

St. _____ Fin. _____

CLIENT INFORMATION SHEET

Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip: _____

E-mail: _____ Phone: (H) _____ (W) _____

Current Occupation: _____ (Cell) _____

Emergency Contact Name _____ AND Phone: _____

Referral Source: _____

Age: _____ Birthday: _____ If Child, Patient, Parent or Guardian Name: _____

1. Please list any medications you are on: _____

2. Vitamins or supplements: _____

3. Blood Type (A, B, AB or O): _____ Physician's Name: _____ Dentist: _____

4. FOODS/LIFESTYLE

How many alcohol beverages do you consume per week? _____

How many sodas per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you exercise? _____

List the three worst foods you eat during the average week: _____; _____; _____

List the three healthiest foods you eat during the average week: _____; _____; _____

Do you smoke? _____ If yes, how many times a day? _____; a week? _____

Rate your stress levels on a scale of 1 – 10 during the average week (10 being most stressed). _____

5. List all surgical removals and/or alterations: _____

6. Have you used Complimentary Healing Methods? (please circle) Herbs, Massage, Homeopathy, Chiropractic, Colonics, Vitamins & Minerals, Reiki, Feldenkrais, Rolfing, Nutrition, Color Therapy, Electromagnetic Testing/Therapies, Acupuncture, Chinese Herbs or Auravedic Herbs.

7. Do you feel the illness you currently have is curable? Yes _____ No _____

8. Do you see a future free from this illness? Yes _____ No _____

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list the 5 major health concern in your order of importance:

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

PART II

Please circle the appropriate number "0 - 3" 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 relief 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 of "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

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 fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III

Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, 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 IV

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 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
Excessive passage of gas	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	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

Category V

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
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 VI

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

Category VII

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 & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VIII

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 IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 X

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 gain 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 falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

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
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Male Only) *

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only) *

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain 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
Decrease in 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 then in the past	0	1	2	3

Category XVI (Menstruating Females Only) *

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 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 break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only) *

Category 1: Menopause symptoms				
How many years have you been menopausal?				
Do you ever have uterine bleeding since menopause?	Yes	No		
Hot flashes	0	1	2	3
Mental foginess	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

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.

PATIENT RELEASE FORM

Monica O'Sullivan, N.D., of Community Health & Healing and Janine Romaner, N.D., of Naturally Healthy, LLC, 3221 S. Cherokee Lane, Suite 1830, Woodstock, GA 30188 do not recommend or dispense prescription drugs, utilize surgery, X-rays or radiation therapy. We do not engage in the practice of medicine or represent ourselves as being licensed by the state of Georgia or any branch of the healing arts. If you are seeking allopathic medical services, you are urged to seek them from a qualified allopathic medical practitioner.

Dr. O'Sullivan, N.D. and Dr. Romaner, N.D. provides naturopathic and healing arts services to private persons by contract. Article 1 of the Constitution of the United States of America guarantees the right to contract. Additionally, we provide non-prescription health products for sale to private persons with whom we contract. Naturopathy is defined in Georgia Code, Chapter 43-34-2 as follows:

"Naturopathy is hereby defined as that philosophy and system of the healing arts embracing prevention, diagnosis and treatment of human ills and functions by the use of several properties of air, light, heat, cold, water, manipulation, with the use of such substances, nutritional as are naturally found in and required by the body excluding drugs, surgery, x-ray and radium therapy and the use of x-ray equipment."

I have read the above and understand what I read. I choose freely to have Dr. O'Sullivan, N.D. and/or Dr. Romaner, N.D. provide me with naturopathic services.

Furthermore, I understand that naturopathy is a system of health care that supports the body's ability to heal and regenerate itself. I understand that there are no promises regarding a "cure" for any disease whatsoever.

CANCELLATION POLICY

Because we see each client as important and offer a generous amount of time per session with each individual, we ask for your cooperation in return by showing up for appointments on time. For any appointment missed without a minimum of 24 hours advance notice (more is appreciated), you will be charged half the appointment fee.

My Name or Parent, Guardian's Name

Child or Dependents Name

Date