pain_____ ___Ear discharge_____
___Heavy ear wax_____ ___Nose bleeds_____ ___Sinus problems_____
___Mucus_____ ___Dry throat/mouth_____ ___Copious saliva (lots)_____
___Mouth/tongue sores_____ ___Sore throats_____ ___Other_____

_____
_____
_____

Musculoskeletal: List location and type of pain, i.e. sharp, dull, radiating, traveling, etc... Use image on last page of this document to depict specific areas of complaint.

___ Neck Pain_____ ___ Muscle Pain_____ ___ Back Pain_____
___ Joint Pain_____ ___ Other muscle or joint problems? ___ Intractable night pain
___ Scar tissue adhesions_____ _____ _____

_____
_____

Are you wearing:

___ Heel Lifts_____ ___ Sole Lifts_____ ___ Inner Soles_____
___ Arch Supports_____ ___ Other_____ ___ Other_____

_____
_____

Dental: List Dates

___Teeth problems_____
___Bridges_____
___Tooth pain_____
___Molars_____
___Jaw clicks_____
___Implants_____
___Periodontal Tx _____
___Dry mouth__

___Cavities_____
___Fillings/amalgams_____
___Head pain_____
___Extractions_____
___Grinding teeth_____
___Dentures_____
___Sealants_____
___Other_____

___Braces_____
___Crowns gold/porcelain_____
___Jaw pain_____
___Surgeries_____
___Facial pain_____
___Swollen/bleeding gums____
___Fluoride Tx_____
___Root Canals_____

Neurologic: List Dates

___ Balance problems_____
___ Vomiting_____
___ Loss of strength_____
___ Stumbling/tripping_____
___ Loss of hand grip_____

___ Vertigo_____
___ Sudden blurry vision_____
___ Weakness limb/body_____
___"Running into walls or things"___
___ Loss of fine motor skills_____

___ Nausea_____
___ Loss of consciousness_____
___ Feel un-coordinated_____
___ Frequently dropping things_____
___ Other_____

Cardio Vascular: List Dates and/or Times

___ High blood pressure_____
___ Low blood pressure_____
___ Chest Pain_____
___ Irregular heartbeat_____
___ Heaviness in chest _____

___ Dizziness_____
___ Fainting_____
___ Cold hands/feet_____
___ Hand/feet swelling_____
___ Other _____

___ Blood Clots_____
___ Phlebitis_____
___ Difficulty breathing_____
___ Rapid pulse_____
___ Other_____

Respiratory and Lungs: List Dates

___Persistent Cough_____
___ Asthma _____
___ COPD_____
___ Asthma_____

___ Coughing Blood_____
___ Production of phlegm_____
___Phlegm Color_____
___ Bronchitis_____

___ Difficulty breathing while lying down
___ Tight chest_____
___ Pneumonia_____
___ Other_____

Genito-Urinary:

___Pain w/urination_____
___Kidney Stones_____
___Venereal Disease/STD _____
___Blood in urine_____
___Impotency_____

___Loss of bladder function_____
___Frequent Urination_____
_____Odor
_____Color
___Prostate problems_____

___Wake to urinate_____
____Time
____Times Per Night
___Urgency to urinate_____
___Other _____

Gastrointestinal:

___ Nausea_____ ___ Gas/bloating_____ ___ Bad breath_____
___ Constipation_____ ___ Diarrhea_____ ___ Pain or cramps_____
___ Vomiting_____ ___ Belching_____ ___ Rectal pain_____
___ Bloody stools bright/dark red___ ___ Hemorrhoids_____ ___ Sensitive abdomen_____
___ Laxative use:___x/wk; type____ ___ Bowel Changes _____
_____ _____

Bowel movements:

____Frequency/day/wk_____ ____Color _____ ___Odor (foul) _____
____Form (loose, compact)_____ ____Texture (smooth, segmented) Other_____

_____
_____
_____

Gynecology and pregnancy:

___ Age of 1st menses_____ ___ Vaginal Sores_____ ___ Vaginal discharge_____
___ Irregular Periods_____ ___ Last Menses_____ ___ Birth Control type _____
___ Number of pregnancies_____ ___ Number of births_____ ___ Live births_____
___ Premature births_____ ___ Miscarriages; What month?____ ___ Breast Lumps (tender?)_____
___ PMS_____ ___ Mood Changes_____ ___ Body Changes_____
___ Cramps_____ ___ Bloating_____ ___ Nausea_____
___ Vomiting_____ ___ Menopause _____ ___ Last PAP_____
___ Last Breast Exam_____ ___ Last Ob/GYN Appt_____

_____
_____
_____

YOUR birth and infancy:

___Born by; (vaginal, c-section)____ ___Breast or Bottle Fed_____ ___Immunized?_____
___Premature_____ How long_____ Fully/Partially_____
___Colic_____ ___Good/Bad sleep habits_____ Reactions?_____
___NICU_____ ___Surgeries after birth_____ ___Stress/Trauma to your mother
while in utero? _____
_____
_____

Neuropsychological:

___ Seizures_____ ___ Depression_____ ___ Anxiety_____
___ Poor memory_____ ___ Foggy thinking_____ ___ Bad Temper_____
___ Concussions_____ ___ Easily stressed_____ ___ Considered/attempted suicide___
___ Treated for emotional concerns_____ ___ Antidepressant medications_____ _____ ___ Other neurological or psych concerns_____

_____
_____
_____

Do you find any dysfunction or concern in the following areas?

___ Relationship with Family_____ ___ Relationships with friends_____ ___ Social Skills_____
___ Career_____ ___ Work_____ ___ Leisure Time_____
___ Hobbies_____ ___ Past time activities_____ ___ Intimate relationships_____
___ Sex_____ ___ Religious Life_____ ___ Spiritual Path_____
___ Childhood Religious teachings___ ___ Past relationships_____ ___ Childhood_____
___ School_____

Habits: List type and quantities where valid

___ Exercise x's/week_____
___ Sports_____
___ Regular Spiritual activity_____
___ Road Rage_____
___ Smoke/chew tobacco_____
___ Un-necessary risk taking_____
_____

Seek conflict_____
___ Walks_____
___ Seatbelts_____
___ Consume Alcohol _____
___ Recreational drugs use_____
___ Caffeine/pills/coffee/tea/drinks__
_____

___ Un-protected sex_____
___ Regular Religious activity_____
___ Helmets/Protective gear _____
___ Crave sugar/salt/fats _____
___ Other_____
___ Participate in community events_____

Nutritional: List typical ounces/servings per week and type

___ Drink soda oz/wk_____
___ Gatorade oz/wk_____
___ Caffeine _____
___ Alcohol _____
___ Nutritional Shakes_____
___ Protein powders_____
___ Meat_____
___ Milk, oz/wk_____
___ Veg, serving/day_____
___ Food Allergies_____

___ Fruit juices oz/wk_____
___ Coffee/black tea _____
___ Chocolate_____
___ Health drinks _____
___ Health bars_____
___ Cravings salt/sweet/fats_____
___ Protein _____
___ Dairy, Type _____
___ Fruits, serving/day_____
___ Chew Gum with Aspartame or Nutra-sweet?_____

Environmental Stressors: Do you have or use (How often?)

___ Scented Laundry Detergent_____
___ Perfumes or Colognes_____
___ Scented Candles or Plug-ins_____
___ Hot Tub_____

___ Scented Dryer Sheets_____
___ Scented Lotions_____
___ Pool_____
___ Memory Foam Bedding (Mattress, Pillow, etc)_____

___ Is your home or office near a major thoroughfare?_____
___ Any "New Construction" at home or work - Paint, Carpet, Tile, Flooring, etc._____
___ Is there or has there been any water damage or flooding at home or work?_____
___ Does your bedroom contain plants, books or any dry cleaned items?_____
___ Are there any bedrooms or living areas in your home located above the garage?_____
___ In the last year have you purchased a new car, appliance or furniture?_____
___ Do you have a water filter? If so, when was the last time the filter was changed?_____
___ Other _____

Current Immunizations: Have you received any of the following? (recently or regularly)

__Shingles:_____Date_____Frequency
__Pneumonia:_____Date_____Frequency
__COVID 19:_____Date_____Booster? _____Which one?
__Other:_____

__HPV:_____Date_____Frequency
__Influenza:_____Date_____Frequency

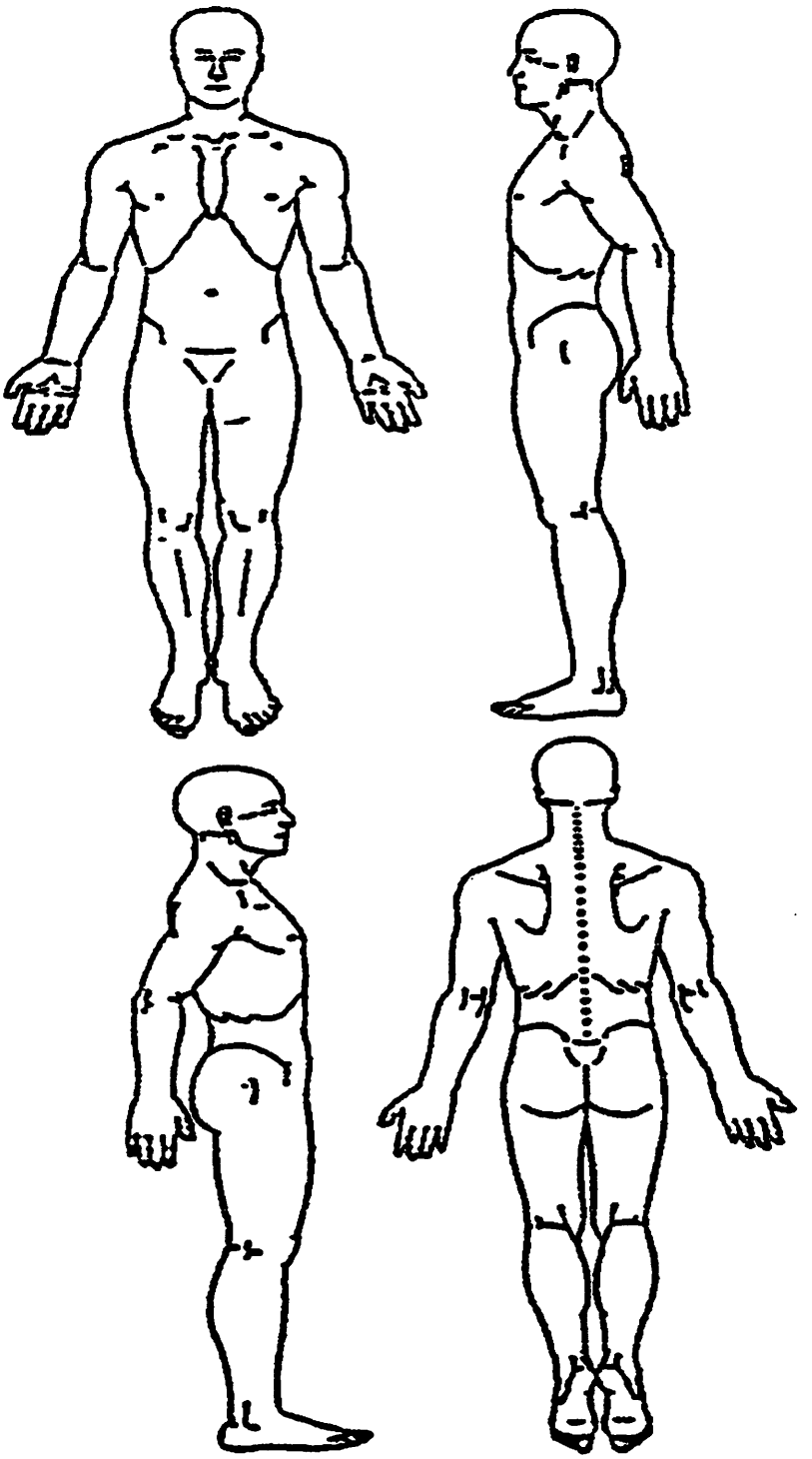
Family History: Medical, Psychological, Social

Concern	Maternal	Paternal	Relationship	Concern	Maternal	Paternal	Relationship
◻ Alcoholism	◻	◻	_____	◻ Neuropathy	◻	◻	_____
◻ Allergies	◻	◻	_____	◻ Neuromuscular Disease	◻	◻	_____
◻ ALS	◻	◻	_____	◻ OCD	◻	◻	_____
◻ Alzheimer's	◻	◻	_____	◻ Osteopenia	◻	◻	_____
◻ Anemia	◻	◻	_____	◻ Osteoporosis	◻	◻	_____
◻ Anxiety	◻	◻	_____	◻ Parkinson's	◻	◻	_____
◻ Asthma	◻	◻	_____	◻ Physical Abuse	◻	◻	_____
◻ Back/Spine Problem	◻	◻	_____	◻ Rheumatoid Arthritis	◻	◻	_____
◻ Bi-Polar	◻	◻	_____	◻ Rigid Upbringing	◻	◻	_____
◻ Cancer	◻	◻	_____	◻ Rigid Religious Beliefs	◻	◻	_____
◻ Dementia	◻	◻	_____	◻ Schizophrenia	◻	◻	_____
◻ Depression	◻	◻	_____	◻ Scleroderma	◻	◻	_____
◻ Diabetes	◻	◻	_____	◻ Seizures	◻	◻	_____
◻ Family Violence	◻	◻	_____	◻ Sexual Abuse	◻	◻	_____
◻ GI Disorders	◻	◻	_____	◻Stroke	◻	◻	_____
◻ Headaches	◻	◻	_____	◻ Substance Abuse	◻	◻	_____
◻ Heart Attack	◻	◻	_____	◻ Suicide (or attempted)	◻	◻	_____
◻ Heart Disease	◻	◻	_____	◻ Thyroid Problems/Disease	◻	◻	_____
◻ High Blood Pressure	◻	◻	_____	◻ Tremors	◻	◻	_____
◻ High Cholesterol	◻	◻	_____	◻ Vascular Disease	◻	◻	_____
◻ Low Cholesterol	◻	◻	_____	◻ Other_____	◻	◻	_____
◻ Lung Disease	◻	◻	_____	◻ Other_____	◻	◻	_____
◻ Lupus	◻	◻	_____	◻ Other_____	◻	◻	_____
◻ Mental Abuse	◻	◻	_____	◻ Other_____	◻	◻	_____
◻ Mental Illness(other)	◻	◻	_____	◻ Other_____	◻	◻	_____
◻ Migraines	◻	◻	_____	◻ Other_____	◻	◻	_____
◻ Multiple-sclerosis	◻	◻	_____	◻ Other_____	◻	◻	_____
◻ Muscular Dystrophy	◻	◻	_____	◻ Other_____	◻	◻	_____
◻ Neglect	◻	◻	_____	◻ Other_____	◻	◻	_____

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that, if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient (or Guardian) Signature _____ Date _____

Please specify any symptom locations below using initials indicated:



XX – Sharp Pain
OO – Dull Ache
TT – Throbbing Pain
CT – Constant
DP – Deep
RR – Radiating
SU – Superficial
BU – Burning
NU – Numbness
TI – Tingling
WE – Weakness

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

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

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3

Category VI (continued)				
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV				
Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*				
How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Health Questionnaire (NTAF)

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

*** Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.**

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Medication History*

Please check any of the following medications you have been or are currently taking.

Acetylcholine Receptor Antagonist – Antimuscarinic Agents
☐Atropine, ☐Ipratopium, ☐Scopolamine, ☐Tiotropium

Acetylcholine Receptor Antagonist - Ganlionic Blockers
☐Mecamylamine, ☐Hexamethonium, ☐Nicotine (high doses), ☐Trimethaphan

Acetylcholinesterase Reactivators
☐Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers
☐Atracurium, ☐Cisatracurium, ☐Doxacurium, ☐Metocurine, ☐Mivacurium, ☐Pancuronium, ☐Rocuronium, ☐Succinylcholine, ☐Tubocurarine, ☐Vecuronium, ☐Hemicholinium

Agonist Modulator of GABA Receptor (benzodiazepines)
☐Xanax®, ☐Lexotanil, ☐Lexotan®, ☐Librium, ☐Klonopin®, ☐Valium®, ☐ProSom®, ☐Rohypnol, ☐Dalmane, ☐Ativan, ☐Loramet®, ☐Sedoxil, ☐Dormicum, ☐Megalodon, ☐Serax®, ☐Restoril, ☐Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)
☐Ambien CR®, ☐Sonata®, ☐Lunesta®, ☐Imovane

Cholinesterase Inhibitors (irreversible)
☐Echotiophate, ☐Isoflurophate, ☐Organophosphate Insecticides, ☐Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)
☐Donepezil, ☐Galatamine, ☐Rivastigmine, ☐Tacrine, ☐THC, ☐Edrophonium, ☐Neostigmine, ☐Physostigmine, ☐Pyridostigmine, ☐Carbamate Insecticides

Dopamine Reuptake Inhibitors
☐Wellbutrin XL® (Bupropion)

Dopamine Receptor Agonists
☐Mirapex®, ☐Sifrol®, ☐Requip®

D2 Dopamine Receptor Blockers (antipsychotics)
☐Thorazine®, ☐Prolixin®, ☐Trilafon®, ☐Compazine®, ☐Mellaril®, ☐Stelazine®, ☐Vesprin®, ☐Nozinan®, ☐Depixol®, ☐Navane®, ☐Fluanxol®, ☐Clopixol®, ☐Acuphase®, ☐Haldol®, ☐Orap®, ☐Clozaril®, ☐Zyprexa®, ☐Zydis®, ☐Seroquel XR®, ☐Geodon®, ☐Solian®, ☐Invega®, ☐Abilify®

GABA Antagonist Competitive binder
☐Flumazenil

Monoamine® Oxidase Inhibitors (MAOI)
☐Marplan®, ☐Aurorix®, ☐Manerix®, ☐Moclodura, ☐Nardil, ☐Adeline®, ☐Eldepryl®, ☐Azilect®, ☐Marsilid®, ☐Iprozid®, ☐Ipronid®, ☐Rivivol, ☐Popilniazida®, ☐Zyvox®, ☐Zyvoxid®

Noradrenergic® and Specific Sertonergic® Antidepressants (NaSSaa)
☐Remeron®, ☐Zispin®, ☐Avanza®, ☐Norset®, ☐Remergil®, ☐Axit®

Selective Serotonin Reuptake Inhibitors
☐Paxil®, ☐Zoloft®, ☐Prozac®, ☐Celexa®, ☐Lexapro®, ☐Luvox®, ☐Cipramil®, ☑Emocal®, ☐Seropram®, ☐Cipralex®, ☐Esteria®, ☐Fontex®, ☐Dapoxetine® ☐Seromex®, ☐Seronil®, ☐Sarafem®, ☐Fluctin®, ☐Faverin®, ☐Seroxat, ☐Aropax®, ☐Deroxat®, ☐Rexetin®, ☐Paroxat®, ☐Lustral®, ☐Serlain®

Selective Serotonin Reuptake Enhancers
☐Stablon®, ☐Coaxil, ☐Tatinol®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
☐Effexor®, ☐Pristiq®, ☐Meridia, ☐Serzone®, ☐Dalcipran®, ☐Despiramin, ☐Duloxetine

Tricylic Antidepressants (TCAs)
☐Elavil®, ☐Endep®, ☐Tryptanol, ☐Trepiline®, ☐Asendin®, ☐Asendis®, ☐Defanyl®, ☐Demolox®, ☐Moxadil®, ☐Anafranil®, ☐Norpramin®, ☐Pertofrane®, ☐Prothiaden®, ☐Adapin®, ☐Sinequan®, ☐Tofranil®, ☐Janamine®, ☐Gamanil®, ☐Aventyl®, ☐Pamelor®, ☐Opipramol®, ☐Vivactil®, ☐Rhotrimine®, ☐Surmontil®

***Please refer to prescribing physician for nutritional interactions with any medications you may be taking.**

The Rejuvenate Wellness Center

Your Daily Food Intake Record: Track your daily eating patterns for one full week, including the approximate amounts of each food. Bring this intake record with your first new patient appointment.

Name: _____ **Patient #:** _____

Day 1 –

Breakfast (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-MORNING SNACK (TIME:_____)
Snack_____
Bowel Movements (# and Consistency)
_____

Lunch (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-DAY SNACK (TIME:_____)
Snack_____
Hours of Sleep:_____

Dinner (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
NIGHTTIME SNACK (TIME:_____)
Snack_____
Quality of Sleep: _____

Check # Glasses Water Consumed Each Day

Day 2 –

Breakfast (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-MORNING SNACK (TIME:_____)
Snack_____
Bowel Movements (# and Consistency)
_____

Lunch (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-DAY SNACK (TIME:_____)
Snack_____
Hours of Sleep:_____

Dinner (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
NIGHTTIME SNACK (TIME:_____)
Snack_____
Quality of Sleep: _____

Check # Glasses Water Consumed Each Day

Day 3 –

Breakfast (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-MORNING SNACK (TIME:_____)
Snack_____
Bowel Movements (# and Consistency)
_____

Lunch (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-DAY SNACK (TIME:_____)
Snack_____
Hours of Sleep:_____

Dinner (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
NIGHTTIME SNACK (TIME:_____)
Snack_____
Quality of Sleep: _____

Check # Glasses Water Consumed Each Day

Day 4 –

Breakfast (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-MORNING SNACK (TIME:_____)
Snack_____
Bowel Movements (# and Consistency)
_____

Lunch (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-DAY SNACK (TIME:_____)
Snack_____
Hours of Sleep:_____

Dinner (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
NIGHTTIME SNACK (TIME:_____)
Snack_____
Quality of Sleep: _____

Check # Glasses Water Consumed Each Day

Day 5 –

Breakfast (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-MORNING SNACK (TIME:_____)
Snack_____
Bowel Movements (# and Consistency)
_____

Lunch (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-DAY SNACK (TIME:_____)
Snack_____
Hours of Sleep:_____

Dinner (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
NIGHTTIME SNACK (TIME:_____)
Snack_____
Quality of Sleep: _____

Check # Glasses Water Consumed Each Day

Day 6 –

Breakfast (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-MORNING SNACK (TIME:_____)
Snack_____
Bowel Movements (# and Consistency)
_____

Lunch (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-DAY SNACK (TIME:_____)
Snack_____
Hours of Sleep:_____

Dinner (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
NIGHTTIME SNACK (TIME:_____)
Snack_____
Quality of Sleep: _____

Check # Glasses Water Consumed Each Day

Day 7 –

Breakfast (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-MORNING SNACK (TIME:_____)
Snack_____
Bowel Movements (# and Consistency)
_____

Lunch (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
MID-DAY SNACK (TIME:_____)
Snack_____
Hours of Sleep:_____

Dinner (Time:_____)
Meat & Dairy_____
Vegetable/Fruit_____
Bread/Cereal/Grain_____
Fats/Butter_____
Candy/Junk Food_____
Water Intake (fl. Oz.)_____
Other Drinks_____
NIGHTTIME SNACK (TIME:_____)
Snack_____
Quality of Sleep: _____

Check # Glasses Water Consumed Each Day

NOTES:_____

The Rejuvenate Wellness Center
6940 S. Holly Cir. #201
Centennial, CO 80112
303-850-0880
www.rejuvenatewellnesscenter.com

PATIENT - DOCTOR AGREEMENTS

The purpose of these agreements is to allow us to more completely serve you and to get the best results in the shortest amount of time. Our experience is that those patients who adhere to the following agreements, get the best results.

PAYMENT OF BILLS-

Whatever arrangements you make with our office, we expect you to honor. If you can't fulfill your arrangement in this area, please let our financial manager know immediately so new arrangements can be made. Accounts past due will be charged a handling fee. Failure to communicate after three billings in the form of payment or explanation will result in immediate legal action.

FIRST APPOINTMENT ARRIVAL-

In order to honor your time and the time of our other patients, please **arrive 15 minutes prior** to your initial appointment with **all of your New Patient forms completed** preceding your arrival. This will allow the office staff to assemble your patient chart and permit Dr. Petropulos to review all of your health history information prior to the start of your appointment time. We feel that this is extremely important, so strict adherence to this expectation is required.

CANCELLING OR CHANGING APPOINTMENTS-

We have set up a specific course of treatment for you. A certain amount of treatments are required in a set amount of time to get the results we both desire. Thus, if you need to change the time of your appointment, attempt to come in another time the same day. If you are unable to keep your appointment within the same day, we require 24 hour notice, otherwise you will be charged for the time reserved.

WAIT TIME-

Due to the inability to predict patient needs, appointments may take longer than anticipated. Waiting can be expected. Please feel free to call our office prior to your appointment to see how the doctor is running. Every attempt to predict wait time will be made at the time of your call. Please feel free to communicate any frustrations concerning this directly to the doctor.

PERFUMES, LOTIONS AND COLOGNES-

For the comfort of our office staff and patients, please refrain from wearing any perfume, cologne, or strongly scented lotions when visiting our office. Many of those with whom you will be in contact suffer from allergies to the above referenced items. Your cooperation in this is greatly appreciated!

DIETS AND FOOD SUPPLEMENTS-

Both should be followed or taken as requested by your doctor. Please communicate any inability to do such, so that the doctor can compensate for any nutritional inadequacy.
You are expected to pay for vitamins at the time of purchase.

_____ _____

Patient Signature Date

HIPAA Notice of Privacy Practices

THE LIFE CENTER
Dr. Peter M. Petropulos
7200 E. Dry Creek Road,
Bldg. A #101
Englewood, Co. 80112

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your protected health information. "Protected health information" is information about you, including demographics information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclose indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name_____ Signature_____

Date_____