

Alternative Care Wellness Center

Dr. Anthony E Faro, III, BS, MS, D.C. DABCI, Certified in Acupuncture
100 S Scenic Hwy #105 Lake Wales FL 33853 - 863-676-BACK - Fax: 863-676-0698

General Information (If more space is needed when filling in info, feel free to provide your own separate sheet.) * not recognized by FL Board.

Name: First _____ Middle _____ Last _____

Preferred Name: _____

Date of Birth: ___/___/___ Age: _____ Gender: Male Female

Genetic Background: African Asian European Ashkenazi Native American
 Middle Eastern Mediterranean Other _____

Highest Education Level: High School Graduate Post-Graduate

Job Title: _____

Nature of Business: _____

Primary Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Alternate Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Best Time and Place to Reach You: _____

Email: _____ Fax: _____

Emergency Contact: Name _____ Phone _____

Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Primary Pharmacy: Name _____ Phone _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Fax*: _____

**It is extremely important that you list the pharmacy's fax number.*

Whom may we thank for referring you? _____

Primary Care Website Media Other _____

Payment Information

Insurance plans including HMO, PPO, TRI Care, Medicaid, and Medicare do not pay for Integrative Medicine procedures. Therefore, Payment is due at time of service, no exceptions. Knowledge and awareness of insurance coverage is the sole responsibility of the patient. Therefore, procedures performed in our clinic **are not reported to the insurance carrier** and do not show up on your MIB an insurance industry list of every service and diagnosis you have. This data is used to determine your insurance rates and pre existing conditions.

Health Concerns & Goals

Please list current and/or ongoing areas of concern you would like to address in order of priority.

What do you hope to achieve with your visits here? _____

When was the last time you felt exceptionally well? _____

Health Concern or Goal #1 (Please describe as many details as you can) _____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: Better Worse About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: Type of pain

- Sharp Dull Throbbing Numbness Aching Shooting Burning
- Tingling Cramps Stiffness Swelling Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 (Please describe as many details as you can) _____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: Better Worse About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: Type of pain

- Sharp Dull Throbbing Numbness Aching Shooting Burning
- Tingling Cramps Stiffness Swelling Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concerns & Goals continued

Health Concern or Goal #3 (Please describe as many details as you can) _____

When did you first notice symptoms appear? _____ Was there a trigger? _____

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Is this condition getting: Better Worse About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: Type of pain

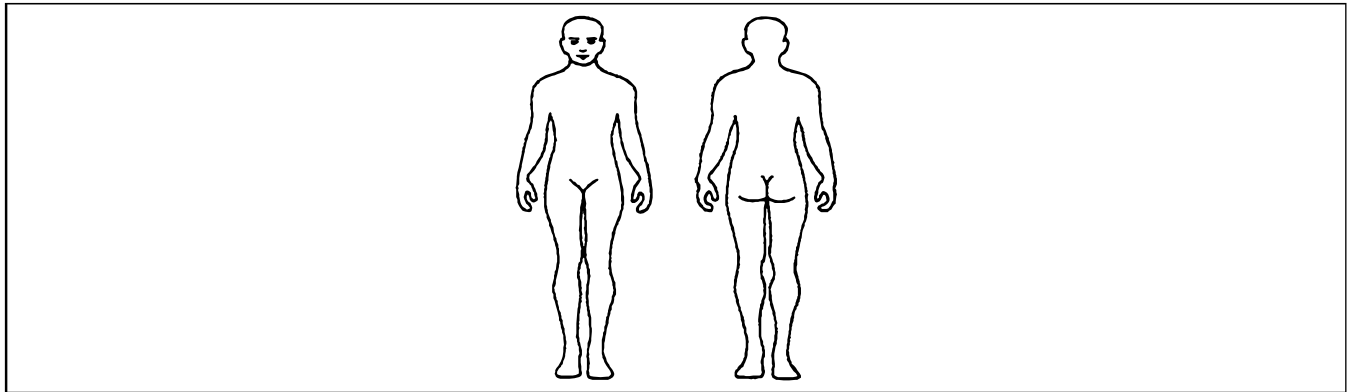
- Sharp Dull Throbbing Numbness Aching Shooting Burning
- Tingling Cramps Stiffness Swelling Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box.



Other comments you think are important _____

Medical History

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

Doctor of Chiropractic Name: _____ City: _____
Treatment Focus: _____

M.D. / D.O. Name: _____ City: _____
Treatment Focus: _____

Physical Therapist Name: _____ City: _____
Treatment Focus: _____

Acupuncture Name: _____ City: _____
Treatment Focus: _____

Other: _____
Name: _____ City: _____
Treatment Focus: _____

Medical History continued

Hospitalizations None

Date _____ - Reason _____

_____ - _____

Allergies

Medication/Supplement/Food

Reaction

Diseases/Diagnosis/Conditions: Check appropriate box and provide Month/Year of onset Past Condition Ongoing Condition

Gastrointestinal

- Irritable Bowel Syndrome ___/___
- Inflammatory Bowel Disease ___/___
- Crohn's ___/___
- Ulcerative Colitis ___/___
- Gastritis or Peptic Ulcer Disease ___/___
- GERD (reflux) ___/___
- Celiac Disease ___/___
- Hemorrhoids ___/___
- Other ___/___ _____

- Endocrine Problems ___/___
- Polycystic Ovarian Syndrome (PCOS) ___/___
- Infertility ___/___
- Weight Gain ___/___
- Weight Loss ___/___
- Frequent Weight Fluctuations ___/___
- Bulimia ___/___
- Anorexia ___/___
- Binge Eating Disorder ___/___
- Night Eating Syndrome ___/___
- Eating Disorder (non-specific) ___/___
- Other ___/___ _____

Cardiovascular

- Heart Attack ___/___
- Other Heart Disease ___/___
- Stroke ___/___
- Elevated Cholesterol ___/___
- Arrhythmia (irregular heart rate) ___/___
- Hypertension (high blood pressure) ___/___
- Rheumatic Fever ___/___
- Mitral Valve Fever ___/___
- Other ___/___ _____

Musculoskeletal/Pain

- Osteoarthritis ___/___
- Fibromyalgia ___/___
- Chronic Pain ___/___
- Tendonitis ___/___
- Tension Headaches ___/___
- TMJ Problems ___/___
- Foot Cramps ___/___
- Joint Deformity ___/___
- Joint Pain ___/___
- Other ___/___ _____

Cancer

- Lung Cancer ___/___
- Breast Cancer ___/___
- Colon Cancer ___/___
- Ovarian Cancer ___/___
- Prostate Cancer ___/___
- Skin Cancer ___/___
- Other ___/___ _____

Genital & Urinary Systems

- Kidney Stones ___/___
- Gout ___/___
- Interstitial Cystitis ___/___
- Frequent Urinary Tract Infections ___/___
- Frequent Yeast Infections ___/___
- Erectile or Sexual Dysfunctions ___/___
- Other ___/___ _____

Metabolic/Endocrine

- Type 1 Diabetes ___/___
- Type 2 Diabetes ___/___
- Hypoglycemia ___/___
- Metabolic Syndrome (Insulin Resistance/ Pre-Diabetes) ___/___
- Hypothyroidism (low thyroid) ___/___
- Hyperthyroidism (overactive thyroid) ___/___

Diseases/Diagnosis/Conditions: *continued*

Inflammatory/Autoimmune

- Chronic Fatigue Syndrome ___/___
- Autoimmune Disease ___/___
- Rheumatoid Arthritis ___/___
- Lupus SLE ___/___
- Immune Deficiency Disease ___/___
- Herpes-Genital ___/___
- Cold Sores ___/___
- Severe Infectious Disease ___/___
- Poor Immune Function (frequent infections) ___/___
- Food Allergies ___/___
- Environmental Allergies ___/___

- Multiple Chemical Sensitivities ___/___
- Latex Allergy ___/___
- Other ___/___ _____

Respiratory Diseases

- Asthma ___/___
- Chronic Sinusitis ___/___
- Bronchitis ___/___
- Emphysema ___/___
- Pneumonia ___/___
- Tuberculosis ___/___
- Sleep Apnea ___/___
- Other ___/___ _____

Head, Eyes, & Ears

- Conjunctivitis ___/___
- Distorted Sense of Smell ___/___
- Distorted Taste ___/___
- Ear Fullness ___/___
- Ear Pain ___/___
- Hearing Loss ___/___
- Hearing Problems ___/___
- Headache ___/___
- Migraine ___/___
- Sensitivity to Loud Noises ___/___
- Vision Problems (other than glasses) ___/___
- Macular Degeneration ___/___
- Vitreous Detachment ___/___
- Retinal Detachment ___/___
- Other ___/___ _____

Nails

- Bitten ___/___
- Brittle ___/___
- Curve Up ___/___
- Frayed ___/___
- Fungus-Fingers ___/___
- Fungus-Toes ___/___
- Pitting ___/___
- Ragged Cuticles ___/___
- Ridges ___/___
- Soft ___/___
- Thickening of Finger Nails ___/___
- Thickening of Toenails ___/___
- White Spots/Lines ___/___
- Other ___/___ _____

Skin Diseases

- Acne on Back ___/___
- Acne on Chest ___/___
- Acne on Face ___/___
- Acne on Shoulders ___/___
- Athlete's Foot ___/___
- Bumps on Back of Upper Arms ___/___
- Cellulite ___/___
- Dark Circles Under Eyes ___/___
- Ears Get Red ___/___
- Easy Bruising ___/___

- Lack of Sweating ___/___
- Hives ___/___
- Jock Itch ___/___
- Lackluster Skin ___/___
- Moles w/ Color/Size Change ___/___
- Oily Skin ___/___
- Pale Skin ___/___
- Patchy Dullness ___/___
- Rash ___/___
- Red Face ___/___
- Sensitive to Bites ___/___
- Sensitive to Poison Ivy/Oak ___/___
- Shingles ___/___
- Skin Darkening ___/___
- Strong Body Odor ___/___
- Hair Loss ___/___
- Vitiligo ___/___
- Eczema ___/___
- Psoriasis ___/___
- Melanoma ___/___
- Skin Cancer ___/___
- Other ___/___ _____

Neurologic/Mood

- Depression ___/___
- Anxiety ___/___
- Bipolar Disorder ___/___
- Schizophrenia ___/___
- Headaches ___/___
- Migraines ___/___
- ADD/ADHD ___/___
- Autism ___/___
- Mild Cognitive Impairment ___/___
- Memory Problems ___/___
- Parkinson's Disease ___/___
- Multiple Sclerosis ___/___
- ALS ___/___
- Seizures ___/___
- Other Neurological Problems _____

Blood Type

- A B AB O Rh+ unknown

Injuries

Check box if yes and provide date/description

- Back Injury ___/___ _____
- Head Injury ___/___ _____
- Neck Injury ___/___ _____
- Broken Bones ___/___ _____
- Other ___/___ _____

Diseases/Diagnosis/Conditions: continued

Female Reproductive

- Breast Cysts ___/___
- Breast Lumps ___/___
- Breast Tenderness ___/___
- Ovarian Cysts ___/___
- Poor Libido ___/___
- Vaginal Discharge ___/___
- Vaginal Odor ___/___
- Vaginal Itch ___/___
- Vaginal Pain with Sex ___/___

Other ___/___ _____

Surgeries

Check box if yes and provide date of surgery

- Appendectomy ___/___
- Hysterectomy +/- Ovaries ___/___
- Gall Bladder ___/___
- Hernia ___/___
- Tonsillectomy ___/___
- Dental Surgery ___/___
- Joint Replacement: Knee/Hip ___/___
- Heart Surgery: Bypass Valve ___/___
- Angioplasty or Stent ___/___
- Pacemaker ___/___
- Other ___/___ _____
- None

Male Reproductive

- Discharge from penis ___/___
- Ejaculation Problem ___/___
- Genital Pain ___/___

- Impotence ___/___
- Prostate or Urinary Infection ___/___
- Lumps in Testicles ___/___
- Poor Libido (Sex Drive) ___/___
- Other ___/___ _____

Preventive Tests

Check box if yes and provide date of most recent test

- Blood Tests ___/___
- Full Physical Exam ___/___
- X-Ray ___/___ Body Part? _____
- Dental X-Ray ___/___
- Bone Density ___/___
- Colonoscopy ___/___
- Cardiac Stress Test ___/___
- EKG ___/___
- Hemocult Test (stool test for blood) ___/___
- MRI ___/___
- CT Scan ___/___
- Upper Endoscopy ___/___
- Upper GI Series ___/___
- Ultrasound ___/___
- Other ___/___ _____

Gynecologic History (for women only)

Obstetric History Check box if yes and provide relevant quantity

- Pregnancy ___ Vaginal Delivery ___ Caesarean Delivery ___ Miscarriage ___ Abortion ___
- Living Children ___ Post Partum Depression ___ Toxemia ___ Gestational Diabetes ___
- Baby over 8 lbs. ___ Premature ___
- Breast Feeding ___ How long? _____ Oral Contraceptives ___ How long? _____

Menstrual History

Age at first period: ___ Menses Frequency: ___ Length: ___ Pain: Yes No
 Clotting: Yes No Has you period ever skipped? Yes No How long? ___
 Last Menstrual Period: _____

Do you use contraception? Yes No If yes: Condom Diaphragm IUD Partner Vasectomy

Women's Disorder/Hormonal Imbalances

- Fibrocystic Breasts Endometriosis Fibroids Infertility
- Painful Periods Heavy Periods PMS
- Last Mammogram: Breast Biopsy ___/___/___ Thermogram ___/___/___
- Last PAP Test: Normal Abnormal
- Date of Last Bone Density: ___/___/___ Results: High Low Within Normal Range
- Are you in menopause? Yes No Age of onset of menopause: _____

Check box if you are experiencing

- Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness
- Decreased Libido Heavy Bleeding Joint Pains Headaches Weight Gain
- Loss of Control of Urine Palpitations
- Use of hormone replacement therapy How Long? _____ What hormones and dosage? _____

Men's History (for men only)

Have you had a PSA done? Yes No Date of last test? ___/___/___
 Highest PSA Level: 0-2 2-4 4-10 >10

Check box if you are experiencing

- Prostate Enlargement Prostate Infection Change in Libido Impotence
- Difficulty Obtaining an Erection Difficulty Maintaining an Erection Prostate Cancer
- Nocturia (*urination at night*) How many times a night? _____
- Urgency/Hesitancy/Change in Urinary Stream Loss of Control of Urine

Medications

Current Medications (*Both prescription and over-the-counter*)

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Previous Medications: Last 10 Years

Medication	Dose	Frequency	Start Date (month/year)	End Date (month/year)	Reason For Use

Nutritional Supplements: (Vitamins, Minerals, Herbs, & Homeopathy) *If more space is needed, please write on separate sheet.*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? Yes No

Describe: _____

Have you had prolonged (3 days or longer) or regular use of NSAIDS (*i.e. Advil, Aleve, Motrin, Aspirin, etc.*)? Yes No

Have you had prolonged or regular use of Tylenol? Yes No

For what reason, and for how long, did you use pain relievers? _____

How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____

Have you had prolonged or regular use of Acid Blocking Drugs (*i.e. Tagamet, Zantac, Prilosec, etc.*)? Yes No

Have you taken antibiotics **more than 1 x** per year? Yes No

Have you had long-term use of antibiotics? (*More than 10 days.*) Yes No

How many times have you taken antibiotics throughout your lifetime? _____

Have you ever used steroids (*i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.*)? Yes No

GI History

Foreign travel? Yes No *Where?* _____

Wilderness Camping Yes No *Where?* _____

Have you had severe: Gastroenteritis Diarrhea

Do you feel like you digest your food well? Yes No

Do you feel bloated after meals? Yes No

Patient Birth History

Term Premature *Pregnancy Complications:* _____

Birth Complications: _____

Breast Fed *How long?* _____ Bottle-fed

Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____

Did you eat candy or sugar as a child? Yes No

Dental History

Dental Surgery? _____

Silver Mercury Fillings *How many?* _____ Gold Fillings Root Canals Implants Tooth Pain

Bleeding Gums Gingivitis Problems with Chewing

Do you floss regularly? Yes No Do you brush regularly? Yes No

What toothpaste do you use? _____ Have you had Fluoride treatments? Yes No

Diet

Do you have known adverse food reactions, allergies, or sensitivities? Yes No *If yes, describe symptoms and list all foods:* _____

Do you have an adverse reaction to caffeine? Yes No

When you drink caffeine do you feel: Irritable or Wired Aches & Pains Headaches

Do you adversely react to: *Check all that apply*

Monosodium Glutamate (MSG) Aspartame (NutraSweet) Preservatives (ex. sodium benzoate)

Cheese Citrus foods Chocolate Alcohol Red Wine Caffeine Bananas Garlic Onion

Sulfite containing foods (wine, dried fruit, salad bars) Other: _____

Environmental & Detoxification Assessment Which of these significantly affect you? *Check all that apply*

Cigarette Smoke Perfumes/Colognes Auto Exhaust Fumes Other: _____

In your home or work environment, are you exposed to: Chemicals Electromagnetic Radiation Mold

How often do you use your cell phone? _____ hrs/day How often do you use your computer? _____ hrs/day _____ hrs/wk

Have you ever turned yellow (*jaundiced*)? Yes No

Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes No

If yes, explain _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

Herbicides Insecticides (*frequent visits of exterminator*) Pesticides Organic Solvents

Heavy Metals Other _____

Chemical Name/Date/Length of Exposure (if known) _____

Do you dry clean your clothes frequently? Yes No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? Yes No

Do you have any pets or farm animals? Yes No

What detergents/soaps do you use (*Brand names*)? _____

What deodorant? _____

What beauty products do you use (*Lotions, Hair products, Make-up, etc.*)? _____

Family History

<i>Check family members that apply</i>	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis <i>(Rheumatoid, Psoriatic, Ankylosing Spondylitis)</i>												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases <i>(such as Lupus)</i>												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities, or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse <i>(such as Alcoholism)</i>												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar / Mood Disorder												
Other:												

Social History

Weight Stats

Height _____ft. _____in. Current Weight _____ Usual Weight Range (+/- 5lbs) _____
 Desired Weight Range (+/- 5lbs) _____ Highest Adult Weight _____ Lowest Adult Weight _____
 Have you experienced weight fluctuations greater than 10lbs? Yes No Body fat % _____
 Is your weight, in the recent past, increasing, decreasing, or staying the same? *If changing describe* _____

Nutrition History

Have you ever had a nutrition consultant? Yes No
 Have you made any changes in your eating habits because of your health? Yes No *Describe* _____

Do you currently follow a special diet or nutritional program? Yes No *Check all that apply*
 Low Fat Low Carbohydrate High Protein Low Sodium Diabetic No Dairy No Wheat
 Gluten Restricted Vegetarian Vegan Ultrametabolism Macrobiotic Paleo
 Specific Program for Weight Loss/Maintenance Type: _____ Other _____
 How often do you weigh yourself? Daily Weekly Monthly Rarely Never
 Have you ever had your metabolism (*resting metabolic rate*) checked? Yes No *If Yes, what was it?* _____
 Do you avoid any particular foods? Yes No *If yes, types & reason* _____

If you could only eat a few foods a week, what would they be? _____

Do you grocery shop? Yes No *If no, who does the shopping?* _____

Do you eat organic foods? Yes No

What percentage of your food is organic (pesticide free, non-GMO, etc.)? _____

How many meals do you eat out per week? 0 – 1 1 – 3 3 – 5 >5 meals per week

Check all factors that apply to your current lifestyle and eating habits

- | | |
|---|---|
| <input type="checkbox"/> Fast Eater | <input type="checkbox"/> Significant other or family members have special dietary needs or food preferences |
| <input type="checkbox"/> Erratic eating pattern | <input type="checkbox"/> Love to eat |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Late night eating | <input type="checkbox"/> Have a negative relationship to food |
| <input type="checkbox"/> Dislike healthy food | <input type="checkbox"/> Struggle with eating issues |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Emotional eater (<i>eat when sad, lonely, depressed, bored</i>) |
| <input type="checkbox"/> Eat more than 50% meals away from home | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Travel frequency | <input type="checkbox"/> Eat too little under stress |
| <input type="checkbox"/> Non-availability of healthy foods | <input type="checkbox"/> Don't care to cook |
| <input type="checkbox"/> Do not plan meals or menus | <input type="checkbox"/> Eating in the middle of the night |
| <input type="checkbox"/> Reliance on convenience | <input type="checkbox"/> Confused about nutrition advice |
| <input type="checkbox"/> Poor snack choices | |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | |

The most important thing I should change about my diet to improve my health is: _____

What foods would be the hardest to reduce or eliminate? _____

Smoking

Currently smoking? Yes No *How many years?* _____ *Packs per day:* _____ *Attempts to quit:* _____

Previous smoking? *How many years?* _____ *Packs per day:* _____ *Date quit:* _____

Secondhand smoke exposure? _____ *From where?* _____

Social History *continued*

Alcohol Intake

How many drinks currently per week? *1 Drink = 5 oz. wine, 12 oz. beer, or 1 oz. spirit*

None 1 -3 4 – 6 7 – 10 > 10 If 'None' – Skip to 'Other Substances'

Most common beverage? _____

Have you ever been told you should cut down your alcohol intake? Yes No

Do you get annoyed when people ask you about your drinking? Yes No

Do you ever feel guilty about your alcohol consumption? Yes No

Do you ever take an eye-opener? Yes No

Do you notice a tolerance to alcohol? *(Can you 'hold' more than others?)* Yes No

Have you ever been unable to remember what you did during a drinking episode? Yes No

Do you get into arguments or physical fights when you have been drinking? Yes No

Have you ever been arrested or hospitalized because of drinking? Yes No

Have you ever thought about getting help to control or stop your drinking? Yes No

Other Substances

Caffeine intake: Yes No Cups/day: Coffee Tea - 1 2 – 4 > 4 a day

Caffeinated sodas or diet sodas intake: Yes No

12 oz. soda per day: 1 2 – 4 > 4 a day Favorite soda: _____

Are you currently using any recreational drugs? Yes No *Type* _____

Have you ever used IV or inhaled recreational drugs? Yes No

Exercise

Current exercise program

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other <i>(Yoga, Pilates, Gyrotonics, etc.)</i>			
Sports or Leisure Activities <i>(Golf, Tennis, Rollerblading, etc.)</i>			

Rate your level of motivation for including exercise in your life? Low Medium High

List your problems that limit activity: _____

Do you feel unusually fatigued after exercise? Yes No *If yes, please describe:* _____

Do you usually sweat when exercising? Yes No

Psychosocial

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No Do you feel your life has meaning and purpose? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No Have you ever experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? Yes No
 Would you describe your experience as a child in your family as happy and secure? Yes No

Social History *continued*

Stress / Coping

Have you ever sought counseling? Yes No Describe _____

Are you currently in therapy? Yes No Describe _____

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

How do you deal with stress? _____

Daily Stressors: Rate on a scale of 1 – 10 Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you practice meditation or relaxation technique? Yes No How often? _____

Check all that apply Yoga Meditation Imagery Breathing Tai Chi Prayer

Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

If yes, please explain _____

Do you regularly give gratitude for everything in your life? Yes No

How would you describe your overall attitude towards life? _____

Do you have a spiritual practice? Yes No Describe _____

Sleep / Rest

Average number of hours you sleep per night: > 10 8 -10 6 – 8 < 6

What time do you typically go to sleep? _____:_____ ^{AM}/_{PM} Do you have trouble going to sleep? Yes No

Do you feel rested upon awakening? Yes No Do you have problems with insomnia? Yes No

Do you snore? Yes No Do you use sleeping aids? Yes No Explain: _____

Roles / Relationship

Marital status Single Married Divorced Gay/Lesbian Long Term Partnership Widow

List Children:

Child's Name	Age	Gender

Who is living in your Household? Number _____ Names _____

Their Employment/Occupation: _____

Resources for emotional support? Check all that apply

Spouse Family Friends Religious/Spiritual Pets Other: _____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At School				
In your job				
In your social life				
With close friends				

With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

Readiness Assessment

In order to improve your health, how willing are you to: *Rate on a scale of: 5 (very willing) to 1 (not willing)*

- Significantly improve your diet _____ 5 4 3 2 1
- Take several nutritional supplements each day _____ 5 4 3 2 1
- Start preparing your own meals _____ 5 4 3 2 1
- Modify your lifestyle _____ 5 4 3 2 1
- Practice a relaxation technique _____ 5 4 3 2 1
- Engage in regular exercise _____ 5 4 3 2 1
- Have periodic lab tests to assess your progress _____ 5 4 3 2 1
- Get regular bodywork such as chiropractic or massage _____ 5 4 3 2 1
- Setting regular appointments _____ 5 4 3 2 1
- Read books or articles to learn about your health and solutions _____ 5 4 3 2 1
- Be fully responsible for your own healing _____ 5 4 3 2 1

Comments: _____

How confident are you of your ability to organize and follow through on the above health related activities?
Rate on a scale of: 5 (very confident) to 1 (not confident at all) 5 4 3 2 1 If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? *Rate on a scale of: 5 (very supportive) to 1 (very unsupportive) 5 4 3 2 1* Comments: _____

How much ongoing support and contact (*office visits*) from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact) 5 4 3 2 1*
 Please list how often you would be willing to make appointments if needed _____
 Comments: _____

4-Day Diet Diary Instructions

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 4 consecutive days including one weekend day. You will find a convenient 4-day diary at the end of this packet. Please feel free to carry it with you as it is often easier to write down what you consume shortly after you consume it, rather than wait until the end of the day.

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- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk – what kind? (whole, 2%, or nonfat); toast – (whole wheat, white, buttered); chicken - (fried, baked, or breaded); coffee – (decaffeinated w/ sugar & ½ ‘n’ ½)
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, **including water**, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits in this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

MSQ – Medical Symptom / Toxicity Questionnaire

Name: _____ Date: _____

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The toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE:

0 = Never or almost never have the symptom
 1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is significant
 3 = Frequently have it, effect is not severe
 4 = Frequently have it, effect is very significant

Digestive Tract

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching or passing gas
- Heartburn
- Intestinal/stomach pain

Total _____

Ears

- Itchy ears total
- Earaches, ear infection
- Drainage from ear
- Ringing in ears, hearing loss

Total _____

Emotions

- Mood swings
- Anxiety, irritability, or aggressiveness
- Depression

Total _____

Energy/Activity

- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

Total _____

Eyes

- Watery or itchy eyes
- Swollen, reddened or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision (*does not include near-or-far-sightedness*)

Total _____

Head

- Headaches
- Faintness
- Dizziness
- Insomnia

Total _____

Heart

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

Total _____

Joints/Muscles

- Pain or aches in joints
- Arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

Total _____

Lungs

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing

Total _____

Mind

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty in making decisions
- Stuttering or stammering
- Stuttered speech
- Slurred speech
- Learning disabilities

Total _____

Mouth/Throat

- Chronic coughing
- Gagging, frequent throat clearing
- Sore throat, hoarseness, loss of voice
- Swollen/discolored tongue, gum, lips
- Canker sores

Total _____

Nose

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

Total _____

Skin

- Acne
- Hives
- Hair loss
- Flushing or hot flashes
- Excessive sweating

Total _____

Weight

- Binge eating
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

Total _____

Other

- Frequent illness
- Frequent or urgent urination
- Genital itch or discharge

Total _____

Grand Total _____

Diet Diary: Name _____ Date _____

Day 1

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) _____
 Stress/Mood/Emotions _____
 Other Comments _____

Day 2

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) _____
 Stress/Mood/Emotions _____
 Other Comments _____

Day 3

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

Day 4

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

**CONSENT AGREEMENT AND WAIVER OF LIABILITY FOR LABORATORY ASSESSMENT
FUNCTIONAL MEDICINE AND NUTRITIONAL THERAPY****PLEASE READ THOROUGHLY!**

Dr. Faro and Alternative Care Wellness Center (ACWC) offer laboratory testing for the purpose of assessing the complete metabolic and biochemical terrain of the patient. He also offers nutritional support as part of his individualized treatment plans.

This office does not treat symptoms or diagnose diseases. Our focus is to uncover the underlying causes of imbalance. Since a nutritional deficiency may be associated with a specific disease, or it may be the cause of the disease, or it may occur as a result of that disease, it is important for you to understand fully that Dr. Faro uses laboratory analysis and other exam findings to uncover deficiencies and their causes, and not for the diagnosis of a medical condition or illness. Dr. Faro prescribes vitamins, minerals, and therapeutic agents for the sole purpose to aid and support the body to restore proper function and optimal wellness. Instead of focusing on disease and illness, Dr. Faro uses many modalities to support the body nutritionally, energetically and spiritually, in addition to educating the patient on how to be responsible caregivers to their own bodies. A fully functioning body will by nature, be less likely to manifest disease or illness. This office also uses laboratory assessment and nutritional therapy for the prevention of illness. Functional laboratory evaluations and scientific nutritional therapy are powerful tools for healing imbalances, as well as for prevention of illness. One must be proactive in their health in order to preserve that health and avoid illness.

The laboratory tests and subsequent nutrient recommendations are not meant to diagnose, treat or cure any specific disease. The nutritional recommendations we make based on laboratory tests, physical and clinical findings, history and symptoms, do not constitute treatment for any specific disease.

In the nutritional management of a case, we routinely prescribe numerous vitamins, minerals, enzymes, homeopathics, nutraceuticals, and other nutritional substances. We do not want you to have any misconceptions about their use in this clinic. In the event that any vitamin, mineral, food or other nutritional substance mentioned above is prescribed or administered in your case, we want you to understand explicitly that its purpose will be for:

- 1) Improvement of your overall nutritional status
- 2) Improvement of your metabolism; including absorption, proper utilization and detoxification
- 3) Improvement of the sense of well-being
- 4) Possible remission or reduction of pain where present.

You must understand that you may not receive any of these benefits, because they do not occur predictably with every patient, and in some cases, they may not occur at all. Also, it is up to you to follow the dietary and/or lifestyle instructions given to you, as this allows the supplements to be utilized properly and be supportive for your healing. Nutritional supplements are an important part of the healing process in that they provide missing or lacking nutrients and can affect metabolic changes in

the body which need support. However, it is vital to understand that nutritional supplements do not "fix" problems or treat symptoms. They are part of a holistic treatment plan which is offered here which includes diet and lifestyle modifications.

Dr. Faro may choose to use multiple routes of administration of nutritional products, including oral or suppository. Dr. Faro has obtained training in the use of oral nutrients. Dr. Faro uses only the highest quality nutritional products available. Most of what he prescribes is only available through licensed qualified healthcare practitioners. They are of higher quality, and in many cases, of greater potency than what is available in supermarkets or health food stores. He has researched every nutritional supplement that he offers so that the patients under his care will receive only the highest quality, scientifically formulated, and clinically proven products. Supplements bought elsewhere are often not put through strict manufacturing processes and may not even contain labeled ingredients. All supplements offered through Dr. Faro are meticulously manufactured by FDA approved, state of the art facilities with advanced raw material testing, production processes, and are verified by third parties as to the purity and potency of each product. Buying a cheaper supplement may only delay the healing process and in some instances may be toxic to your body and exacerbate a condition.

Dr. Faro has also received training in the administration of nutraceuticals and continues to stay current on the latest research and clinical effectiveness using natural therapeutics. It is important that you follow his instructions to the best of your ability. This office will not be responsible for any adverse reactions or absence of effectivity. In order to improve your health outcome, please implement all suggestions given (including dietary and lifestyle changes). The individualized treatment plan given to you is dependent on all facets working synergistically together. To give a simple analogy, how well does a car move with only two or three wheels? **Healing is a partnership and you must be willing to do your part.**

There are always **risks and benefits** associated with any therapy. Supplements are prescribed in your case because there has been a clinical need or indication established. They may also be recommended as purely preventive or supportive in nature. However, everybody reacts differently to something new. And often when the body is undergoing a shift, it may feel uncomfortable for a period of time. Please advise Dr. Faro if any reactions appear, as they may be part of the healing process or signify that a change in dosage or product is needed. Possible unintended reactions include stomach pain/cramps, rashes, headaches, fatigue, allergy, joint pain, vomiting, sweating, increase in body odor, etc. If any severe allergic reaction is noted, please discontinue use and call Dr. Faro immediately. **863-676-2225** or cell **863-605-0177**.

It is also important that you return to our office for scheduled appointments to review the results and interpretation of your test(s). Our office policy (not state law) requires that you see or discuss your results with Dr. Faro **before** we can release the results of the test to you or to anyone else. These tests allow you and Dr. Faro to better understand your unique physiology and design an effective and thorough health care plan. Follow up tests are often required as well, in order to ensure that the underlying imbalances are improving with treatment. It is also highly encouraged to acquire annual preventive laboratory exams so that the baseline tests can be compared and trends observed over time. Knowing your individual, biochemical uniqueness is of great advantage when interpreting laboratory tests. Allowing the same doctor to run your annual labs and physical exam can cut down on unnecessary tests and procedures.

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Payment, Insurance, Refunds: Payment is due at time of service, no exceptions. Payment for service is not conditional on response to care. ACWC only bills insurance for chiropractic services, Laboratory exams are not chiropractic services and therefore we do not bill insurance for labs, nor are we contracted with any insurance company for Laboratory testing. You may choose to bill your insurance yourself. If you choose all reimbursements are between you and your insurance company. No refunds are given for any reason for services rendered.

Return Policy: Once a supplement is purchased, it cannot be returned for any reason, even if the bottle/package is unopened. Once the supplement leaves this office, we can no longer guarantee the potency, purity or condition of the product, how it was handled, stored, etc. (Please keep all supplements in a cool, dry place or refrigerated if indicated).

By signing below I am attesting that I HAVE READ AND UNDERSTAND THE ABOVE, and have had all my questions answered satisfactorily. I hereby place myself under Dr. Faro’s care for such advice, prescription, treatment and administration as may appear to be indicated in his professional judgment. I understand there is no guarantee of results of care. I agree to hold Dr. Faro and Alternative Care Wellness Center free of any and all liability for any adverse reactions that may result from testing procedures (blood draw) and/or administration of nutraceuticals or other treatments.

DO NOT SIGN unless you have read and fully understand this document.

Patient (print): _____ Date: _____

Signature: _____

I consent to DNA Testing for medical/conditions; YES/N

DNA Signature: _____

Witness: _____