

## Assessment Forms

### Functional Medicine

Functional Healthcare involves looking at the body's systems that create change in your metabolism as interlinked and complex, instead of merely identifying one part of your metabolism as elevated or depressed. In Functional Healthcare, factors that change metabolism, altering your body's response, will be evaluated first. This means that we do an evaluation of the complex interactions of organ function; creation, transport and absorption of hormones; detoxification; digestion and gut function; sugar metabolism; and your body's ability to deal with stress.

The following form will assist us in identifying the vicious cycles that feed each other causing your current health condition. We can then provide support, counseling and a treatment program to unlock these vicious cycles, enabling you to regain a health you may have not thought possible.

**Metabolic & Neurotransmitter Assessment Form**

**Fill out all areas of both forms**

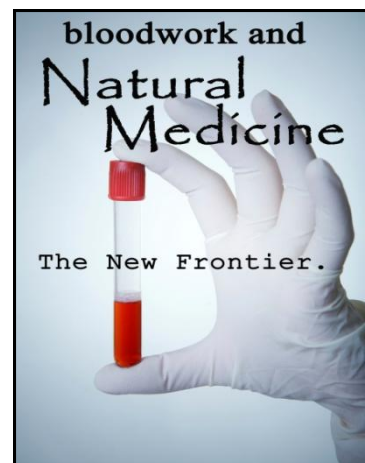
**Fill out the Metabolic Assessment Form**

**Fill out the Neurotransmitter Analysis Form**

**Fax or email forms to Wellness Alternatives**

Fax: 636.779.1456 or

email to [dpeterson@stlwa.com](mailto:dpeterson@stlwa.com)



**Please complete all pages and send all the pages to us for your personalized evaluation.**

**Comments:**

**Contact Information:**

**Name:**

**Address:**

**E-mail:**

**Phone:**

CONFIDENTIALITY NOTICE: This fax and any attachments may contain CONFIDENTIAL information including PROTECTED HEALTH INFORMATION. If you are not the intended recipient, any use or disclosure is strictly prohibited. You are requested to destroy this fax and any attachments and notify the sender immediately. WELLNESS ALTERNATIVES HIPPA SECURITY OFFICER at 636.227.4949 Thank You

**Wellness Alternatives**  
**REGISTRATION FORM**  
(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Case # \_\_\_\_\_

PATIENT INFORMATION					
Patient's First Name      Middle      Last			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Partner
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)	Age	Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address / P.O. Box		Social Security		Home Phone No.(      )	
City		State		ZIP Code	
Occupation	Employer			Phone No. (      ) <input type="checkbox"/> Cell <input type="checkbox"/> Employer	
<b>Whom do we thank for referring you to us? (Please check one box)</b>					
<input type="checkbox"/> Dr. <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Publication <input type="checkbox"/> Family <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Friend _____ <input type="checkbox"/> Other _____					
Email address _____      Online newsletter list: <input type="checkbox"/> Yes <input type="checkbox"/> No					

**You Are Responsible for your Bill.**

WE WILL PROVIDE YOU WITH A RECEIPT THAT YOU CAN SUBMIT  
TO YOUR INSURANCE COMPANY.

Please indicate primary payment:     Cash     Check     MasterCard     VISA

Current Health Condition		
<b>Purpose of This Appointment: Major Complaint</b>		
<b>When / How Did This Condition Begin:</b>		
Year	Reason	Doctor First Seen:
<b>Other Doctors Seen For This Condition:</b>		
Year	Reason	Hospital

PERSONAL HEALTH HISTORY		
Surgeries: <input type="checkbox"/> Spinal <input type="checkbox"/> Appendix <input type="checkbox"/> Gallbladder <input type="checkbox"/> Heart <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Hernia		
Medications	<input type="checkbox"/> Insulin	<input type="checkbox"/> Depression
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Blood Pressure
	<input type="checkbox"/> Influenza	<input type="checkbox"/> Anti-Inflammatory
Hospitalizations Or Medical Doctors Seen in the past 6 months and Current Medications		
Year	Reason	Hospital/Doctor
Chiropractic Treatment and their Supplement Recommendations		
Year	Reason	Doctor
List Any Other Holistic Treatments or Therapist/Healers and their Supplement Recommendations		
Year	Reason	Holistic Therapist/Healer

**Why Wellness Alternatives? People come to us for a variety of reasons.**

- ( ) **Relief Care** – Symptomatic relief of pain or discomfort: We recommend SOT Chiropractic.
- ( ) **Restorative Care** – The cause of the problem corrected and relieved: We recommend Functional Medicine.
- ( ) **Comprehensive Care** – I choose to have what ever is malfunctioning in my body brought to the highest state of health possible with SOT/Chiropractic and Functional Medicine care.
- ( ) **Weight Loss** – I want help losing weight.
- ( ) **I want the Doctor to select the type of care appropriate for my condition.**

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

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

<b>Category I</b>			
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
<b>Category II</b>			
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
<b>Category III</b>			
Stomach pain, burning, or aching 1- 4 hours after eating . . . . .	0	1	2 3
Use 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 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
<b>Category IV</b>			
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
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

<b>Category V</b>			
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	
<b>Category VI</b>			
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, or have 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
<b>Category VII</b>			
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
<b>Category VIII</b>			
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

<b>Category IX</b>				
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
<b>Category X</b>				
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
<b>Category XI</b>				
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
<b>Category XII</b>				
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
<b>Category XIII</b>				
Increased sex drive . . . . .	0	1	2	3
Tolerance to sugars reduced . . . . .	0	1	2	3
“Splitting” type headaches . . . . .	0	1	2	3

<b>Category XIV (Males only)</b>				
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 evacuation . . . . .	0	1	2	3
Leg nervousness at night . . . . .	0	1	2	3
<b>Category XV (Males only)</b>				
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 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
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 than in the past . . . . .	0	1	2	3
<b>Category XVI (Menstruating Females Only)</b>				
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 breakouts . . . . .	0	1	2	3
Facial hair growth . . . . .	0	1	2	3
Hair loss/thinning . . . . .	0	1	2	3
<b>Category XVII (Menopausal Females Only)</b>				
How many years have you been menopausal? _____				
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

How many alcoholic beverages do you consume per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times a week do you eat fish? \_\_\_\_\_

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: \_\_\_\_\_

Rate your stress levels on a scale of 1-10 during the average week: \_\_\_\_\_

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

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

# 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

# Medication History\*

Please check any of the following medications you have been or are currently taking.

## Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine,  Ipratropium,  Scopolamine,  Tiotropium

## Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine,  Hexamethonium,  Nicotine (high doses),  Trimethaphan

## Acetylcholinesterase Reactivators

Pralidoxime

## Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium,  Cisatracurium,  Doxacurium,  Metocurine,  Mivacurium,  Pancuronium,  Rocuronium,  Succinylcholine,  Tubocurarine,  Vecuronium,  Hemicholinium

## Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax®,  Lexotanil,  Lexotan®,  Librium,  Klonopin®,  Valium®,  ProSom®,  Rohypnol,  Dalmane,  Ativan,  Loramet®,  Sedoxil,  Dormicum,  Megalodon,  Serax®,  Restoril,  Halcion

## Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien CR®,  Sonata®,  Lunesta®,  Imovane

## Cholinesterase Inhibitors (irreversible)

Echothiophate,  Isoflurophate,  Organophosphate Insecticides,  Organophosphate-containing nerve agents

## Cholinesterase Inhibitors (reversible)

Donepezil,  Galatamine,  Rivastigmine,  Tacrine,  THC,  Edrophonium,  Neostigmine,  Physostigmine,  Pyridostigmine,  Carbamate Insecticides

## Dopamine Reuptake Inhibitors

Wellbutrin XL® (Bupropion)

## Dopamine Receptor Agonists

Mirapex®,  Sifrol®,  Requip®

## D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine®,  Prolixin®,  Trilafon®,  Compazine®,  Mellaril®,  Stelazine®,  Vesprin®,  Nozinan®,  Depixol®,  Navane®,  Fluanxol®,  Clopixol®,  Acuphase®,  Haldol®,  Orap®,  Clozaril®,  Zyprexa®,  Zydys®,  Seroquel XR®,  Geodon®,  Solian®,  Invega®,  Abilify®

## GABA Antagonist Competitive binder

Flumazenil

## Monoamine® Oxidase Inhibitors (MAOI)

Marplan®,  Aurorix®,  Manerix®,  Moclodura,  Nardil,  Adeline®,  Eldepryl®,  Azilect®,  Marsilid®,  Iprozid®,  Ipronid®,  Rivivol,  Popilniazida®,  Zyvox®,  Zyvoxid®

## Noradrenergic® and Specific Sertonegic® Antidepressants (NaSSaa)

Remeron®,  Zispin®,  Avanza®,  Norset®,  Remergil®,  Axit®

## Selective Serotonin Reuptake Inhibitors

Paxil®,  Zoloft®,  Prozac®,  Celexa®,  Lexapro®,  Luvox®,  Cipramil®,  Emocal®,  Seropram®,  Cipralex®,  Esteria®,  Fontex®,  Dapoxetine®,  Seromex®,  Seronil®,  Sarafem®,  Fluctin®,  Faverin®,  Seroxat,  Aropax®,  Deroxat®,  Rextetin®,  Paroxat®,  Lustral®,  Serlain®

## Selective Serotonin Reuptake Enhancers

Stablon®,  Coaxil,  Tatinol®

## Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor®,  Pristiq®,  Meridia,  Serzone®,  Dalcipran®,  Despiramin,  Duloxetine

## Tricyclic Antidepressants (TCAs)

Elavil®,  Endep®,  Tryptanol,  Trepiline®,  Asendin®,  Asendis®,  Defanyl®,  Demolox®,  Moxadil®,  Anafranil®,  Norpramin®,  Pertofrane®,  Prothiaden®,  Adapin®,  Sinequan®,  Tofranil®,  Janamine®,  Gamamil®,  Aventyl®,  Pamelor®,  Opipramol®,  Vivactil®,  Rhotrimine®,  Surmontil®

\*Please refer to prescribing physician for nutritional interactions with any medications you may be taking.

*Wellness Alternatives*

266 Lamp & Lantern Village | Town & Country, MO 63017 | 636-227-4949

I understand payment is expected at time of service and understand the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my body. It is understood and agreed the amount paid the Doctor, for x-rays and laboratory testing, is for examination and analysis only. The patient also agrees that he/she is responsible for all bill(s) incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I understand any nutritional supplements purchased at Wellness Alternatives may not be returned after leaving the premises.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian's Signature

Authorizing Care: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize DLS to release health information electronically (email or fax) or paper to:

Wellness Alternatives – David Peterson, DC

Name of person or facility to receive health information

266 Lamp and Lantern Village Town and Country, MO 63017

Street Address, City, State, Zip

636-227-4949

636-779-1456

[dpeterson@stlwa.com](mailto:dpeterson@stlwa.com)

Phone

Fax

Email

**INFORMATION TO BE RELEASED**

Laboratory Report(s) Date of Report \_\_\_\_\_

Requisition Number

Billing Statements

SIGNATURE \_\_\_\_\_

Date: \_\_\_\_\_

(Signature of Patient or Patient's legal representative)

Printed Name: \_\_\_\_\_

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

I, \_\_\_\_\_, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. 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 operations. 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 this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications 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.
4. 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.
5. 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.
6. 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.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. 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.**

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative\*

\_\_\_\_\_  
Relationship

Date Signed \_\_\_\_\_

Witness: \_\_\_\_\_

\*Attorney-In-Fact, Guardian, Parent if a minor