**Chase After Health**[**159B McMaster Street**](https://maps.google.com/?q=159B+McMaster+Street+%0D%0AOwego,+NY+13827&entry=gmail&source=g) **Owego, NY 13827
(607) 972-1383****ChaseAfterHealth@gmail.com** **ChaseAfterHealth.com**

Dear New Client,

I am looking forward to seeing you in my office as a new client. There are a few things I want you to be aware of before you come in for your scheduled appointment. On your first visit to my office I will spend about an hour with you. The visit will consist of a full consultation so please bring any tests you have had done previously and upon arrival urine and saliva will be collected to run the bio-assessment test called RBTI. A ½ hour follow-up appointment will be set for the following week. The first visit fee is $129.00 which includes the ½ hour follow-up. Future visits are $89.00 which includes RBTI testing. If RBTI testing is deemed not necessary, the charge will be $60.00.

Attached to this letter are a Client Intake Form, Bach Flowers Questionnaire, and Wellness Agreement that should be filled out and brought to your appointment.

**Office Hours**: Office Hours are by appointment only. Appointments can be made by calling 607-972-1383.

**Follow up**: It is important to have a follow-up within 30-45 days after the second visit in which we will lay out your health plan. Be prepared to make the commitment to your health and follow through on an action plan. Depending on the state of your health, this can take from 3 months to 6 months, but varies from client to client.

**Emergency Care**: In the case of a medical emergency, please see your family physician or the emergency room of the nearest hospital.

**Payment**: Payment is expected in full at time of service. Cash, checks, credit cards are accepted. A $40 fee is charged for returned checks. We do not accept Medicare, medical assistance or handle insurance claims. On occasion, Chase after Health LLC will negotiate to accept partial payment, or at our discretion, waive payment, based on individual client circumstances. We do not refund for services that have already been provided

Supplement purchases are separate from fees for services. Payment for supplements is expected at time of purchase. I DO NOT ACCEPT RETURNS ON PRODUCT PURCHASES.

**Cancellation Policy**: As a courtesy to all clients seeking appointments, 24 hour notice is required for cancellation of appointments. If cancellation is not received 24 hours prior to your scheduled appointment, you will be billed for a basic office visit. Future appointments may require prepayment for services expected. Chronic cancellations may result in denial of future services.

**Right to Refuse Service:** Chase after Health LLC has the right to refuse service to you for client noncompliance or repeated lateness or cancellation.

 **Nondiscrimination**: Chase after Health LLC has a nondiscrimination policy. We do not discriminate on the basis of gender, race, age, creed, religion or national origin.

*I agree to pay for services rendered at time of service. I consent to the above terms of service as agreed upon between Chase after Health LLC and myself. I have read and understand the policies of the Chase after Health LLC. I agree to comply with the policies stated.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Authorized Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Client Intake Data**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street,City,State,Zip)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a physician, who, and for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

Have you had any major illness, injuries? Women, please include information about childbirth (include dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical Procedures/Hospitalizations**

|  |  |  |
| --- | --- | --- |
| **Date** | **Procedure** | **Notes** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Nutritional data:**

How many ounces of water/day? \_\_\_\_\_\_\_\_\_ What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other beverages and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use artificial sweeteners? \_\_\_\_\_ If so, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often and in what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat breakfast? \_\_\_\_\_\_\_\_ If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many servings of these do you eat per week:

Fresh fruit \_\_\_\_\_\_\_\_\_\_\_Raw vegetables \_\_\_\_\_\_\_\_\_\_\_\_\_Fermented foods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fast foods \_\_\_\_\_\_\_\_\_\_\_Meat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Eggs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dairy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Wheat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What food do you crave? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What foods do you dislike the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Timing:**

What is the first thing you do when you get up in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you eat your first meal? \_\_\_\_\_\_\_\_\_\_\_\_Last meal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which meal is your largest of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe a typical “largest meal”\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Movement:**

Do you exercise/move/participate in fun sweaty activity? If so, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you look forward to it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel when you are finished? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sleep:**

What time do you go to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How long do you sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, why and at what time(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel rested when you wake up for the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain when you first get up?\_\_\_\_\_\_\_ If so, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it go away upon moving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eliminations:**

Do you have daily bowel eliminations? \_\_\_\_\_\_ If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please describe your elimination pattern. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Females:**

Are you post-menopausal? \_\_\_\_\_\_If yes, at what age did you enter menopause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the characteristics of your menopausal experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you now, or in the near future, planning to become pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your menstrual cycle regular? \_\_\_\_\_\_\_\_\_\_Longer than 28 days? \_\_\_\_\_\_\_\_\_\_\_\_Shorter? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your flow longer or shorter than 5 days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have cramps or clotting? \_\_\_\_\_\_\_\_\_Would you describe the color of your menses as more red, more

purple, or more brown? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience PMS, cyclical headaches, or cravings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supplements/medications:**

Do you take any supplements? \_\_\_\_\_\_\_\_\_\_\_\_ If so, what, how often and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any OTC medications routinely (such as Aleve or Aspirin)? If so what and how often? \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take prescription medications (prescribed by a licensed medical professional?) If so what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Complaint History**

What brings you into the office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had similar issues? \_\_\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate below where you are experiencing concerns.**



Place an “X” on the line below to indicate the level of the problem.

(No Symptoms) 1————————————————————————————————10 (Extreme Symptoms)

What have you done or used to get relief? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your expectations for this visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check the following conditions that apply to you, past and present. Add comments for clarification as needed.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Musculoskeletal** |  |  | **Skin** |  |  | **Reproductive/Urinary** |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | □ Headaches | □ Rashes |  | □ Burning on Urination |  |
|  | □ Joint Stiffness/Swelling |  | □ Itching/Burning |  | □ Nighttime Urination |  |
|  | □ Spasms/Cramps |  | □ Hives |  | □ Blood in Urine |  |
|  | □ Strains/Sprains |  | □ Eczema |  | □ Erectile Dysfunction |  |
|  | □ Neck Pain |  | □ Athlete’s Foot |  | □ Prostate Problems |  |
|  | □ Upper/Mid Back Pain |  | □ Warts |  | □ Abnormal Discharge |  |
|  | □ Low Back Pain |  | □ Moles |  | □ Yeast Infection |  |
|  | □ Shoulder, Neck, Arm, Hand Pain |  | □ Acne |  | □ Bladder Leakage |  |
|  | □ Hip, Leg, Foot Pain |  | □ Cosmetic Surgery |  | □ Pregnancy |  |  |  |  |
|  | □ Chest/Rib Pain |  | □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | □ Current | □ Previous |  |
|  | □ Numbness/Weakness |  |  |  |  |  |  | □ PMS |  |  |  |  |
|  | □ Problems Walking |  | **Gastrointestinal** |  | □ Menopause |  |  |  |  |
|  | □ Jaw Pain/TMJD |  | □ Gum Bleeding |  |  |  | □ Pelvic Inflammatory Disease |  |
|  | □ Tendonitis |  | □ Nervous Stomach |  | □ Endometriosis |  |
|  | □ Bursitis |  | □ Indigestion |  | □ Hysterectomy |  |
|  | □ Arthritis |  | □ Heartburn/Reflux |  | □ Fertility Concerns |  |
|  | □ Osteoporosis |  | □ Nausea/Vomiting |  | □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | □ Scoliosis |  | □ Change in Bowel Patterns/IBS |  |  |  |  |  |  |  |
|  | □ Bone or Joint Disease |  | □ Constipation |  | **Other** |  |  |  |  |
|  | □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | □ Diarrhea |  | □ Loss | of Appetite |  |
|  |  |  |  |  | □ Jaundice |  | □ Forgetfulness/Memory Loss |  |
|  | **Circulatory/Respiratory** |  | □ Abdominal Pain |  | □ Confusion |  |  |  |  |
|  | □ Dizziness |  |  | □ Gall Bladder Problems/Removal |  | □ Depression |  |  |  |  |
|  | □ Shortness of Breath |  | □ Diverticulitis |  | □ Anxiety |  |  |  |  |
|  | □ Fainting |  | □ Crohn’s Disease |  | □ Weight Loss/Weight Gain |  |
|  | □ Cold Hands/Feet |  | □ Colitis |  | □ Fatigue |  |  |  |  |
|  | □ Cold Sweats |  | □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | □ Fever |  |  |  |  |
|  | □ Chills |  |  |  |  |  |  | □ Loss of Hair |  |  |  |  |
|  | □ Swollen Ankles |  | **Nervous/Eyes/ENT** |  | □ Hot/Cold Intolerance |  |
|  | □ Difficulty Lying Flat |  | □ Numbness/Tingling |  |  | □ Difficulty Concentrating |  |
|  | □ Pressure Sores |  | □ Loss of Strength/Weakness |  | □ Hearing Impaired |  |
|  | □ Varicose Veins |  | □ Paralysis |  | □ Visually Impaired |  |
|  | □ Blood Clots |  | □ Twitching |  | □ Eating Disorder |  |
|  | □ Heart Conditions/Chest Pain |  | □ Chronic Pain |  | □ Diabetes |  |  |  |  |
|  | □ Palpitations |  | □ Sleep Disorders |  | □ Fibromyalgia |  |  |  |  |
|  | □ Allergies |  | □ Ulcers |  | □ Post/Polio Syndrome |  |
|  | □ Sinus Problems |  | □ Herpes/Shingles |  | □ Cancer |  |  |  |  |
|  | □ Asthma |  | □ Cerebral Palsy |  | □ Rheumatoid Arthritis |  |
|  | □ Cough |  | □ Epilepsy/Seizures |  | □ Infectious Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | □ Coughing Blood |  | □ Chronic Fatigue Syndrome |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | □ Wheezing |  | □ Multiple Sclerosis |  | □ Congenital/Acquired Disabilities\_\_\_\_\_ |  |
|  | □ Excessive Bleeding |  | □ Muscular Dystrophy |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | □ Pace Maker |  | □ Parkinson’s Disease |  | □ Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | □ Lymphedema |  | □ Difficulty Hearing |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | □ Ringing in the Ears |  | □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |  | □ Eye Correction |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |  | □ Double Vision |  |  |  |  |  |  |  |
|  |  |  |  |  | □ Cataracts |  |  |  |  |  |  |  |
|  |  |  |  |  | □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Height | Weight |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



**Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Social History**

Do you drink alcohol? \_\_\_\_\_ If yes, what type and amount per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco or smoke? \_\_\_\_\_ If yes, what type and amount per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever use tobacco or smoke? \_\_\_\_\_ If yes, for how long and when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ If yes, what type and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume caffeine? \_\_\_\_\_ If yes, what type and amount per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your top 5 favorite foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you typically drink for beverages throughout the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you go to bed? \_\_\_\_\_\_\_\_ How many hours do you sleep per night? \_\_\_\_\_\_\_\_\_\_\_

What position do you sleep in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours per day do you perform the following? Lifting \_\_\_\_\_ Sitting \_\_\_\_\_ Bending \_\_\_\_\_ Computer Use \_\_\_\_

Do you experience an abnormally high amount of stress? If yes, from what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you truly ready for change? \_\_\_\_\_\_\_\_ If no, what is holding you back and what support do you need to achieve your goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Are you adopted? \_\_\_\_\_ If yes, can you fill out the following concerning your *natural* parents? If not, mark N/A.

Is your father alive? If yes, how old? \_\_\_\_\_ If no, what was the cause of death and age at death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your mother alive? If yes, how old? \_\_\_\_\_ If no, what was the cause of death and age at death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any disease or illness in your family? (parents, siblings, children, aunts, uncles, grandparents) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, list what they are and who suffered(s) from them. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In particular, does anyone in your family have: (If yes, write “F” for father, “M” mother, “S” Sister, “B” Brother.)

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_ Heart Disease | \_\_\_\_ Lung Disease | \_\_\_\_ Liver Disease | \_\_\_\_ Kidney Disease |
| \_\_\_\_ Cancer | \_\_\_\_ Stroke | \_\_\_\_ Diabetes | \_\_\_\_ Asthma |
| \_\_\_\_ Tuberculosis | \_\_\_\_ Arthritis | \_\_\_\_ Chronic Pain | \_\_\_\_ Headaches |
| \_\_\_\_ Scoliosis | \_\_\_\_ Trouble Sleeping | \_\_\_\_ Mental Illness | \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_ |

*I acknowledge and agree that I am here to learn about nutrition and better health practices and that I will be offered*

*information about food, supplements, herbs, or any other information deemed important by my health professional, to*

*serve as a guide to improve my general health and well-being. I am aware that the information provided on this form will*

*be used by Chase after Health, LLC. in regard to my education, and that my rights concerning the privacy of said information is safeguarded. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I am not, on this visit or any subsequent visit, an agent for federal, state, or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to the consultation on nutritional matters intended for the maintenance of the best state of natural health and do not involve the diagnosing, treatment, or prescribing of remedies for disease. I understand that I am responsible for all costs of care incurred, as determined by my health professional. Any fees for professional services will be immediately due and payable.*

Client or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RBTI/REAMS TESTING INSTRUCTIONS**

• The day of your appointment, do things as you normally

would.

• Eat up to 2 hours before your appointment. Only liquids in mouth

after that.

• Stop drinking everything 20 minutes before appointment.

• It is ok to bring a snack with you to eat after collection of

urine and saliva has been made.

• Urine and saliva sample will be collected upon arrival, and

information will be shared at next appointment.