AMERICAN WELLNESS CARE

LYNNE E. KAVULICH, D.C., D.A.C.B.N
DOCTOR OF CHIROPRACTIC • BIOCRANIAL THERAPY
DIPLOMATE OF AMERICAN CLINICAL BOARD OF NUTRITION
DIPLOMATE OF AMERICAN BOARD OF ANTI-AGING

Welcome and thank you for choosing American Wellness Care. We invite you to have a preview prior to your appointment by visiting our website, www.americanwellnesscare.com.

We have scheduled your Nutritional Wellness Appointment on _____ at_____. This appointment includes your comprehensive consultation and individualized clinical testing.

The fee of $250.00 will cover your entire appointment including your consultation, review of your health history and individualized clinical testing. You will be given a receipt for insurance should it be a covered service for you. **Kindly give 48 hours notice if you need to reschedule the appointment**. This will allow those on our waiting list to be scheduled. We cannot guarantee that a missed appointment can be rescheduled.

Some of our services include:

- Chiropractic, BioCranial and Cranial – Sacral Therapy
- Customized Nutrition Programs for Optimal Body Composition, Balancing Hormones Naturally, Abundant Energy, Healthy Cholesterol , Normalizing your Digestion, Allergy Control
- Massage – Doctor prescribed and specialty massages
- Therapeutic low level Laser and Acupoint Therapy (non-needle)
- Infratonic Qigong Therapy for Stress and Pain
- Self-Help Postural Enhancement and Pain Relief Sessions
- Wellness and Nutrition Seminars: Loving Menopause, Maintaining Cardiovascular Wellness, The Hormone – Mood Connection, Food Craving Control, Bone and Joint Health and No More Bloating

Should you have any questions before your appointment, feel free to call our office. We look forward to seeing you. Kindly come prepared with your completed paperwork and any pertinent medical records or blood work.

To your health,

Dr. Lynne E. Kavulich

1061 ROUTE 82 HOPEWELL JUNCTION, N.Y. 12533 (845) 221-1201 FAX: (845) 221-0289

American Wellness Care
NEW PATIENT INFORMATION FORM

Please print clearly:

Name:_____ Date:_____

Address:_____ Apt#:_____

City _____ State _____ ZIP _____

Circle preferred contact number:

Home Phone (____) _____-_____ Work Phone (____) _____-_____ ext. ____

Cell Phone (____) _____-_____ **E-mail address:** _____

REFERRED BY:_____

Date of Birth_____Age ____ Sex: M/F Occupation_____

Race (Circle One)

White Asian Japanese Hispanic Italian French Other_____ I choose not to specify

Ethnicity (Circle One)

Hispanic or Latino Not Hispanic or Latino Other_____ I choose not to specify

Preferred Language (Circle One)

English Spanish Italian French Other_____ I choose not to specify

Overall health (Circle One): Excellent / Good / Fair / Poor / Other:

Office Use: Height _____ Weight _____ B.P_____

Chief Complaint:

Please list your major problems and/or symptoms and the approximate date it began (if none, please write your reasons for seeking this consultation) please rank in order or importance to you.

When problem began

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

Current medication :

_____

_____

_____

Nutritional Supplements you are taking: _____

_____

_____

_____

_____

Do you currently smoke tobacco of any kind? (Circle One) Yes Former Smoker Never Been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

What's your level of interest in quitting smoke? No interest 0 1 2 3 4 5 6 7 8 9 10 **Very interested**

American Wellness Care
NEW PATIENT INFORMATION FORM

List any known allergies (Medication, Food and/or Environment) _____

_____

_____

_____

Has any doctor diagnosed you with Hypertension presently? _____

If yes, please describe: _____

Has any doctor diagnosed you with Diabetes presently? _____ **Type I** _____ **Type II** _____

If yes, other comments regarding diabetes: _____

Alcohol Consumption Circle One: **None** **Casual** **Moderate** **Heavy**

Caffeine Consumption Circle One: **None** **<3cups/day** **3-6 cups/day** **>6 cups per day**

Women: Are you pregnant? _____ **Last menstrual period:** _____

Personal History:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date: _____

_____

_____

Past Accidents or injuries: _____

_____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ___

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

_____

_____

American Wellness Care
NEW PATIENT INFORMATION FORM

Family History:

Relative	Living Age	History	Deceased Age	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

SYMPTOM SURVEY FORM

NAME_____ DOCTOR_____ DATE _____

AGE _____ SEX M ____ F_____

Phone # (_____) _____

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3
(1) for **MILD** symptoms
(2) for **MODERATE** symptoms
(3) for **SEVERE** symptoms
Leave the box **BLANK** if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up - fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feel "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleeps - hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression - "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptive to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry Skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movement painful or difficult
82 ☐ Worries, feels insecure
83 ☐ Felling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attaches
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

DR. LYNNE E. KAVULICH
AMERICAN WELLNESS CARE
1061 Route 82
Hopewell Jct. NY 12533
(845) 221-1201
www.americanwellnesscare.com

GROUP 6

98 ☐ Loss of taste for meat
99 ☐ Lower bowel gas several hours after eating
100 ☐ Burning stomach sensations, eating relieves
101 ☐ Coated tongue
102 ☐ Pass large amounts of foul-smelling gas
103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ☐ Mucus colitis or "irritable bowel"
105 ☐ Gas shortly after eating
106 ☐ Stomach "bloating" after eating

GROUP 7
(A)

107 ☐ Insomnia
108 ☐ Nervousness
109 ☐ Can't gain weight
110 ☐ Intolerance to heat
111 ☐ Highly emotional
112 ☐ Flush easily
113 ☐ Night sweats
114 ☐ Thin, moist skin
115 ☐ Inward trembling
116 ☐ Heart palpitates
117 ☐ Increased appetite without weight gain
118 ☐ Pulse fast at rest
119 ☐ Eyelids and face twitch
120 ☐ Irritable and restless
121 ☐ Can't work under pressure

(B)

122 ☐ Increase in weight
123 ☐ Decrease in appetite
124 ☐ Fatigue easily
125 ☐ Ringing in ears
126 ☐ Sleepy during day
127 ☐ Sensitive to cold
128 ☐ Dry or scaly skin
129 ☐ Constipation
130 ☐ Metal sluggishness
131 ☐ Hair coarse, falls out
132 ☐ Headaches upon arising wear off during day
133 ☐ Slow pulse, below 65
134 ☐ Frequency of urination
135 ☐ Impaired hearing
136 ☐ Reduced initiative

GROUP 7 (continued)

(C)

137 ☐ Failing memory
138 ☐ Low blood pressure
139 ☐ Increased sex drive
140 ☐ Headaches, "splitting or rending" type
141 ☐ Decreased sugar tolerance

(D)

142 ☐ Abnormal thirst
143 ☐ Bloating of abdomen
144 ☐ Weight gain around hips or waist
145 ☐ Sex drive reduced or lacking
146 ☐ Tendency to ulcers, colitis
147 ☐ Increased sugar tolerance
148 ☐ Women: menstrual disorders
149 ☐ Young girls: lack of menstrual function

(E)

150 ☐ Dizziness
151 ☐ Headaches
152 ☐ Hot flashes
153 ☐ Increased blood pressure
154 ☐ Hair growth on face or body (female)
155 ☐ Sugar in urine (not diabetes)
156 ☐ Masculine tendencies (female)

(F)

157 ☐ Weakness, dizziness
158 ☐ Chronic fatigue
159 ☐ Low blood pressure
160 ☐ Nails weak, ridged
161 ☐ Tendency to hives
162 ☐ Arthritic tendencies
163 ☐ Perspiration increase
164 ☐ Bowel disorders
165 ☐ Poor circulation
166 ☐ Swollen ankles
167 ☐ Crave salt
168 ☐ Brown spots or bronzing of skin
169 ☐ Allergies - tendency to asthma
170 ☐ Weakness after colds, influenza
171 ☐ Exhaustion - muscular and nervous
172 ☐ Respiratory disorders

FEMALE ONLY

173 ☐ Very easily fatigued
174 ☐ Premenstrual tension
175 ☐ Painful menses
176 ☐ Depressed feeling before menstruation
177 ☐ Menstruation excessive and prolonged
178 ☐ Painful breasts
179 ☐ Menstruate too frequently
180 ☐ Vaginal discharge
181 ☐ Hysterectomy/ovaries removed
182 ☐ Menopausal hot flashes
183 ☐ Menses scanty or missed
184 ☐ Acne, worse at menses
185 ☐ Depression of long standing

MALES ONLY

186 ☐ Prostate trouble
187 ☐ Urination difficult or dribbling
188 ☐ Night urination frequent
189 ☐ Depression
190 ☐ Pain on inside of legs or heels
191 ☐ Feeling of incomplete bowel evacuation
192 ☐ Lack of energy
193 ☐ Migrating aches and pains
194 ☐ Tire too easily
195 ☐ Avoid activity
196 ☐ Leg nervousness at night
197 ☐ Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

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

DR. LYNNE E. KAVULICH
AMERICAN WELLNESS CARE

1061 Route 82
Hopewell Jct. NY 12533

(845) 221-1201
www.americanwellnesscare.com

Healthy Living Questionnaire

Patient Name: _____ Date: _____

Age: _____ Gender: ☐ Male ☐ Female

Current Weight: _____

Do you consider yourself:
☐ underweight ☐ overweight ☐ just right

Unintentional weight loss or gain of 10 pounds or more in the last three months: Yes ☐ No ☐

Recent changes in your ability to:
☐ see ☐ hear ☐ taste
☐ smell ☐ feel hot/cold sensations

1. Check the Following Statements That Apply:
   - ☐ Occasionally or frequently skip meals
   - ☐ Suffer from fatigue
   - ☐ Currently overweight
   - ☐ Crave sweets or carbohydrates
   - ☐ Crave stimulants, such as caffeine or soft drinks
   - ☐ Suffer from chronic pain
   - ☐ Suffer from headaches

2a. Activity Level – Check Your Current Level of Work or Lifestyle:
   - ☐ Level 1 – Very Light Work: Sitting, standing, driving, reading, computer, etc.
   - ☐ Level 2 – Light Work: Light housework, labor, childcare, mechanic, some sitting, etc.
   - ☐ Level 3 – Moderate Work: Heavy gardening, housework, labor, no sitting, etc.
   - ☐ Level 4 – Heavy Work: Heavy manual labor, construction, digging, etc.

2b. Exercise Level – Check Your Current Level of Exercise:
   - ☐ None
   - ☐ Level A – Light Exercise: 1-3 times per week, easy pace, stretching, walking, etc.
   - ☐ Level B – Moderate Exercise: 2-3 times per week, moderate pace, some weights, etc.
   - ☐ Level C – Heavy Exercise: 3-4 times per week, vigorous pace, weights, fast running, etc.

3. Balance Eating – Check Which Apply:
   - ☐ Mixed food diet (animal and vegetable sources)
   - ☐ Vegetarian
   - ☐ Vegan
   - ☐ Salt Restriction
   - ☐ Fat Restriction
   - ☐ Starch/carbohydrate restriction
   - ☐ The Zone Diet
   - ☐ Total calorie restriction
   - ☐ Specific food restrictions of:
     - ☐ dairy ☐ wheat ☐ eggs
     - ☐ soy ☐ corn ☐ all gluten
   - ☐ Other _____

   Servings per day:
   - Fruits (citrus, melons, etc.) _____
   - Dark green or deep yellow/orange vegetables _____
   - Grains (unprocessed) _____
   - Beans, peas, legumes _____
   - Dairy, eggs _____
   - Meat, poultry, fish _____

4. Eating Frequency – Check Which Apply:
   - ☐ Skip breakfast or other meals _____
   - ☐ Three meals/day
   - ☐ Two meals/day
   - ☐ One meal/day
   - ☐ Graze-small frequent meals (how many/day) _____
   - ☐ Generally eat on the run

5. Exercise Frequency and Schedule – Check Which Apply:
   - ☐ 5-7 days per week
   - ☐ 3-4 days per week
   - ☐ 1-2 days per week
   - ☐ 45 min or more duration per workout
   - ☐ 30-45 min or more duration per workout
   - ☐ Less than 30 min
   - ☐ Use of personal trainer
   - ☐ Member of fitness club
   - ☐ Own exercise equipment
   - ☐ Walk: days/week _____
   - ☐ Run, jog, Jump rope, other aerobic: days/week _____
   - ☐ Weight lift: days/week _____
   - ☐ Stretch: days/week _____
   - ☐ Yoga: days/week _____
   - ☐ Other _____ days/week _____

Healthy Living Questionnaire~Page 2

6. Stimulant Use Habits – Check Which Apply:

☐ Tobacco:
- Cigarettes: #/day_____
- Cigars: #/day_____
- Pipe: #/day_____

☑ Alcohol:
- Wine: # glasses/day or week_____
- Liquor: # ounces/day or week_____
- Beer: # glasses/day or week_____

☐ Caffeine:
- Coffee: # of 6 oz cups/day _____
- Tea: # of 6 oz cups/day _____
- Soda w/caffeine: # of cans/day _____
- Soda w/o caffeine: # of cans/day _____
- Other sources_____

☐ Water:
- # glasses/day _____

7. Stress Habits – Check Which Apply:

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents: Y ☐ N ☐
Do you suffer from insomnia/sleep disorders? Y ☐ N ☐
Do you often abruptly awake from sleep? Y ☐ N ☐
Do you suffer from depression/mood swings? Y ☐ N ☐

8. Supplement Use Habits – Check Which Apply:

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ GLA (Evening primrose)
- ☐ Calcium, source_____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe_____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (lutein, resveritol, etc.)
- ☐ Herbs – teas
- ☐ Herbs – extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Superfoods (bee pollen, phytonutrient blends)
- ☐ Liquid meals (Ensure)
- ☐ Other_____

9. Energy – Vitality

I'd like to:
- ☐ Have more energy
- ☐ Have longer endurance
- ☐ Have more motivation
- ☐ Sleep better
- ☐ Be less tired after lunch
- ☐ Feel more vital
- ☐ Regain vitality and vigor of my younger years
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not use so many over the counter drugs
- ☐ Stop using laxatives
- ☐ Be free of pain

10. Longevity – Life Enrichment

I'd like to:
- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Monitor biomarkers of aging
- ☐ Have less facial wrinkles
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to a creating wellness lifestyle

11. Body Composition – Fat/Muscle

I'd like to:
- ☐ Be stronger
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Burn more body fat
- ☐ Be more flexible
- ☐ Lose weight

12. Stress Reduction – Mental/Emotional

I'd like to:
- ☐ Be happier
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Be more focused
- ☐ Think more clearly
- ☐ Improve my memory
- ☐ Learn how to reduce stress
- ☐ Learn how to meditate

COMMENTS

CONTEXT OF CARE

Name _____ Date ____-____-____

1. Why did you choose to come to this clinic instead of another? _____

_____

2. What frustrations have you experienced at other clinics? _____

_____

3. What do you want to take place over the course of your care here? _____

_____

4. How long do you feel this will take? _____

_____

5. What might it cost you if you don't significantly improve your lifestyle and any other factors contributing to poor health? _____

_____

6. What is your present level of commitment to addressing any underlying causes of your signs and symptoms? (1-10 with 10 being the most) _____

7. What potential obstacles do you foresee in addressing the lifestyle factors affecting your health, and following the recommendations we are sharing with you?

_____

8. Who would be willing to support you in your health goals? _____

_____