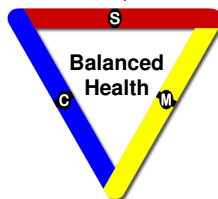


Natural Health Center

The Art & Science of Natural Healthcare



13384 Jones Road ♦ Houston, TX 77070

Phone: (281) 897-8818 ♦ www.nhchouston.com ♦ Fax: (281) 897-8817

Comprehensive Moderate/Severe Complexity New Patient Instructions and Information

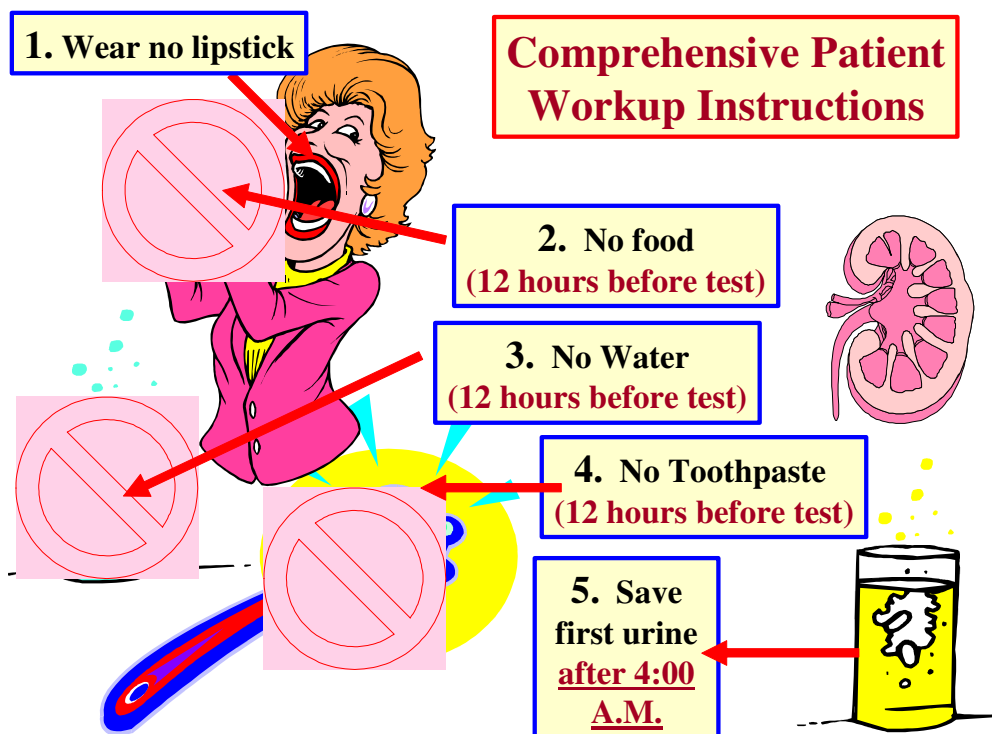
Thank you for choosing Natural Health Center for your natural healthcare needs. In order for you to get the most out of the new patient workup there are a few simple guidelines that should be followed:

1. Have the all of the paperwork in this packet completed prior to arrival for your 1st appointment, and call the clinic in advance if you have any questions regarding any of the paperwork.
2. Bring your 1st morning urine sample collected after 4AM, toothbrush and toothpaste with you to the clinic in order to brush your teeth after collecting your saliva sample.
 - If you don't have a urine cup any brand new plastic cup will do. You can even stop by a Star Buck's and get a small clear plastic cup with a lid.
3. Please arrive 15 minute early, as we will need to collect a saliva sample from you before we can begin testing.

That is it! Below is a diagram, which outlines the **5 steps you need to follow** in order to prepare yourself for your comprehensive workup.

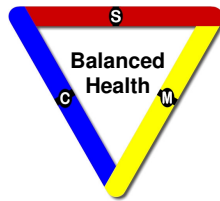
We look forward to meeting you,

Natural Health Center Staff



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Confidential Intake Form

CONTACT INFORMATION

Last Name

First Name

Address

City

State

Zip

Email Address

Home Phone

Work Phone

Cell Phone

()

()

()

Employer

Position

OTHER INFORMATION

Birthday (mm/dd/yy)

Age

Gender

Social Security Number

Driver's License #

/ /

M / F

- -

Referred by

GENERAL HEALTH INFORMATION

Height

Weight

Adult Min.

Adult Max.

' "

lbs

lbs

lbs

PURPOSE(S) AND/OR HEALTH CONCERN(S)

Instructions: List the purpose(s) of this appointment and/or each major health concern you have.

1. _____

2. _____

3. _____

4. _____

5. _____

Current Health History

HEALTH CONCERN INFORMATION

Instructions: Fill out separate 'Current Health History' sheets for each health concern you listed above (there are multiple sheets provided for each). Mark the location of the concern or area pain on the diagram provided.

Purpose/Concern: _____

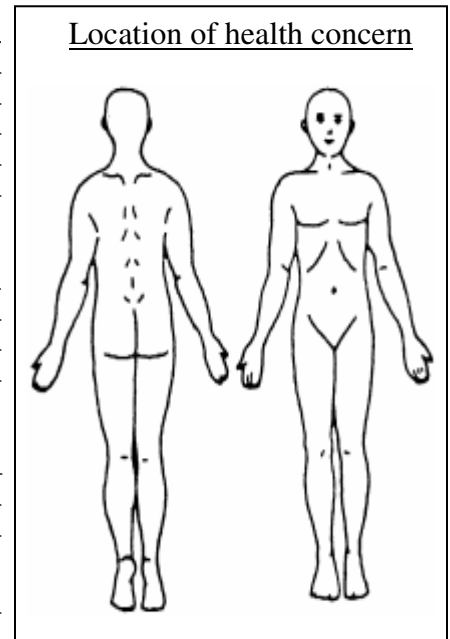
When did this begin? _____

How (if known) did this begin? _____

Have you had this before? No Yes, when: _____

What makes this worse? _____

What makes this better? _____



Circle the current intensity of this on a scale of 0 (no problem) to 10 (the worst): 0 1 2 3 4 5 6 7 8 9 10

Is this getting worse? No Yes Comes and goes It is constant

Is this worse at a certain time of day/month? _____

What does this prevent you from doing? _____

Did you see other doctors for this? No Yes, Dr.'s name(s): _____

Treatment: _____ Results: _____

Is this an accident related condition? No Work injury Automobile injury Other injury

NOTES

Past Health History – Page 1

PAST SURGERIES

Check any of the following surgeries you have had. Include approximate dates:

- Appendectomy _____ Tonsillectomy: _____ Gall Bladder: _____ Hernia: _____
 Back: _____ Neck: _____ Broken Bones: _____ Mastectomy: _____

List any others. Include approximate dates:

1. _____ Date: _____
2. _____ Date: _____

PAST DISEASES AND INFECTIONS

Check any of the following diseases or infections you have had:

Notes:

- | | | | |
|--|---|--|-------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Eczema | _____ |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | _____ |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | _____ |
| <input type="checkbox"/> HIV + | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> High Cholesterol | _____ |

PAST TRAUMAS AND ACCIDENTS

List all previous traumas or accidents that might be related to your current health concern(s):

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

HOSPITALIZATIONS

List any/all previous hospitalization you have had, please include approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

ALLERGIES

List any known allergies you have: _____

HABITS AND SOCIAL HISTORY

Check any of the following that apply and describe the amount:

- | <u>Intake</u> | <u>Quantity</u> | <u>Intake</u> | <u>Quantity</u> |
|---|-----------------|---|-----------------|
| <input type="checkbox"/> Coffee | _____ | <input type="checkbox"/> Sugar/Starches | _____ |
| <input type="checkbox"/> Tea | _____ | <input type="checkbox"/> Soft Drinks | _____ |
| <input type="checkbox"/> Alcohol | _____ | <input type="checkbox"/> Fast Food | _____ |
| <input type="checkbox"/> Cigarettes | _____ | <input type="checkbox"/> Meals/Day | _____ |
| <input type="checkbox"/> Cigars | _____ | <input type="checkbox"/> Exercise | _____ |
| <input type="checkbox"/> Other Tobacco | _____ | <input type="checkbox"/> Sleep | _____ |
| <input type="checkbox"/> Recreational Drugs | _____ | <input type="checkbox"/> Other | _____ |

Past Health History – Page 2

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS

Medication	Dose/Frequency	Purpose	Medication	Dose/Frequency	Purpose
1.	/		11.	/	
2.	/		12.	/	
3.	/		13.	/	
4.	/		14.	/	
5.	/		15.	/	
6.	/		16.	/	
7.	/		17.	/	
8.	/		18.	/	
9.	/		19.	/	
10.	/		20.	/	

FAMILY HISTORY

Instructions: Please indicate if any of the following family members have any disease(s), if they have passed on please indicate the cause of death and approximate age when they died.

Father:
Father's Mother:
Father's Father:
Father's Grandparents:
Father's Siblings:
Mother:
Mother's Mother:
Mother's Father:
Mother's Grandparents:
Mother's Siblings:
Your Siblings:
Your Children:

FEMALE ONLY SECTION

Are your periods regular? Yes No, explain: _____

Age of onset: _____ Date of last period: _____ How often do you have your cycle? Every _____ days.

Your period lasts for: _____ days (start to finish). Menstrual flow: Light Medium Heavy Other: _____

Do you take birth control pills or HRT? No Yes, what type: _____

Check all of the following premenstrual symptoms that apply:

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heavy Bleeding | <input type="checkbox"/> Bloating | <input type="checkbox"/> Depression | <input type="checkbox"/> Muscle Pains |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Joint Pains |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Clots | <input type="checkbox"/> Breast Enlargement | <input type="checkbox"/> Food Cravings | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Water Retention | <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Sweet Cravings | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Chocolate Cravings | <input type="checkbox"/> Foggy Thinking |
| <input type="checkbox"/> Fat Gain | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Blood Sugar Problems | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Decreased Sex Drive |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Infertility | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Polycystic Ovaries | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Cervical Dysplasia | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Cancer |

MALE ONLY SECTION

Do you have a history of prostate problems? No Yes, explain: _____

List any additional male related changes/issues/concerns: _____

Past Health History – Page 3

REVIEW OF SYSTEMS

1A Survey

1. Have you ever taken Pondimin (Fenfluramine) in the past? Yes No
2. In the last year, have you experienced any of the following problems? Check all that apply:
 - Eating Disorders
 - Compulsivity (including compulsive eating)
 - Increased hunger & weight gain after dieting
 - Myoclonus (twitching muscles or legs)
 - Depression
 - Anxiety
 - Panic Attacks
 - Irritable Bowel Syndrome
 - Migraine Headaches
 - PMS
 - Insomnia (sleep <4 hours per night with wake ups)
 - Anorexia
 - Bulimia
 - Impulsivity
 - Obsessionality
 - Fibromyalgia
 - Neurodermatitis
 - Sleep Apnea
 - TMJ Syndrome
 - Bipolar Disorder
 - Mania
 - Aggression
 - Self-Injury
 - Chronic Pain States

NOTES:

Natural Health Center Clinic Policies

NOTICE OF FINANCIAL RESPONSIBILITY

The Natural Health Center is very pleased to have you as a new patient. We are honored you have selected our clinic for your care.

In many cases, your insurance will pay for part or all of chiropractic care. We will work with you to insure that you have all necessary documentation to file with your insurance carrier, motor vehicle insurer, or work related insurer, so they can process and pay your claims in a timely manner. However, our relationship is directly with you and not with your insurance company. You are receiving the services, and therefore you have the final responsibility to pay for those services.

Should you be covered by Medicare, you will not be eligible to submit your claims to them since we are not a Medicare provider.

If you are receiving treatment as a result of a motor vehicle accident, you are responsible for paying all costs for treatment not reimbursed by the Personal Injury Protection (PIP) coverage under a motor vehicle insurance policy or other insurance policy. If your motor claim is in dispute and there is no other insurance coverage for your treatments, we may agree to wait for payment until your legal case is settled or we may agree to accept regular monthly payments on your account. In any event, you are ultimately responsible for payment in full for services that you receive.

If it is necessary to initiate action to collect any unpaid balance on your account, you agree to pay reasonable costs of collection, including necessary attorney fees and court costs.

COLLECTION POLICY

1. The office collection policy is to collect full payment for the services rendered at the time of service.
2. There will be a charge of \$125.00 for appointments not cancelled within 48 hours before the scheduled appointment.
3. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Natural Health Center or its billing agent to release any information acquired in the course of my care to my insurance company or persons representing my case.

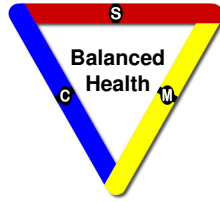
ACKNOWLEDGEMENT OF CLINIC POLICIES

My signature below is proof that I have read and understand the above policies for Natural Health Center.

Signature _____ Date _____

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Notice of Investigational Testing Procedures

Please be informed that the Natural Health Center is involved in a clinical trial of an investigational lab device called the Bio Cellular Analyzer (BCA). Because this device is classified as investigational the federal government requires the following:

- 1. Patients must be informed that the FDA has not yet approved this device.**
- 2. Data gathered from this test may be ANONYMOUSLY submitted as part of the approval process. (Your name will not appear on any test data in this process.)**
- 3. The Federal government (Medicare and/or Medicaid) cannot be billed for this test.**
- 4. The data obtained from this test cannot be the exclusive criteria used in clinical decision making.**

Live blood analysis is also considered investigational. We (the Natural Health Center) are not currently involved in an investigational trial for live blood analysis. However, items 1, 3, and 4 above will also be applied to this test.

I agree with full recognition that the BCA test is experimental and that my testing data may be utilized as part of the BCA clinical trial. I further agree to submit to Live Blood Analysis with full recognition that this is not an FDA approved test.

My signature below indicates that I have read and understand all of the above information and is valid from the date written below through 12/31/2099.

Signature

Date

Printed Name

Natural Health Center

Date

Printed Name

MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name _____ Date _____

Please rate each of the following symptoms based upon your health profile for the past 30 days:

Point Scale:

0 = **Never** or **Almost Never** have the symptom
1 = **Occasionally** have it, effect is not severe
2 = **Occasionally** have it, effect is severe

3 = **Frequently** have it, effect is not severe
4 = **Frequently** have it, effect is severe

Digestive Systems:

- _____ Nausea or vomiting
- _____ Diarrhea
- _____ Constipation
- _____ Belching, passing gas
- _____ Bloating Feeling
- _____ Heartburn
- _____ Intestinal/stomach pain

Ears:

- _____ Itchy ears
- _____ Earaches, ear infections
- _____ Drainage from ear
- _____ Ringing in ears
- _____ Hearing loss

Emotions:

- _____ Mood Swings
- _____ Anxiety, fear, nervousness
- _____ Anger, irritability, aggressiveness
- _____ Depression

Energy / Activity:

- _____ Fatigue, sluggishness
- _____ Apathy, lethargy
- _____ Hyperactivity
- _____ Restlessness

Eyes:

- _____ Watery or itchy eyes
- _____ Swollen, reddened or sticky eyelids
- _____ Bags or dark circles under eyes
- _____ Blurred or tunnel vision

Head:

- _____ Headaches
- _____ Faintness
- _____ Dizziness
- _____ Insomnia

Heart:

- _____ Chest Pain
- _____ Skipped Heartbeat
- _____ Rapid heartbeat

Weight:

- _____ Binge eating/drinking
- _____ Craving certain foods
- _____ Excessive weight
- _____ Water retention
- _____ Underweight
- _____ Compulsive eating

Joint / Muscles:

- _____ Pain or aches in joints
- _____ Arthritis
- _____ Stiffness, limited movement
- _____ Weakness or tiredness on joints
- _____ Pain or aches in muscles

Lungs:

- _____ Chest Congestion
- _____ Asthma, bronchitis
- _____ Shortness of breath
- _____ Difficulty breathing

Mind:

- _____ Poor memory
- _____ Confusion
- _____ Difficulty making decisions
- _____ Stuttering or stammering
- _____ Slurred speech
- _____ Learning Disabilities
- _____ Poor concentration
- _____ Poor Coordination

Mouth / Throat:

- _____ Chronic coughing
- _____ Gagging, frequent need to clear throat
- _____ Sore throat, hoarseness
- _____ Swollen or discolored tongue, gums, lips
- _____ Canker Sores

Nose:

- _____ Stuffy Nose
- _____ Sinus Problems
- _____ Hay Fever
- _____ Sneezing attacks
- _____ Excessive mucus formation

Skin:

- _____ Acne
- _____ Hives, rashes, dry skin
- _____ Hair loss
- _____ Flushing, hot flashes
- _____ Excessive sweating

Other:

- _____ Frequent illness
- _____ Frequent or urgent urination
- _____ Genital itch or discharge

Grand Total: _____