ELIXIR
LIFESTYLE MEDICINE

From pain relief to stress relief and enhancing your wellbeing with acupuncture, Traditional Chinese Medicine, nutritional counseling and bodywork, it is our pleasure to be your partner on your quest for greater health. To simplify your visit and ensure fair and prompt service, please note the following office policies:

* We have a 24-hour cancellation policy. This means you will be charged in full for not keeping your appointment, unless we have notice AT LEAST 24-hours in advance.

* Please be timely. If you are late, it shortens your treatment time. Other patients will not be delayed to accommodate your late arrival.

* If you are more than 20 minutes late, you will have missed your appointment and incur a missed appointment fee.

* If your insurance doesn't cover your treatment, you will be responsible for paying in full. This includes the New Patient Intake on your first appointment & any extra services that are not covered by your insurance. This means that you will personally need to pay for services. No exceptions.

* Once established with your insurance company, your co-pay is due at the time of service. We reserve the right to refuse care to patients who do not meet the co-pay requirement, or whose payments are in arrears.

* As a courtesy we will provide a printed superbill for out of network patients.

* Supplements must be paid in full at the time of pick up. Unopened supplements may be returned within 14 days. There will be a 15% restocking fee.

* Opened supplements and custom herbal formulas are non-refundable.

* We accept cash, checks, and credit cards.

* Outstanding balances over 30 days are subject to a 1.5% fee, and there will be a $25.00 fee on ALL bounced checks.

* If your account has a balance and is not paid within 60 days from the due date, your account will be turned over to collections and your credit will be negatively affected.

* Treatments provided are non-refundable after services are rendered.

Yours in Health, Elixir Lifestyle Medicine

Patient Signature: _______________   Date: _______________

ELIXIR
LIFESTYLE MEDICINE

Health History Form

Name: ____ Date: __________________________________

Age: ______ Date of Birth: _________________ City & State of Birth: ________________________

Sex at Birth: ____________Preferred Gender Identity: _______________________________

Address: ______________________________City: ____________ State: __________ Zip: ____________

Phone #:____________________________Email Address:____

Marital Status: ____

Occupation: ____

Person(s) to reach in an emergency: ____

Relationship(s): ____________________________ Phone #'s: ____________________________________

May I thank someone for referring you to me? ____

Health History Questionnaire

What are your top THREE most important health problems or goals? Please, list in order of importance.

1.)____

2.)____

3.)____

Do you have a diagnosed illness or disease that we should list as a part of your health history?

____

General

Weight today _________lbs. Weight one year ago? ____________lbs.

Desired Weight ___________lbs. Height ______________________________

Who is your primary care physician? ____

Are you currently receiving healthcare for any reason? Yes No

If yes, where and from whom? ____

For what reason(s)? ____

____

Are you hypersensitive or allergic to:

Any drugs? ____

Any foods? ____

Any environmental things? ____

Do you use tobacco, currently? Y N Smoked previously? Y N

How much, how often? ____________________
How many years?_________________________
How many packs per day? _________________

Current Medications/ Supplements/Herbs/Homeopathic:

Please list ALL vitamins, herbs, supplements, prescription medication and over the counter medications you are taking, on a regular basis. Please include how often taken and milligram amount.

____

____

____

Y= Yes, P= Past, N= No

Gastrointestinal

Trouble Swallowing? Y P N
Change in thirst? Y P N
Nausea/ Vomiting Y P N
Blood in stool? Y P N
Pain or cramps (not menstrual)? Y P N
Belching or passing gas? Y P N
Ulcer History? Y P N
Gallbladder problems? Y P N
History of eating disorders? Y P N

Heartburn/ Reflux? Y P N
Change in appetite? Y P N
Bowel Movements HOW OFTEN? ______
Is this a change? ________________________
Constipation? Y P N
Diarrhea? Y P N
Liver Disease? Y P N
Hemorrhoids? Y P N

Eyes

Glaucoma? Y P N
Impaired Vision? Y P N
Eye pain/ strain? Y P N
Visual disturbances? Y P N

Cataracts? Y P N
Tearing or dryness? Y P N
Glasses or contacts? Y P N

Neurological

Loss of memory? Y P N
Seizures? Y P N
Muscle Weakness? Y P N

Vertigo or dizziness? Y P N
Paralysis? Y P N
Numbness or tingling? Y P N

Musculoskeletal

Osteopenia/ osteoporosis? Y P N
Joint pain or stiffness? Y P N
Muscle spasms or cramps? Y P N

Bones density study? Y P N Date:_____________
Arthritis? Y P N
Sciatica? Y P N

Respiratory

Shortness of breath? Y P N
Asthma? Y P N
Pneumonia? Y P N
Cough? Y P N

Emphysema? Y P N
Bronchitis? Y P N
Tuberculosis history? Y P N
Wheezing? Y P N

Urinary

Increased frequency? Y P N
Pain on urination? Y P N
Kidney Stones? Y P N
Inability to hold urine? Y P N
Frequent infections? Y P N

Mental/ Emotional

Memory Problems? Y P N
Poor concentration? Y P N
Mood swings? Y P N
Anxiety or nervousness? Y P N
Psychological difficulties? Y P N
Tension/ Easily stressed? Y P N
Considered or attempted suicide? Y P N
Depression? Y P N

Neck

Pain or stiffness? Y P N
Swollen glands? Y P N
Goiter? Y P N
Lumps? Y P N

Head

Headaches? Y P N
Migraines? Y P N
Jaw/ TMJ problems? Y P N
Head injury history? Y P N

Mouth and Throat

Hoarseness? Y P N
Frequent sore throat? Y P N
Sore tongue/ lips? Y P N
Dental problems? Y P N
Teeth grinding? Y P N
Gum problems? Y P N

Ears

Earaches? Y P N
Ringing? Y P N
Dizziness? Y P N
Impaired hearing? Y P N

Nose and Sinuses

Sinus problems?	Y P N	Loss of smell?	Y P N
Frequent colds?	Y P N	Nose bleeds?	Y P N
Stuffiness?	Y P N	Hay fever?	Y P N

Skin

Unusual lumps/ lesions/ moles?	Y P N	Night sweats?	Y P N
Rashes, Eczema, or hives?	Y P N	Acne or boils?	Y P N
Itching?	Y P N	Perpetual hair loss?	Y P N

Endocrine

Fatigue?	Y P N	Seasonal depression?	Y P N
Hypo or hyperthyroid?	Y P N	Heat or cold intolerance?	Y P N
Excessive thirst or hunger?	Y P N	Diabetes?	Y P N
Hypoglycemia?	Y P N	Cold hands or feet?	Y P N

Cardiovascular

High blood pressure/ strokes?	Y P N	Swelling in ankles/ feet?	Y P N
Heart disease/ heart attack?	Y P N	Angina/ chest pain?	Y P N
Blood clot history?	Y P N	Palpitations/ Fluttering?	Y P N
High cholesterol?	Y P N	Murmurs/ valve problems?	Y P N

Blood/ Peripheral Vascular

Easy bleeding or bruising?	Y P N	Circulatory problems?	Y P N
Varicose veins?	Y P N	Anemia History?	Y P N

Seasonal Allergies

Itchy eyes?	Y P N	Stuffiness?	Y P N
Loss of smell?	Y P N	Itchy ears?	Y P N
Sneezing?	Y P N	Chronic mucus productions?	Y P N

Female Reproductive System

Age of first menses? _________________
Age/ date of last menses? ____________
1st day of last menses? _______________
Length between periods? _____________days
Are cycles regular? Y P N
Duration of bleeding/period? ______________Days
Bleeding between periods? Y P N
Painful menses? Y P N
Heavy or excessive flow? Y P N
PMS? Y P N
If yes, what are your symptoms?
____
____

Birth control? Y N
What type? _________________________
Number of pregnancies _____________
Number of live births ______________
Number of miscarriages _____________

Abnormal PAP history? Y P N
Cervical dysplasia? Y P N
Have you had any gynecological surgeries?
____
____

Endometriosis? Y P N
Ovarian cysts? Y P N
Fibroid tumors? Y P N
Fertility problems? Y P N
Sexually transmitted diseases? Y P N

Menopausal symptoms? Y P N
Do you do breast self-exams? Y P N
Have breast lumps? Y P N
Breast pain or tenderness? Y P N
Nipple discharge? Y P N
Fibrocystic breasts? Y P N

Male Reproductive System

Any discharge or sores? Y P N
Testicular pain? Y P N
Testicular masses? Y P N
Erectile dysfunction? Y P N
Number of children? __________

Prostate problems? Y P N
Hernia history? Y P N
Sexually transmitted diseases? Y P N
Birth control ____________________

Special Studies

What imaging or other special studies have you had pertaining to your current problem(s), within the past year?

____

____

Hospitalizations and Surgery

What surgeries have you had and when?

____

____

When have you been hospitalized and what for?

____

Screenings:

Date of last physical exam? ____________ Colonoscopy? _______________

Males: Prostate exam_________ **Females**: Date of last PAP?__________Mammogram?_________

Family History

Please note if any of these disease/ problems are/ were applicable to your parents, grandparents, uncles, aunts, siblings or children. Please not for whom it was a problem.
Cancer & Type
Diabetes
Heart Disease
High Blood Pressure
Strokes
Mental Illness

Are your parents, grandparents, siblings and children all still living? If not, please put their cause of death and at what age(s), if you know?

____

____

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snack: ____

Beverages: ____

For the following sections, please use this key:

Y= a condition you have now   N= a condition you have never had   P= had in the past

Main interest and hobbies: ____

Do you exercise? YES NO If yes, what kind? ______________________________________

How often? ___________________ How much time spent per week? _______________________

Average 7-8 hours sleep?	Y N	Spend time outside?	Y N
Sleep well?	Y N	Watch television?	Y N
Awaken rested?	Y N	How many hours/ day? _______________	
Have a history of any abuse?	Y N	Read?	Y N
Any major traumas?	Y N	How many hours/ day? _______________	
Do you eat at least three meals a day?	Y N	Use alcoholic beverages?	Y N
Do you eat out often?	Y N	How much, how often? _____________	
Do you go on diets often?	Y N	Treated for alcoholism?	Y P N
Do you drink coffee?	Y N	Do you drink cola or other sodas?	Y P N
Do you drink black or green tea?	Y N	Do you add salt to your food?	Y N
Do you eat refined sugar?	Y N		

Do you travel often for work? Y N

Are you exposed to any chemicals of occupational hazards as a part of your day or work?

____

When during the day is your energy the best? _____________ The worst? ___________________

How do your current conditions affect you?

____

____

What do you feel needs to happen to you to feel better/ get better?

____

Is there any information about your health that you would like to add?

____

I certify that the information given on this form is true and correct. I understand that this information will be used for the purpose of a natural medical consultation. I acknowledge by my signature that I have read and understand these statements.

____
Signature   Date

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ________

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ________

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ________

10. Did a household member go to prison?
    Yes No If yes enter 1 ________

Now add up your "Yes" answers: _______ This is your ACE Score

Metabolic Assessment Form™

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** ______________

PART I

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

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

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

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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

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

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

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

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

Category XVI				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

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

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

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

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

PART III

How many alcoholic beverages do you consume per week? ________

How many caffeinated beverages do you consume per day? ________

How many times do you eat out per week? ________

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

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

How many times do you eat fish per week? ________

How many times do you work out per week? ________

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

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

PART IV

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

____

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

____

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Health Questionnaire (NTAF)

Name: ______________________________ Age: ______ Sex: ________ Date: ____________________

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

SECTION A

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

SECTION B

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

SECTION C

SECTION C1

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

SECTION C2

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

SECTION 1 - S

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

SECTION 2 - D

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

SECTION 3 - G

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

SECTION 4 - ACH

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

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

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Medication History

Please circle any of the following medication you have been or are currently taking.

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

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

Acetylcholinesterase Reactivators
Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers
Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazpines)
Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSon, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax , Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazpines)
Ambien, Sonata, Lunesta, Imovane

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

Cholinesterase Inhibitors (reversible)
Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticidses

Dopamine Reuptake Inhibitors
Wellbutrin (Bupropion)

Dopamine Receptor Agonists
Mirapex, Sifrol, Requip

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

GABA Antagonist Competitive binder
Flumazenil

Monoamine Oxidase Inhibitor (MAOI)
Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

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

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

Selective Serotonin Reuptake Enhancers
Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricylic Antidepresseants (TCAs)
Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

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PYROLURIA

Pyroluria is the result of a genetically-caused over-production of a group of chemicals called kyrptopyrroles. These pyrroles bind with B_6 and zinc and dump them into the urine which is then excreted from the body creating emotional disaster. A high incidence of Pyrrole Disorder is found in individuals on the autism spectrum, individuals with anxiety disorder, depression, obsessive-compulsive disorder, schizophrenia, bipolar disorder, Asperger's, AD(H)D, and alcoholism (44%). However, pyroluria is quickly and easily corrected when diagnosed.

MAJOR INDICATIONS

YES NO
___ ___ Do you sunburn easily? Do you have fair or pale skin?
___ ___ Do you tend to avoid stressful situations?
___ ___ Do you have poor dream recall or only exciting dreams (nightmares)?
___ ___ Is it hard to recall what you've just read?
___ ___ Are your eyes sensitive to bright lights?
___ ___ Do you get frequent colds or infections?
___ ___ Are there white spots/flecks on your fingernails?
___ ___ Are you prone to acne, eczema, or psoriasis?
___ ___ Do you have stretch marks on your skin?
___ ___ Do you prefer not to eat breakfast or even experience light nausea in the morning?
___ ___ Are there severe mood problems, mental illness, or alcoholism in your family?

INDICATIONS THAT ARE OCCASIONALLY PRESENT

YES NO
___ ___ Do you have a reduced amount of head hair or do you have prematurely gray hair?
___ ___ Are you becoming more of a loner as you age?
___ ___ Have you been anxious, fearful, or felt a lot of inner tension since childhood?
___ ___ If you are over age 16, do you have bouts of depression and/or nervous exhaustion?
___ ___ Do you have headaches?
___ ___ Did you reach puberty earlier or later than normal?
___ ___ Do you sneeze in sunlight?
___ ___ Do loud noises bother you?
___ ___ Do you prefer the company of one or two close friends rather than a gathering of friends?
___ ___ Have you noticed a sweet smell (fruity odor) to your breath or sweat when ill or stressed? (Rare symptom)
___ ___ Do you have a poor appetite or a poor sense of taste? Do you enjoy spicy food?
___ ___ Do you have any upper abdominal or spleen pain? As a child, did you get a "stitch" in your side when you ran? (1 in 10 have this symptom)
___ ___ Do your knees crack or ache?
___ ___ Are you anemic? (1 in 10 have this symptom)
___ ___ Are you easily upset (internally) by criticism?
___ ___ Do you have frequent mood swings?
___ ___ Do you tend to carry any excess fat in your lower extremities rather than evenly distributed around your body (a pear-shaped figure)?

If you have any of the disorders listed at the beginning of this test and you answered "yes" to five or more of the MAJOR INDICATIONS and "yes" to some of the OCCASIONALLY PRESENT questions, you should have a Pyrrole urine test.

© 2013 This questionnaire, originally developed by Carl Pfeiffer, PhD., has been updated by Suka Chapel-Horst, RN, PhD, in consultation with William J. Walsh, PhD.

This condition, if present, is 100% correctable with the proper micronutrients and complete recovery can occur in one to three weeks.

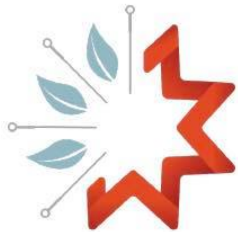
To obtain a Pyrrole urine test kit and a medical consultation, go to www.pyroluriatesting.com or contact:
Suka-Chapel-Horst, PhD, RN at 417-380-3254 for more information.

WEEKLY FOOD DIARY

GOALS:

	SUN	MON	TUE	WED	THU	FRI	SAT
Date							
Breakfast							
Lunch							
Dinner							
Snacks							
Water	○○○○ ○○○○	○○○○ ○○○○	○○○○ ○○○○	○○○○ ○○○○	○○○○ ○○○○	○○○○ ○○○○	○○○○ ○○○○
Notes							

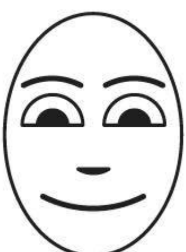
Weekly Food Diary © 2019 Vertex42 LLC



American Society™ of Acupuncturists

www.ASAcu.org

Defense and Veterans Pain Rating Scale



MILD *(Green)*

MODERATE *(Yellow)*

SEVERE *(Red)*

Rating	Description
0	No pain
1	Hardly notice pain
2	Notice pain, does not interfere with activities
3	Sometimes distracts me
4	Distracts me, can do usual activities
5	Interrupts some activities
6	Hard to ignore, avoid usual activities
7	Focus of attention, prevents doing daily activities
8	Awful, hard to do anything
9	Can't bear the pain, unable to do anything
10	As bad as it could be, nothing else matters

ELIXIR
LIFESTYLE MEDICINE

Informed Consent

I hereby request and consent to acupuncture treatments and other procedures within the scope of practice of Licensed Acupuncture for myself (or the patient named below, for whom I am legally responsible) by the acupuncturist named above.

I have been informed and understand that, as in the practice of medicine, the practice of Acupuncture entails some risks with treatment, including but not limited to slight bruising, tingling near the needling sites that may last a few days, nausea, a punctured lung or other internal organ, and infection. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications which may be possible, and I choose to rely on her expertise to exercise appropriate judgment during the course of the procedure which she deems appropriate at the time, and based upon the facts then known, in my best interest. If I suspect that I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reaction(s) to herbs, I will promptly inform the acupuncturist.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the acupuncture procedure. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_______________________________________ ____________________________
Signature of Patient or Patient's Representative Date

X_______________________________________ ____________________________
Print Name of Patient Print Name of Patient Representative

I acknowledge that a 1.5% fee will be added to any balance over 30 days past due.

X__________
Initials

I realize that I am responsible for a payment in full for a missed appointment charge if less than 24 hours notice is given for changing a scheduled appointment. A 1.5% fee will be added to any balance over 30 days past due. If your account is in arrears over 90 days it will be turned over to a collection agency.

X____________
Initials

I understand that if, for any reason, my insurance does not cover my acupuncture sessions, that payment is my personal responsibility, and that I will provide such payments.

X____
Signature

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

________________________, HEREBY STATES that by signing below, I acknowledge and agree as follows:

The Practice's Privacy notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operation. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing the Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, **in writing,** at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

X______________________________
Name of Individual (Print)

X_____________________________
Signature of Individual

X_______________________________
Signature of Legal Representative
(e.g. Attorney, Guardian, Parent if a minor)

____
Relationship

ELIXIR
LIFESTYLE MEDICINE

It is the office policy to keep your credit card on file in order to secure your appointments. As you know, our office is very busy and keeps a waiting list. If you miss your appointment, that is a time slot we could have offered another patient.

Your credit card information is kept in a secure, locked file and will only be used if you cancel with less than 24 hours-notice or don't keep the time we've allotted specifically for your care.

We hope you understand that this policy is in place so we can continue to put your healthcare first and serve you with the respect, focus and intention you deserve.

ELIXIR
LIFESTYLE MEDICINE

Credit Card Authorization Form

PLEASE NOTE THIS AUTHORIZATION WILL ONLY BE USED FOR MISSED APPOINTMENT FEES AND UNPAID BALANCES.

Credit Card Details

Credit Card # ____

Expiration Date ____________

CVC ____________

Credit Card Holder Name ____

Billing Address

Street ____

City____________________________________ State_______ Zip______________

Acknowledgement & Agreement

I hereby authorize my signature to be on file with Elixir Lifestyle Medicine for the purpose of client sessions that I schedule but fail to keep without providing 24 hours notice. I understand that all credit card transactions are subject to a 5% fee. I authorize the respective credit card company designated by my card on file to accept this form in lieu of my signature appearing on the individual credit card receipt for the services provided. By signing the authorization form, I acknowledge and agree to be financially responsible for any and all charges invoiced to me by Elixir Lifestyle Medicine. I confirm that I am the credit card holder responsible for the credit card number I have indicated. I agree to permit Elixir Lifestyle Medicine to submit unsigned credit card vouchers, stating that my signature is on file, or to amend, alter, complete or execute on my behalf, credit card vouchers in my name for payment of charges. I further agree that in the event my credit card becomes invalid, I personally guarantee payment and will provide Elixir Lifestyle Medicine with a new valid credit card number upon request, to be charged for the payment of any outstanding balances owed.

____
Card Holder Signature

____ ______________________
Print Name Date

Out of respect for our chemically sensitive patients

THIS IS A FRAGRANCE FREE OFFICE

Please refrain from wearing perfume, aftershave and scented body lotions on the day of your treatment

Thank you for Your Understanding