BIG SKY
WELLNESS CENTER
More Health. More Life.

*Thank you for your interest in becoming a patient of our office!*

You have taken the first exciting step toward the recovery of your health—your most valuable possession!

To get started, we need a couple of items:

1. Please complete the enclosed forms.
   Allow enough time to be very thorough. (Some patients have related that it has taken an hour or two to complete these forms, so allow yourself plenty of time.) The more details you provide, the better your health can be assessed.

2. Complete the four-day food journal (enclosed). Please be VERY detailed.

3. Obtain copies of ALL test results, including bloodwork, allergy tests, and hormone test results for the past FOUR YEARS. Please obtain copies even if they were "normal." (Please sign the Release of Records page if you would like our office to obtain these records directly.)

4. Mail all back to our office.

Once we have received all the above information, we will call you to schedule your New Patient Consultation.

Thank you in advance for your time and effort in completing these forms. The information obtained will provide valuable information allowing for the appropriate course of treatment.

I look forward to meeting you soon.

Sincerely,

Dr. Julie Schleusner

PO Box 1090
Paulden, AZ 86334
928-260-4747

**Big Sky Wellness Center**
**PO Box 1090**
**Paulden, AZ 86334**
**928-260-4747 (office)**
**928-447-7988 (fax)**

BIG SKY WELLNESS CENTER
More Health. More Life.

# PATIENT HEALTH HISTORY

Date: _____

Name: _____

Physical Address: _____ Occupation: _____

City: _____State:_____ Zip: _____ Employer: _____

Mailing Address: _____

City: _____State:____ Zip: _____

Home Phone #: _____ E-Mail: _____

Cell Phone #: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: □Male □Female Weight: _____ Height: _____

Marital Status: □Married □Single □Divorced □Separated □Other_____

Name of Spouse or Nearest Relative: _____ Phone: _____

Referred by: _____ May we thank them for the referral? □Yes □No

## Please list below the top 3 main reasons for your appointment, in order of importance.

- **Please tell me about it in <u>as much detail as possible</u>.**
- **Please list the very <u>first time</u> that you noticed the condition.**

1.

2.

3.

If you were to guess, what do you think is the cause of your complaints?

What other healthcare providers have you seen regarding this problem(s)?

What diagnosis were you given?

Date of last physical examination: _____

Date of last blood work and results: _____

Do you suffer from any condition other than that for which you are now consulting us? □Yes □No _____

Please list any operations or surgeries:

□ I have never had any operations or surgeries

Current medications (prescription or over-the-counter): For what purpose are you taking these medications?

If you are taking NO prescription or over-the-counter medications (Ibuprofen, Aleve, Prilosec, etc.) Please check here: □

_____ _____

_____ _____

_____ _____

_____ _____

Current Supplements: For what purpose are you taking these supplements?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**Eating Style:** Based on how you eat on a regular basis, please circle all that apply:

Fast eater
Erratic eater
Emotional eater (stressed, board, sad, etc.)
Late night eater
Time constraints
Dislike “heatlhy” food
Travel frequently
Do not plan meals/menus
Rely on convenience items
Family member(s) have different tastes
Love to eat
Eat too much
Eat because I have to
Negative relationship with food
Struggle with eating issues
Confused about food/nutrition
Frequently eat fast food
Poor snack choices

If you do, how much time do you spend cooking/preparing meals each day?_____

List any foods that you crave or would have a difficult time living without: _____
(e.g. coffee, donuts, chocolate, cheese)

**Specific Food Restriction:**

□ Dairy
□ Wheat
□ Eggs
□ Soy
□ Corn
□ All gluten
□ Other: _____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work_____Family_____Social_____Financial_____Health_____Other_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

| **To improve your health, how ready/willing are you to…** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| Significantly modify your diet | | | | | |
| Take nutritional supplements each day | | | | | |
| Keep a record of everything you eat each day | | | | | |
| Modify your lifestyle (ex: work demands, sleep habits, physical activity) | | | | | |
| Practice relaxation techniques | | | | | |
| Engage in regular exercise/physical activity | | | | | |
| Have periodic lab tests to assess your progress | | | | | |

What have you tried to do to improve your state of health?

□ Diet modification □ Fasting □ Vitamins/minerals □ Herbs
□ Homeopathy □ Chiropractic □ Acupuncture □ Conventional Drugs
□ Other: _____

Is your general health currently getting better, worse, or staying the same. How do you know?

How long do you feel this will take?

Do you believe there is a solution to your health concerns?

Do you believe you can be 100% healthy and pain-free?

What percent of improvement in your symptoms do you expect to notice?

**Patient's/Guardian's Signature:**_____ **Date:** _____

# Nutritional Assessment Questionnaire 1.5

**Name**: _____ **Date:** _____/____/_____

**Birth Date:** _____ **Gender:** _____

## PART I Read the following questions and circle the number that applies:

**KEY:** **0 = Do not consume or use** **2 = Consume or use weekly**
**1 = Consume or use 2 to 3 times monthly** **3 = Consume or use daily**

### DIET 58

**1.** 0 1 2 3 Alcohol
**2.** 0 1 2 3 Artificial sweeteners
**3.** 0 1 2 3 Candy, desserts, refined sugar
**4.** 0 1 2 3 Carbonated beverages
**5.** 0 1 2 3 Chewing tobacco
**6.** 0 1 2 3 Cigarettes
**7.** 0 1 2 3 Cigars/pipes
**8.** 0 1 2 3 Caffeinated beverages
**9.** 0 1 2 3 Fast foods
**10.** 0 1 2 3 Fried foods
**11.** 0 1 2 3 Luncheon meats
**12.** 0 1 2 3 Margarine
**13.** 0 1 2 3 Milk products
**14.** 0 1 Radiation exposure (0=no, 1=yes)
**15.** 0 1 2 3 Refined flour/baked goods
**16.** 0 1 2 3 Vitamins and minerals
**17.** 0 1 2 3 Water, distilled
**18.** 0 1 2 3 Water, tap
**19.** 0 1 2 3 Water, well
**20.** 0 1 2 3 Diet often for weight control

### LIFESTYLE 12

**21.** 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
**22.** 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
**23.** 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
**24.** 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

### MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes): 54

**25.** 0 1 Antacids
**26.** 0 1 Antianxiety medications
**27.** 0 1 Antibiotics
**28.** 0 1 Anticonvulsants
**29.** 0 1 Antidepressants
**30.** 0 1 Antifungals
**31.** 0 1 Aspirin/Ibuprofen
**32.** 0 1 Asthma inhalers
**33.** 0 1 Beta blockers
**34.** 0 1 Birth control pills/implant contraceptives
**35.** 0 1 Chemotherapy
**36.** 0 1 Cholesterol lowering medications
**37.** 0 1 Cortisone/steroids
**38.** 0 1 Diabetic medications/insulin
**39.** 0 1 Diuretics
**40.** 0 1 Estrogen or progesterone (pharmaceutical, prescription)
**41.** 0 1 Estrogen or progesterone (natural)
**42.** 0 1 Heart medications
**43.** 0 1 High blood pressure medications
**44.** 0 1 Laxatives
**45.** 0 1 Recreational drugs
**46.** 0 1 Relaxants/Sleeping pills
**47.** 0 1 Testosterone (natural or prescription)
**48.** 0 1 Thyroid medication
**49.** 0 1 Acetaminophen (Tylenol)
**50.** 0 1 Ulcer medications
**51.** 0 1 Sildenafal citrate (Viagra)

## PART II (See key at bottom of page)

### Section 1 – Upper Gastrointestinal System 55

**52.** 0 1 2 3 Belching or gas within one hour after eating
**53.** 0 1 2 3 Heartburn or acid reflux
**54.** 0 1 2 3 Bloating within one hour after eating
**55.** 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes)
**56.** 0 1 2 3 Bad breath (halitosis)
**57.** 0 1 2 3 Loss of taste for meat
**58.** 0 1 2 3 Sweat has a strong odor
**59.** 0 1 2 3 Stomach upset by taking vitamins
**60.** 0 1 2 3 Sense of excess fullness after meals
**61.** 0 1 2 3 Feel like skipping breakfast
**62.** 0 1 2 3 Feel better if you don't eat
**63.** 0 1 2 3 Sleepy after meals
**64.** 0 1 2 3 Fingernails chip, peel or break easily
**65.** 0 1 2 3 Anemia unresponsive to iron
**66.** 0 1 2 3 Stomach pains or cramps
**67.** 0 1 2 3 Diarrhea, chronic
**68.** 0 1 2 3 Diarrhea shortly after meals
**69.** 0 1 2 3 Black or tarry colored stools
**70.** 0 1 2 3 Undigested food in stool

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

## Section 2 – Liver and Gallbladder

68

**71.** 0 1 2 3 Pain between shoulder blades
**72.** 0 1 2 3 Stomach upset by greasy foods
**73.** 0 1 2 3 Greasy or shiny stools
**74.** 0 1 2 3 Nausea
**75.** 0 1 2 3 Sea, car, airplane or motion sickness
**76.** 0 1 History of morning sickness (0 = no, 1 = yes)
**77.** 0 1 2 3 Light or clay colored stools
**78.** 0 1 2 3 Dry skin, itchy feet or skin peels on feet
**79.** 0 1 2 3 Headache over eyes
**80.** 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
**81.** 0 1 Gallbladder removed (0=no, 1=yes)
**82.** 0 1 2 3 Bitter taste in mouth, especially after meals
**83.** 0 1 Become sick if you were to drink wine (0=no, 1=yes)
**84.** 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
**85.** 0 1 Easily hung over if you were to drink wine (0=no, 1=yes)
**86.** 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
**87.** 0 1 Recovering alcoholic (0=no, 1=yes)
**88.** 0 1 History of drug or alcohol abuse (0=no, 1=yes)
**89.** 0 1 History of hepatitis (0=no, 1=yes)
**90.** 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
**91.** 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
**92.** 0 1 2 3 Sensitive to tobacco smoke
**93.** 0 1 2 3 Exposure to diesel fumes
**94.** 0 1 2 3 Pain under right side of rib cage
**95.** 0 1 2 3 Hemorrhoids or varicose veins
**96.** 0 1 2 3 Nutrasweet (aspartame) consumption
**97.** 0 1 2 3 Sensitive to Nutrasweet (aspartame)
**98.** 0 1 2 3 Chronic fatigue or Fibromyalgia

## Section 3 – Small Intestine

47

**99.** 0 1 2 3 Food allergies
**100.** 0 1 2 3 Abdominal bloating 1 to 2 hours after eating
**101.** 0 1 Specific foods make you tired or bloated (0=no, 1=yes)
**102.** 0 1 2 3 Pulse speeds after eating
**103.** 0 1 2 3 Airborne allergies
**104.** 0 1 2 3 Experience hives
**105.** 0 1 2 3 Sinus congestion, "stuffy head"
**106.** 0 1 2 3 Crave bread or noodles
**107.** 0 1 2 3 Alternating constipation and diarrhea
**108.** 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=currently mild condition, 3=severe)
**109.** 0 1 2 3 Wheat or grain sensitivity
**110.** 0 1 2 3 Dairy sensitivity
**111.** 0 1 Are there foods you could not give up (0=no, 1=yes)
**112.** 0 1 2 3 Asthma, sinus infections, stuffy nose
**113.** 0 1 2 3 Bizarre vivid dreams, nightmares
**114.** 0 1 2 3 Use over-the-counter pain medications
**115.** 0 1 2 3 Feel spacey or unreal

## Section 4 – Large Intestine

58

**116.** 0 1 2 3 Anus itches
**117.** 0 1 2 3 Coated tongue
**118.** 0 1 2 3 Feel worse in moldy or musty place
**119.** 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
**120.** 0 1 2 3 Fungus or yeast infections
**121.** 0 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
**122.** 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
**123.** 0 1 2 3 Stools hard or difficult to pass
**124.** 0 1 History of parasites (0=no, 1=yes)
**125.** 0 1 2 3 Less than one bowel movement per day
**126.** 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
**127.** 0 1 2 3 Stools are not well formed (loose)
**128.** 0 1 2 3 Irritable bowel or mucus colitis
**129.** 0 1 2 3 Blood in stool
**130.** 0 1 2 3 Mucus in stool
**131.** 0 1 2 3 Excessive foul smelling lower bowel gas
**132.** 0 1 2 3 Bad breath or strong body odors
**133.** 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
**134.** 0 1 2 3 Cramping in lower abdominal region
**135.** 0 1 2 3 Dark circles under eyes

## Section 5 – Mineral Needs

75

**136.** 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
**137.** 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
**138.** 0 1 History of stress fracture (0=no, 1=yes)
**139.** 0 1 2 3 Bone loss (reduced density on bone scan)
**140.** 0 1 Are you shorter than you used to be? (0=no, 1=yes)
**141.** 0 1 2 3 Calf, foot or toe cramps at rest
**142.** 0 1 2 3 Cold sores, fever blisters or herpes lesions
**143.** 0 1 2 3 Frequent fevers
**144.** 0 1 2 3 Frequent skin rashes and/or hives
**145.** 0 1 Herniated disc (0=no, 1=yes)
**146.** 0 1 2 3 Excessively flexible joints, "double jointed"
**147.** 0 1 2 3 Joints pop or click
**148.** 0 1 2 3 Pain or swelling in joints
**149.** 0 1 2 3 Bursitis or tendonitis
**150.** 0 1 History of bone spurs (0=no, 1=yes)
**151.** 0 1 2 3 Morning stiffness
**152.** 0 1 2 3 Nausea with vomiting
**153.** 0 1 2 3 Crave chocolate
**154.** 0 1 2 3 Feet have a strong odor
**155.** 0 1 2 3 History of anemia
**156.** 0 1 2 3 Whites of eyes (sclera) blue tinted
**157.** 0 1 2 3 Hoarseness
**158.** 0 1 2 3 Difficulty swallowing
**159.** 0 1 2 3 Lump in throat
**160.** 0 1 2 3 Dry mouth, eyes and/or nose
**161.** 0 1 2 3 Gag easily
**162.** 0 1 2 3 White spots on fingernails
**163.** 0 1 2 3 Cuts heal slowly and/or scar easily
**164.** 0 1 2 3 Decreased sense of taste or smell

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

## Section 6 – Essential Fatty Acids

22

**165.** 0 1 Experience pain relief with aspirin (0=no, 1=yes)
**166.** 0 1 2 3 Crave fatty or greasy foods
**167.** 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
**168.** 0 1 2 3 Tension headaches at base of skull
**169.** 0 1 2 3 Headaches when out in the hot sun
**170.** 0 1 2 3 Sunburn easily or suffer sun poisoning
**171.** 0 1 2 3 Muscles easily fatigued
**172.** 0 1 2 3 Dry flaky skin or dandruff

## Section 7 – Sugar Handling

39

**173.** 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
**174.** 0 1 2 3 Crave sweets
**175.** 0 1 2 3 Binge or uncontrolled eating
**176.** 0 1 2 3 Excessive appetite
**177.** 0 1 2 3 Crave coffee or sugar in the afternoon
**178.** 0 1 2 3 Sleepy in afternoon
**179.** 0 1 2 3 Fatigue that is relieved by eating
**180.** 0 1 2 3 Headache if meals are skipped or delayed
**181.** 0 1 2 3 Irritable before meals
**182.** 0 1 2 3 Shaky if meals delayed
**183.** 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
**184.** 0 1 2 3 Frequent thirst
**185.** 0 1 2 3 Frequent urination

## Section 8 – Vitamin Need

81

**186.** 0 1 2 3 Muscles become easily fatigued
**187.** 0 1 2 3 Feel exhausted or sore after moderate exercise
**188.** 0 1 2 3 Vulnerable to insect bites
**189.** 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
**190.** 0 1 2 3 Enlarged heart or congestive heart failure
**191.** 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
**192.** 0 1 2 3 Ringing in the ears (Tinnitus)
**193.** 0 1 2 3 Numbness, tingling or itching in hands and feet
**194.** 0 1 2 3 Depressed
**195.** 0 1 2 3 Fear of impending doom
**196.** 0 1 2 3 Worrier, apprehensive, anxious
**197.** 0 1 2 3 Nervous or agitated
**198.** 0 1 2 3 Feelings of insecurity
**199.** 0 1 2 3 Heart races
**200.** 0 1 2 3 Can hear heart beat on pillow at night
**201.** 0 1 2 3 Whole body or limb jerk as falling asleep
**202.** 0 1 2 3 Night sweats
**203.** 0 1 2 3 Restless leg syndrome
**204.** 0 1 2 3 Cracks at corner of mouth (Cheilosis)
**205.** 0 1 2 3 Fragile skin, easily chaffed, as in shaving
**206.** 0 1 2 3 Polyps or warts
**207.** 0 1 2 3 MSG sensitivity
**208.** 0 1 2 3 Wake up without remembering dreams
**209.** 0 1 2 3 Small bumps on back of arms
**210.** 0 1 2 3 Strong light at night irritates eyes
**211.** 0 1 2 3 Nose bleeds and/or tend to bruise easily
**212.** 0 1 2 3 Bleeding gums especially when brushing teeth

## Section 9 – Adrenal

78

**213.** 0 1 2 3 Tend to be a "night person"
**214.** 0 1 2 3 Difficulty falling asleep
**215.** 0 1 2 3 Slow starter in the morning
**216.** 0 1 2 3 Tend to be keyed up, trouble calming down
**217.** 0 1 2 3 Blood pressure above 120/80
**218.** 0 1 2 3 Headache after exercising
**219.** 0 1 2 3 Feeling wired or jittery after drinking coffee
**220.** 0 1 2 3 Clench or grind teeth
**221.** 0 1 2 3 Calm on the outside, troubled on the inside
**222.** 0 1 2 3 Chronic low back pain, worse with fatigue
**223.** 0 1 2 3 Become dizzy when standing up suddenly
**224.** 0 1 2 3 Difficulty maintaining manipulative correction
**225.** 0 1 2 3 Pain after manipulative correction
**226.** 0 1 2 3 Arthritic tendencies
**227.** 0 1 2 3 Crave salty foods
**228.** 0 1 2 3 Salt foods before tasting
**229.** 0 1 2 3 Perspire easily
**230.** 0 1 2 3 Chronic fatigue, or get drowsy often
**231.** 0 1 2 3 Afternoon yawning
**232.** 0 1 2 3 Afternoon headache
**233.** 0 1 2 3 Asthma, wheezing or difficulty breathing
**234.** 0 1 2 3 Pain on the medial or inner side of the knee
**235.** 0 1 2 3 Tendency to sprain ankles or "shin splints"
**236.** 0 1 2 3 Tendency to need sunglasses
**237.** 0 1 2 3 Allergies and/or hives
**238.** 0 1 2 3 Weakness, dizziness

## Section 10 – Pituitary

29

**239.** 0 1 Height over 6' 6" (0=no, 1=yes)
**240.** 0 1 Early sexual development (before age 10) (0=no, 1=yes)
**241.** 0 1 2 3 Increased libido
**242.** 0 1 2 3 Splitting type headache
**243.** 0 1 2 3 Memory failing
**244.** 0 1 Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)
**245.** 0 1 Height under 4' 10" (0=no, 1=yes)
**246.** 0 1 2 3 Decreased libido
**247.** 0 1 2 3 Excessive thirst
**248.** 0 1 2 3 Weight gain around hips or waist
**249.** 0 1 2 3 Menstrual disorders
**250.** 0 1 Delayed sexual development (after age 13) (0=no, 1=yes)
**251.** 0 1 2 3 Tendency to ulcers or colitis

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

## Section 11 – Thyroid

48

**252.** 0 1 2 3 Sensitive/allergic to iodine
**253.** 0 1 2 3 Difficulty gaining weight, even with large appetite
**254.** 0 1 2 3 Nervous, emotional, can't work under pressure
**255.** 0 1 2 3 Inward trembling
**256.** 0 1 2 3 Flush easily
**257.** 0 1 2 3 Fast pulse at rest
**258.** 0 1 2 3 Intolerance to high temperatures
**259.** 0 1 2 3 Difficulty losing weight
**260.** 0 1 2 3 Mentally sluggish, reduced initiative
**261.** 0 1 2 3 Easily fatigued, sleepy during the day
**262.** 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
**263.** 0 1 2 3 Constipation, chronic
**264.** 0 1 2 3 Excessive hair loss and/or coarse hair
**265.** 0 1 2 3 Morning headaches, wear off during the day
**266.** 0 1 2 3 Loss of lateral 1/3 of eyebrow
**267.** 0 1 2 3 Seasonal sadness

## Section 12 – Men Only

27

**268.** 0 1 2 3 Prostate problems
**269.** 0 1 2 3 Difficulty with urination, dribbling
**270.** 0 1 2 3 Difficult to start and stop urine stream
**271.** 0 1 2 3 Pain or burning with urination
**272.** 0 1 2 3 Waking to urinate at night
**273.** 0 1 2 3 Interruption of stream during urination
**274.** 0 1 2 3 Pain on inside of legs or heels
**275.** 0 1 2 3 Feeling of incomplete bowel evacuation
**276.** 0 1 2 3 Decreased sexual function

## Section 13 – Women Only

60

**277.** 0 1 2 3 Depression during periods
**278.** 0 1 2 3 Mood swings associated with periods (PMS)
**279.** 0 1 2 3 Crave chocolate around periods
**280.** 0 1 2 3 Breast tenderness associated with cycle
**281.** 0 1 2 3 Excessive menstrual flow
**282.** 0 1 2 3 Scanty blood flow during periods
**283.** 0 1 2 3 Occasional skipped periods
**284.** 0 1 2 3 Variations in menstrual cycles
**285.** 0 1 2 3 Endometriosis
**286.** 0 1 2 3 Uterine fibroids
**287.** 0 1 2 3 Breast fibroids, benign masses
**288.** 0 1 2 3 Painful intercourse (dysparenia)
**289.** 0 1 2 3 Vaginal discharge
**290.** 0 1 2 3 Vaginal dryness
**291.** 0 1 2 3 Vaginal itchiness
**292.** 0 1 2 3 Gain weight around hips, thighs and buttocks
**293.** 0 1 2 3 Excess facial or body hair
**294.** 0 1 2 3 Hot flashes
**295.** 0 1 2 3 Night sweats (in menopausal females)
**296.** 0 1 2 3 Thinning skin

## Section 14 – Cardiovascular

30

**297.** 0 1 2 3 Aware of heavy and/or irregular breathing
**298.** 0 1 2 3 Discomfort at high altitudes
**299.** 0 1 2 3 "Air hunger" or sigh frequently
**300.** 0 1 2 3 Compelled to open windows in a closed room
**301.** 0 1 2 3 Shortness of breath with moderate exertion
**302.** 0 1 2 3 Ankles swell, especially at end of day
**303.** 0 1 2 3 Cough at night
**304.** 0 1 2 3 Blush or face turns red for no reason
**305.** 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
**306.** 0 1 2 3 Muscle cramps with exertion

## Section 15 – Kidney and Bladder

13

**307.** 0 1 2 3 Pain in mid-back region
**308.** 0 1 2 3 Puffy around the eyes, dark circles under eyes
**309.** 0 1 History of kidney stones (0=no, 1=yes)
**310.** 0 1 2 3 Cloudy, bloody or darkened urine
**311.** 0 1 2 3 Urine has a strong odor

## Section 16 – Immune system

30

**312.** 0 1 2 3 Runny or drippy nose
**313.** 0 1 2 3 Catch colds at the beginning of winter
**314.** 0 1 2 3 Mucus producing cough
**315.** 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
**316.** 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
**317.** 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
**318.** 0 1 2 3 Acne (adult)
**319.** 0 1 2 3 Itchy skin (Dermatitis)
**320.** 0 1 2 3 Cysts, boils, rashes
**321.** 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

# Frequently Asked Questions

***How much will the first visit cost?***
We schedule 1 ½ hours for the New Patient Consultation—allowing ample time to discuss all your health concerns. Fees are based on a rate of $45 per 15-minute increment. Therefore, your New Patient Consultation may cost $180-$270. (Recommend nutritional supplements or additional tests are not included in this price.)

***How much do subsequent visits cost?***
Services vary based on individual needs. Visits typically range from $90 to $180—based on time. This price does not include nutritional supplements. Subsequent visits are typically 30-45 minutes.

***Does insurance cover these services?***
Not typically. Following your consultation, an invoice will be emailed to you that can be paid directly through our website. Please let us know if you need a "super bill" to submit to your insurance company—this is a little different format. Big Sky Wellness Center does not bill insurance.

***How long will it take to feel better?***
This is a great question! Timeframes for recovery are very individual., so we will discuss this with you during your appointment.

***What is it that you do, exactly?***
At this time, we are only available for phone consultations and Zoom appointments. Previously, we operated a little differently when our office was located in Montana. Our office is a very specialized chiropractic and nutritionally oriented office. Services are recommended based on individual needs. Some of the techniques that *may* be utilized are:

- Chiropractic adjustments *(currently unavailable)*
- Specifically designed nutritional recommendations
- Zyto-Limbic Stress Assessments
- Hormone testing
- Blood tests
- Detoxification foot cleanse
- Diet and lifestyle counseling
- SET-DB Allergy desensitization technique *(Currently unavailable)*

Big Sky Wellness Center
PO Box 1090, Paulden, AZ 86334
Office: 928-260-4747

More information regarding these techniques can be found online at:
BigSkyWellnessCenter.Com.

***Can you help me?***
A wide range of health conditions have been helped. During your New Patient Consultation, we will discuss if yours is a case for which favorable results are anticipated. If necessary, referrals to other providers will be addressed.

A few of the many areas in which excellent results have been achieved are:

| | | |
|---|---|---|
| Neck and low back pain | Low energy | Auto-immune Conditions |
| Headaches | Allergies | *and many, many more…* |
| Digestive issues | Frequent colds | |
| Female issues | Thyroid Issues | |

***Will I need a blood test and where do I get that done?***
During your consultation, we will determine if additional tests are needed to evaluate your current health situation.

Thank You!

Dr. Julie Schleusner

Big Sky Wellness Center
PO Box 1090, Paulden, AZ 86334
Office: 928-260-4747

# INFORMED CONSENT FORM & TERMS FOR NUTRITIONAL COUNSELING

I _____ give consent to Julie Schleusner, D.C. and Big Sky Wellness Center to provide Nutritional Counseling to myself or the client for which I am legally responsible. The consultation will provide information and guidance about health factors within my own control: my diet, nutrition and lifestyle.

I understand that Julie Schleusner, D.C., is a chiropractor – not a medical physician – and does not dispense medical advice, nor will she diagnose or treat medical conditions, but will provide nutritional support and education for an already diagnosed condition. In addition, she provides education to enhance my knowledge of health through the use of whole foods, dietary supplements, and emotional awareness. While nutrition and botanical support can be an important complement to medical care, I understand these services are not a substitute for medical care.

The nutritional evaluation or testing methods available to me are not intended to diagnose disease. Rather, these assessment tests are designed as a guide to developing an appropriate health-supportive program for me and to monitor my progress in achieving my goals.

Medical records, personal information, and history divulged in session to Big Sky Wellness Center will be kept confidential unless consent to share my medical and nutritional information by way of signed release has been completed. I acknowledge that I have read and understand the HIPAA privacy agreement Big Sky Wellness Center provided in hard copy form.

**Payment** is due at the time of service. Cash, check, and major credit cards are accepted.

**Insurance:** Big Sky Wellness Center does not bill insurance. If you have insurance, please notify our staff and a super bill can be printed for you to submit to your insurance for possible reimbursement.

**Fees:** All fees are based upon individual services rendered and may vary from visit to visit depending upon the doctor's specific recommendations. Our new patient office visit typically is $180-270.00, which does not include any supplements. Any additional fees, if necessary, will be discussed with you prior to treatment

**Missed Appointments:** The courtesy of a 24- hour notice to cancel an appointment is requested. The full visit fee will be assessed for canceling an appointment with less than 24-hour notice. "No Show" appointments and patients with continued canceled appointments (with less than 24-hour notice) will be considered for dismissal from this practice.

**Past Due Balances:** All patients with past due balances of 90 days will be turned over to our collection agency. Additionally, the patient will be responsible for any and all additional collection fees and /or attorney and court costs.

I understand and agree to the above Informed Consent and Terms of Big Sky Wellness Center.

_____

Client or Guardian's Signature Date

_____

Print Name

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

# Daily Record of Food Intake

*Your diet may be the key to better health.*

Each day record all the items you eat and drink. Be sure to include the approximate amount of each item.

Name: _____

**Quality of sleep last night**: (poor) 1 2 3 4 5 (great)
**Hours of sleep last night:**

**BREAKFAST:**
*Time*:
□ Home
□ Restaurant

**MID-MORNING SNACK:**
*Time:*
□ Home
□ Restaurant

**LUNCH:**
*Time:*
□ Home
□ Restaurant

**MID-AFTERNOON SNACK:**
*Time:*
□ Home
□ Restaurant

**DINNER:**
*Time:*
□ Home
□ Restaurant

**NIGHTTIME SNACK:**
*Time:*
□ Home
□ Restaurant

Notable Symptoms & Time:

**Glasses of <u>plain</u> water consumed today**:

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