WELLNESS
Functional Medicine
at Bleu Rx Solutions

Kelli Brumfield, CNP-BC

Fee Schedule

New Patient Consultation (90 mins) - $250

Office Visit (60 mins) - $175

Office Visit (45 mins) - $140

Office Visit (30 mins) - $125

TeleMed Visit (15 mins) - $55

Visits in excess of appointment times are billed at the applicable provider in 15-minute intervals.

The Fee schedule is subject to change.

We accept cash, cards, credit cards, Care Credit and Health Savings Cards.

Kelly Brumfield, FNP-BC

Bleu Rx Solutions

44608 J Meadie Knight Dr

Franklinton, La 70438

Phone: 985-289-2100

Fax: 985-289-2121

Functional Medicine Adult New Patient Intake Forms

These forms & your medical records must be submitted to our office at least 5 days prior to your first appointment

Did you remember to?

- Read all the practice documents
- Obtain your medical records and/or results from previously seem physicians and have them sent at least 7 days prior to your appointment to:

Bleu Rx Solutions
44608 J Meadie Knight Dr, Franklinton La 70438
Fax #: 985-289-2121

Fill out and/or sign the following forms

- Important Patient Information
- Informed consent regarding email or the internet use of protected personal information
- Notice of Medicare Denial
- General Information
- Medical Questionnaire
- 3-Day Diet Diary
- MSQ- Medical Symptom/Toxicity Questionnaire

Thank you,
We are looking forward to working with you.

Please keep pages 1-7 for your records

Dear Patient,

WELCOME! We look forward to meeting you and working with you.

WHAT TO EXPECT DURING YOUR CONSULTATION AT BLEU RX SOLUTIONS

1. You arrive to the office for initial wellness labs
   a. Update personal forms and sign consent forms if not already done previously
   b. Please come fasting (6 hrs.), we will draw blood at your visit. Bring a snack if you like. If you take thyroid medication, please DO NOT take it the morning of your appointment.
   c. Pay for labs, supplements. You will be notified once your labs are finalized to schedule for your initial consults.
2. Functional Medicine Initial Consultation
   a. Vitals are taken, picture is taken, HIPPA forms and policies are signed.
   b. Consult with Mrs. Kelli Brumfield, FNP (90 mins)
   c. Pay for labs, consult, supplements
3. Functional Medicine Initial Follow Up Consults:
   a. Consult with Kelli Brumfield to review labs and progress (60 min)
4. Wrap up and Check Out
   a. Pay for consult, labs
   b. Schedule follow-up appointments
   c. Obtain an invoice to send to your insurance company reimbursement if wanted

Practice Policies for Patients

Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve your goals at Bleu Rx Solutions.

It is important to read all of the enclosed information carefully and return it to our office at least 5 business days prior to your appointment. You can return it to our office by mail, email (info@bleurxsolutions.com) or fax (985-289-2121). Our system is not interactive, so you will need to print out the documents and then rescan them if you choose to email them to us.

Having these forms 5 days in advance will allow Mrs. Kelli Brumfield to review your chart and help solve your problems more efficiently and enhance the quality of care you receive. If your INTAKE FORM and Medical Records have not been received at least 5 days prior to your initial appointment, it may take Kelli Brumfield up to 30 minutes of your appointment time to review your chart.

Website:

Information about Wellness at Bleu Rx Solutions and all relevant patient forms are available through the website: www.bleurxsolutions.com and may be found on the new patient page.

Medical Records from other doctors/clinics/hospitals

Medical records can only be released with your authorization. It is your responsibility to obtain previous medical records from other physicians, or health care providers that you wish Mrs. Kelli Brumfield to review. Please contact your physician or other health care provider to obtain these records and make sure that we have received them at least 5 days prior to your initial appointment.

Copies of Medical Records & Labs from our office

You will be given a copy of your labs at each visit to keep for your records. Should you need additional copies of your medical records, a $25 fee will be charged for copies and postage.

Functional Medicine Consultation Fees

Initial Consultation is $250. This includes your visit with Kelli Brumfield, FNP.

Initial Follow-up is $175. This includes your visit with Kelli Brumfield, FNP.

All other appointments or consultations are based on time; see fee schedule.

Lab Tests

We have a phlebotomist at our office to draw your blood for your initial wellness panel. Please arrive fasting for your bloodwork. The initial wellness panel is $120 and is required prior to your initial consultation. Any further lab work needed can be scheduled/purchased after your initial consultation. Some labs that involve stool, urine, or saliva samples are done by you in your

home. You will be given all lab kits and step by step instructions for at home tests. Once all of the final lab results are received, we will go over them at your follow up visits.

Supplements

All of the supplements that are recommended are available in our office or on our online dispensary. You are not obligated to purchase supplements from our office. Our online dispensary:

Designs for Health: http://www.designsforhealth.com/u/savannahmurray

Thorne: www.thorne.com/u/bleurxsolutions

Credit Cards

We require a credit card number at the time of scheduling your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs, and supplements unless otherwise specified by you at the time of check out.

Cancellation and Rescheduling of Appointments

There is a 48 hr. (2 business days) cancellation and rescheduling policy. Your appointment must be cancelled or rescheduled at least 48 hrs. (2 business days) prior to your consultation time, or you will be charged a cancellation fee unless we are able to fill your appointment time. The cancellation fee for a **new patient** appointment is *half the cost* of the appointment, the cancellation fee for all other appointments is $50. You may cancel your appointment by calling the office at 985-289-2100.

Late Arrival Appointments

We are committed to being on time with patients' appointments in order to prevent clients from waiting. If you arrive late to the office for your consult, your appointment will end at the scheduled time, and you will be charged for the length of the originally scheduled visit.

Follow Up Appointments

At the time of check out you will be scheduled for a follow up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 48 hrs./2 business days prior to your scheduled appointment.

Payment Options

Cash, checks or credit cards are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations,

laboratory testing and nutritional supplements will be itemized, and payment is due on the day of service.

Insurance Information

Medical insurance is not accepted, and our office cannot assist you with claim resolution. In addition, Kelli Brumfield, FNP is not a Medicare provider. You will be provided with a billing summary that you can submit to your insurance carrier. Kelli Brumfield, FNP does not submit their medical notes to insurance companies.

Office Hours

Our office hours are Monday-Friday, 8am – 5pm CST.

Phone calls and messages

- Phone messages left will be responded to within 24 hours (during business hours).
- To reach the office please call (985-289-2100)
- If you call after hours, the office staff will return your call on the next business day
- If you have a medical emergency, call 911 or go directly to the nearest ER.
- When leaving a message, please be brief and include the following information:
    - Full name, spell your last name, and date of birth
    - Reason for calling
    - Phone numbers
    - Email address (if desired)

Prescription Refill Request

For prescription refills, we ask that you contact your pharmacy and have them fax over the medical refill request. Our fax number is 985-289-2121. **It may take up to 48 hours to process a prescription refill.**

Email

If you would like to schedule an appointment, or cancel an appointment, have lab kit questions or administrative questions, please email: info@bleurxsolutions.com

If you have a medical question for Kelli Brumfield, please email her at kelli@bleurxsolutions.com

If you would like to order supplements from us, or would like us to have a supplement order ready for you to pick up at the office, please send an email to: info@bleurxsolution.com

We look forward to your journey to Wellness at Bleu Rx Solutions,

The Bleu Rx Solutions Team

Important Patient Information

Appointments:

- Initial consult is $250 and follow up consult is $175. The first appointment is 90 minutes with Kelli Brumfield, FNP.
- Each additional follow up is priced depending on time, please see fee schedule.
- There is a 48 hr. (2 day) cancellation policy (please see cancellation policy in the Practice Policies for Patients). We reserve the right to charge your credit card per our policy on all appointments that are not canceled or rescheduled within the 2-day window. By signing below, you agree to our cancellation policy and authorize Bleu Rx Solutions to charge your credit card on file for any missed visits.

Lab Tests:

All lab results will be reviewed with you at the time of your follow up appointment. We do not email lab results to patients. The exception to this is if you have a follow up appointment by phone, we will email your labs to you prior to your appointment.

Refunds/Returns

Supplements (except for probiotics and protein powders) and Functional Lab Kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase.

Billing/Insurance

- You will receive an invoice at the completion of your visit that you may submit to your insurance for reimbursement. We do not help with insurance claim resolution.
- Payment for the office visit, phone consultation, or lab tests is expected at the time services are rendered.
- Bleu Rx Solutions does not accept insurance; however, you can submit your patient statement to our insurance carrier.

_____ _____

Patient Signature Date

Bleu Rx Solutions provides patients the opportunity to communicate with them by email. Transmitting confidential health information by email, however, has a number of risks, both general and specific, that should be considered before using email.

1. Risks
    a. General email risks are the following: email can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward email to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an email; email is easier to falsify than handwritten, or signed documents; backup copies of email may exist even after the sender, or recipient has deleted his/her history.
    b. Specific email risks are the following: email containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected health information will have access to the email messages; patients who send or receive email from their place of employment risk having their employer read their email.
2. It is the policy of Bleu Rx Solutions that all email messages sent or received, which concern the diagnosis, or treatment of the patient will be a part of that patient's protected personal health information and we will treat such email messages, or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Bleu Rx Solutions will use reasonable means to protect the security and confidentiality of email, or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of email or internet communications.
3. Patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to use the email includes agreement with the following conditions:
    a. All email to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As part of the protected personal health information, other individuals, Kelli Brumfield, FNP, physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to email messages contained in protected personal health information.
    b. Bleu Rx Solutions practitioners may forward email messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the email outside the practice without the consent of the patient as required by law.
    c. We at Bleu Rx Solutions will endeavor to read emails promptly but can provide no assurance that the recipient of the particular email will read the email message promptly. Therefore, email must not be used in a medical emergency.
    d. It is the responsibility of the sender to determine whether the intended recipient received the email and when they respond.

ALL MEDICARE PATIENTS MUST SIGN THIS FORM

Notice of possible Medicare denial

Medicare will only pay for services determined to be reasonable and necessary under Section 182 (a)(1) of Medicare Law. If a particular service is considered unacceptable and unnecessary under Medicare standards, Medicare will deny payment for those excluded services.

Medicare Notice

Kelli Brumfield, FNP is not a Medicare provider; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent by the patient; payment reimbursement is not guaranteed and is subject to Medicare eligibility/reimbursement rules and regulations.

Patient Acknowledgement

My physician, and/or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons stated above.

Patient Signature_____

Print name_____

Date_____

INFORMED CONSENT REGARDING EMAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

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GENERAL INFORMATION

Name: _____

Preferred Name: _____

Date of Birth: _____ Age: _____

Gender: ____Male ____Female

Genetic Background: ____African ____European ____Native American ____Mediterranean

____Asian ____Ashkenazi ____Middle Eastern

Highest Education Level: ____High School _____Under-Graduate ____ Post-Graduate

Job Title: _____

Nature of Business: _____

Primary Address: _____

_____

Phone Number: (home) _____ **(cell)** _____ **(work)** _____

(fax) _____ **(email address)** _____

Emergency Contact Information:

Name: _____ **Phone Number:** _____

Address: _____

_____

Physician's Name: _____

Phone Number: _____ **Fax Number:** _____

Referred by: _____Google (which words) _____

_____ Media _____

_____Family Member_____

_____Friend_____

_____Other _____

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PHARMACY INFORMATION

Primary Pharmacy:

Name: _____ **Phone Number:** _____

Address: _____

_____

Email: _____ **Fax:** _____

Compounding/Supplement Pharmacy:

Name: _____ **Phone Number:** _____

Address: _____

_____

Email: _____ **Fax:** _____

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

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BLEU RX SOLUTIONS FUNCTIONAL MEDICINE QUESTIONNAIRE

ALLERGIES

Medication/Supplements/Food: _____

_____

Reaction: _____

_____

COMPLAINTS/CONCERNS What do you hope to achieve in your visit with us?

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe
Example: Post Nasal Drip		**X**	

Prior Treatment/Approach	Excellent	Good	Fair
Example: Elimination Diet	**X**		

MEDICAL HISTORY DISEASES /DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of ons

GASTROINTESTINAL

___Irritable Bowel Syndrome_____
___Inflammatory Bowel Disease _____
___Crohn's_____
___Ulcerative Colitis_____
___Gastritis or Peptic Ulcer Disease_____
___GERD (reflux) _____
___Celiac Disease _____
___Other _____

CARDIOVASCULAR

___Heart Attack_____
___Other Heart Disease_____
___Stroke_____
___Elevated Cholesterol_____
___Arrythmia(irregular heart rate_____
___Hypertension(high blood pressure)_____
___Rheumatic Fever _____
___Mitral Valve Prolapse_____
___Other_____

METABOLIC/ENDOCRINE

___Type 1 Diabetes_____
___Type 2 Diabetes_____
___Hypoglycemia_____
___Metabolic Syndrome_____
___(Insulin Resistance or Pre-Diabetes)
___Hypothyroidism(low thyroid)_____
___Hyperthyroidism(overactive thyroid)_____
___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_____

CANCER

___Lung Cancer_____
___Breast Cancer_____
___Colon Cancer_____
___Ovarian Cancer_____
___Prostate Cancer_____
___Skin Cancer_____

GENITAL AND URINARY

___Kidney Stones _____
___Gout_____
___Interstitial Cystitis_____
___Frequent Urinary Tract Infections_____
___Frequent Yeast Infections_____
___Erectile or Sexual Dysfunction_____
___Other_____

MUSCULOSKELETAL/PAIN

___Osteoarthritis_____
___Fibromyalgia_____
___Chronic Pain_____
___Other_____

DISEASES/DIAGNOSIS/CONDITIONS

RESPIRATORY DISEASES

___Asthma_____
___Chronic Sinusitis_____
___Bronchitis_____
___Emphysema_____
___Pneumonia_____
___Tuberculosis_____
___Sleep Apnea_____
___Other_____

SKIN DISEASES

___Eczema_____
___Psoriasis_____
___Acne_____
___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_____

PREVENTIVE TESTS AND DATE OF LAST TEST

___Full Physical Exam_____
___Bone Density_____
___Colonoscopy_____
___Cardiac Stress Test_____
___EBT Heart Scan_____
___EKG_____
___Hemoccult Test-stool test for blood_____
___MRI_____
___CT scan_____
___Upper Endoscopy_____
___Upper GI Series_____
___Ultrasound_____

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INJURIES

Check box if yes: ___Back Injury ___Head Injury ___Neck Injury ___Broken Bones

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_____

BLOOD TYPE ___A ___B ___AB ___O ___Rh+ ___Unknown

HOSPITALIZATIONS:

___None

Date	Reason

GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

OBSTETRIC HISTORY (*Check box if yes and provide number)*

___Pregnancies_____ ___Caesarean_____ ___Vaginal Deliveries_____
___Miscarriage_____ ___Abortion_____ ___Living Children_____
___Post Partum Depression ___Toxemia ___Gestational Diabetes Baby Over 8 Pounds
___Breast Feeding For how long? _____

MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length: _____ Pain: ___Yes ___No____
Clotting: ___Yes ___No
Has your period ever skipped? _____ For how long? _____
Last Menstrual Period: _____

Use of hormonal contraception such as: ___Birth Control Pills ___Patch ___Nuva Ring
How long? _____
Do you use contraception? ___Yes ___No
___Condom ___Diaphragm ___IUD ___Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

___Fibrocystic Breasts ___Endometriosis ___Fibroids ___Infertility
___Painful Periods ___Heavy Periods ___PMS
Last Mammogram: _____ Breast Biopsy/Date: _____
Last PAP test: _____ ___Normal ___Abnormal
Last Bone Density: _____ Results: ___High ___Low ___Within Normal Range
Are you in menopause? ___Yes ___No
Age at Menopause_____
___Hot Flashes ___Mood Swings ___Concentration/Memory Problems ___Vaginal Dryness
___Decreased Libido

WOMEN'S DISORDERS/HORMONAL IMBALANCES *(CONTINUED)*

___Heavy Bleeding ___Joint Pains ___Headaches ___Weight Gain
___Loss of Control of Urine ___Palpitations
___Use of Hormone Replacement Therapy How Long? _____

MEN'S HISTORY (FOR MEN ONLY)

Have you had a PSA done? ___Yes ___No
PSA Level: ___0-2 ___2-4 ___4-10 ___>10
___Prostate Enlargement ___Prostate Infection ___Change in Libido ___Impotence
___Difficulty Obtaining an Erection ___Difficulty Maintaining an Erection
___Nocturia (urination at night) How many times at night? _____
___Urgency/Hesitancy/Change in Urinary Stream ___Loss of Control of Urine

GI HISTORY

Foreign Travel? ___Yes ___No Where? _____
Wilderness Camping? ___Yes ___No Where? _____
Have you ever 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 a lot of candy or sugar as a child? ___Yes ___No

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DENTAL HISTORY

___Silver Mercury Fillings How many? _____
___Gold Fillings
___Root Canals How many? _____
___Implants
___Tooth Pain
___Bleeding Gums
___Gingivitis
___Problems with chewing
Do you floss regularly? ___Yes ___No

MEDICATIONS
CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE(MONTH/YEAR)	REASON FOR USE

PREVIOUS MEDICATIONS: *Last 10 years*

MEDICATION	DOSE	FREQUENCY	START DATE(MONTH/YEAR)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS(VITAMINS/MINERALS/

SUPPLEMENT AND 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 or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ___Yes ___No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? ___Yes ___No
Frequent antibiotics > 3 times/year ___Yes ___No
Long term antibiotics ___Yes ___No
Use of steroids (prednisone, nasal allergy inhalers) in the past ___Yes ___No
Use of oral contraceptives ___Yes ___No

FAMILY HISTORY

Please choose from the following family member(s) as it applies to that person:
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_____

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FAMILY HISTORY *(CONTINUED)*

Heart Disease_____

Hypertension_____

Obesity_____

Diabetes_____

Stroke_____

Inflammatory Arthritis(Rheumatoid, Psoriatic, Ankylosing Sondylitis)_____

Inflammatory Bowel Disease_____

Multiple Sclerosis_____

Thyroid Problems(Lupus)_____

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 (such as alcoholism)_____

Psychiatric Disorders_____

Depression_____

Schizophrenia_____

ADHD_____

FAMILY HISTORY *(CONTINUED)*

Autism_____

Bipolar Disease_____

Other: _____

_____

SOCIAL HISTORY/NUTRITION HISTORY

Have you ever had a nutrition consultation? ___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 Diary

___No Wheat ___Gluten Restricted ___Vegetarian ___Vegan

___Specific Program for Weight Loss/Maintenance Type: _____

___Other_____

Height(feet/inches) _____ Current Weight_____

Usual Weight Range +/- 5lbs_____ Desired Weight Range +/- 5lbs _____

Highest adult weight_____ Lowest adult weight_____

Weight Fluctuations (>10lbs.) ___Yes ___No Body Fat%_____

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

SOCIAL HISTORY/NUTRITION HISTORY (Continued)

If yes, types and 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 read food labels? ___Yes ___No

Do you cook? ___Yes ___No If no, who does the cooking? _____

How many meals do you eat out per week? ___0-1 ___1-3 ___3-5 ___>5 meals per week

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

___Fast eater

___Erratic eating pattern

___Eat too much

___Late night eating

___Dislike healthy food

___Time constraints

___Eat more than 50% meals away from home

___Travel frequently

___Non-availability of healthy foods

___Do not plan meals or menus

___Reliance on convenience items

___Poor snack choices

___Emotional eater (eats when sad, lonely, depressed, bored)

___Significant other or family members don't like healthy

___Significant other or family members have special dietary needs or food preference

___Love to eat

___Eat because I have to

___Have a negative relationship with food

___Struggle with eating issues

___Eat too much under stress

___Eat too little under stress

___Don't care to cook

___Eating in the middle of the night

___Confused about nutrition advice

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

_____

_____

_____

SMOKING

Currently Smoking? ___Yes ___No

How many years? _____ Packs per day? _____ Attempts to quit? _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits

___None ___1-3 ___4-6 ___7-10 ___>10 If "None," skip to other Substances

Previous alcohol intake? ___Yes (___Mild ___Moderate ___High) ___None

Have you ever been told you should cut down on 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

Coffee cups/day: ___1 ___2-4 ___>4 Tea cups/day: ___1 ___2-4 ___>4

Caffeinated Sodas or Diet Sodas Intake: ___Yes ___No

12-ounce can/bottle: ___1 ___2-4 ___>4 per day

List favorite type (Ex. Diet Coke, Pepsi, Etc.): _____

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: (List type of activity, number of sessions/weeks, and duration)

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, Pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life. ___Low ___Medium ___High

EXERCISE (Continued)

List 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

STRESS/COPING

Have you ever sought counseling? ___Yes ___No

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

Daily Stressors: Rate on scale of 1-10

Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you practice meditation or relaxation techniques? ___Yes ___No How Often? ____

Check all that apply: ___Meditation ___Imagery ___Breathing ___Tai Chi ___Prayer

___Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ___Yes ___No

SLEEP/REST

Average number of hours you sleep per night: ___>10 ___8-10 ___6-8 ___<6

Do you have trouble falling asleep? ___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 Household? Number _____
Names: _____
Their Employment/Occupations: _____
Resources for emotional support?
Check all that apply:
___Spouse ___Family ___Friends ___Religious/Spiritual ___Pets ___Other: _____
Are you satisfied with your sex life? ___Yes ___No

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

ENVIRONMENTAL AND DETOXIFCATION ASSESS

Do you have known adverse food reactions or sensitivities? ___Yes ___No

If yes, describe symptoms: _____

_____

Do you have any food allergies or sensitivities? ___Yes ___No

If yes, list all: _____

_____

Do you have an adverse reaction to caffeine? ___Yes ___No

When you drink caffeine do you feel: ___Irritable or wired ___Aches & Pains

Do you adversely react to (Check all that apply):

___Monosodium glutamate (MSG) ___Aspartame (NutraSweet) ___Caffeine ___Bananas ___Garlic

___Onion ___Cheese ___Citrus Foods ___Chocolate ___Alcohol ___Red Wine ___

___Sulfate Containing Foods (wine, dried fruit, salad bars) ___Preservatives (ex. Sodium benzoate)

___Other: _____

Which of these significantly affect you? Check all that apply:

___Cigarette Smoke ___Perfumes/Colognes ___Auto Exhaust Fumes ___Other

In your work or home environment, are you exposed to:

___Chemicals ___Electromagnetic Radiation ___Mold

Have you ever turned yellow(jaundiced) ___Yes ___No

Have you ever been told you have Gilbert's syndrome or a liver disorder? ___Yes ___No

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: _____

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

SYMPTOM REVIEW

Please check all current symptoms or those present in during the past 6 months.

GENERAL

__Cold Hands & Feet
__Cold Intolerance
__Low Body Temperature
__Low Blood Pressure
__Daytime Sleepiness
__Difficulty Falling Asleep
__Early Waking
__Fatigue
__Fever
__Flushing
__Heat Intolerance
__Night Waking
__Nightmares
__No Dream Recall

HEAD, EYES & EARS

__Conjunctivitis
__Distorted Sense of Smell
__Distorted Taste
__Ear Fullness
__Ear Pain
__Ear Ringing/Buzzing
__Lid Margin Redness
__Eye Crusting
__Eye Pain

MUSCULOSKELETAL

__Back Muscle Spasm
__Calf Cramps
__Chest Tightness
__Food Cramps
__Joint Deformity
__Joint Pain
__Joint Redness
__Joint Stiffness
__Muscle Pain
__Muscle Spasms
__Muscle Stiffness

Muscle Twitches

__Around Eyes
__Arms or Legs
__Muscle Weakness
__Neck Muscle Spasm
__Tendonitis
__Tension Headache
__TMJ Problems

MOOD/NERVES

__Agoraphobia
__Anxiety
__Auditory Hallucinations
__ Black-out
__Fearfulness
__Irritability
__Light-headedness
__Numbness
__Other Phobias
__Panic Attacks
__Paranoia
__Seizures
__Suicidal Thoughts
__Tingling
__Tremor/Trembling
__Visual Hallucinations

EATING

__Binge Eating
__Bulimia
__Can't Gain Weight
__Can't Lose Weight
__Can't Maintain Health Weight
__Frequent Dieting
__Poor Appetite
__Salt Cravings
__Carbohydrate Craving
(breads, pastas)
__Sweet Cravings
(candy, cookies, cakes)

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SYMPTOM REVIEW *(CONTINUED)*

__Hearing Loss
__Hearing Problems
__Headache
__Migraine
__Sensitivity to Loud Noises
__Vision Problems
(other than glasses)
__Macular Degeneration
__Vitreous Detachment
__Retinal Detachment

__Depression

Difficulty
__Concentrating
__With Balance
__With Thinking
__With Judgement
__With Speech
__With Memory
__Dizziness
__Fainting

__Chocolate Cravings
__Caffeine Dependency

DIGESTION

__Anal spasms
__Bad Teeth
__Bleeding Gums

Bloating of:
__Lower Abdomen
__Whole Abdomen
__Bloating After Meals
__Blood in Stools
__Burping
__Canker Sores
__Cold Sores
__Constipation
__Cracking at Corner of Lips
__Cramps
__Dentures w/Poor Chewing
__Diarrhea
__Alternating Diarrhea and Constipation
__Difficulty Swallowing
__Dry Mouth
__Excess Flatulence/Gas
__Fissures
__Foods "Repeat" (Reflux)
__Gas
__Heartburn
__Hemorrhoids

__Liver Disease/Jaundice (Yellow Eyes or Skin)
__Abnormal Liver Function Tests
__ Lower Abdominal Pain
__Mucus in Stools
__Periodontal Disease
__Sore Tongue
__Strong Stool Odor
__Undigested Food in Stool

SKIN PROBLEMS

__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
__Eczema
__Hives
__Jock Itch
__Lackluster Skin

__Vitiligo

ITCHING SKIN

__Skin in General
__Anus
__Arms
__Ear Canals
__Eyes
__Feet
__Hands
__Legs
__Nipples
__Nose
__Penis
__Roof of Mouth
__Scalp
__Throat

SKIN, DRYNESS OF

__Eyes
__Feet
__Cracking?
__Peeling?
__Hair __Unmanageable?
__Hands
__Cracking?

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SYMPTOM REVIEW *(CONTINUED)*

__Indigestion
__Nausea
__Upper Abdominal Pain
__Vomiting

Intolerance to:

__Lactose
__All Diary Products
__Gluten (Wheat, Rye, Barley)
__Corn
__Eggs
__Fatty Foods
__Yeast

__Moles w/Color/Size Change
__Oily Skin
__Pale Skin
__Patchy Dullness
__Rash
__Red Face
__Sensitivity to Bites
__Sensitivity to Poison Ivy/Oak
__Shingles
__Skin Darkening
__Strong Body Odor
__Hair Loss

__Peeling?
__Mouth/Throat
__Scalp
__Dandruff?
__Skin in General

SYMPTOM REVIEW(CONTINUED)

LYMPH NODES
__Enlarged/neck
__Tender/neck
__Other Enlarged/Tender
__Lymph Nodes

NAILS
__Bitten
__Brittle
__Curve Up
__Frayed
__Fungus-Fingers
__Fungus-Toes
__Pitting
__Ragged Cuticles
__Ridges
__Soft

Thickening of:

__Fingernails
__Toenails
__White Spots/Lines

RESPIRATORY
__Snoring
__Wheezing
__Winter Stuffiness

CARDIOVASCULAR
__Angina/chest pain
__Breathlessness
__Heart Murmur
__Irregular Pulse
__Palpitations
__Phlebitis
__Swollen Ankles/Feet
__Varicose Veins

URINARY
__Bed wetting
__Hesitancy
(trouble getting started)
__Infection
__Kidney Disease
__Leaking/Incontinence
__Pain/Burning
__Prostate Infection

__Poor Libido (Sex Drive)
__Vaginal Discharge
__Vaginal Odor
__Vaginal Itch
__Vaginal Pain with Sex

PREMENSTRUAL:

__Bloating Breast Tenderness
__Carbohydrate Cravings
__Chocolate Cravings
__Constipation
__Deceased Sleep
__Diarrhea
__Fatigue
__Increased Sleep
__Irritability

MENSTRUAL:

__Cramps
__Heavy Periods
__Irregular Periods
__No Periods
__Scanty Periods
__Spotting Between

__Bad Breath
__Bad Odor in Nose
__Cough-Dry
__Cough-Productive
__Hoarseness
__Sore Throat
Hay Fever:
__Spring
__Summer
__Fall
__Change of Season
__Nasal Stuffiness
__Nose Bleeds
__Postnasal Drip
__Sinus Fullness
__Sinus Infection
__Urgency

MALE REPRODUCTIVE

__Discharge from Penis
__Ejaculation Problem
__Genital Pain
__Impotence
__Prostate or Urinary Infection
__Lumps in Testicles
__Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

__Breast Cysts
__Breast Lumps
__Breast Tenderness
__Ovarian Cyst

READINESS ASSESSMENT

Rate on a scale of 5 (***very willing***) to 1 (***not willing***)
In order to improve your health, how willing are you to:
Significantly modify your diet: ___5 ___4 ___3 ___2 ___1
Take several nutritional supplements each day: ___5 ___4 ___3 ___2 ___1
Keep a record of everything you eat each day: ___5 ___4 ___3 ___2 ___1
Modify your lifestyle (e.g., work demands, sleep habits): ___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
Comment_____
_____
_____

Rate on scale of 5 (***very confident***) to 1 (***not confident at all***):
How confident are you of your ability to organize and follow through on the above health related activities? ___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? _____

_____

_____

Rate on a scale of 5 (***very supportive***) to 1 (***very unsupportive***):
At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ___5 ___4 ___3 ___2 ___1
Comments: _____

_____

_____

Rate on a scale of 5 (***very frequent contact***) to 1 (***very infrequent contact***):
How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?
___5 ___4 ___3 ___2 ___1
Comments: _____

_____

_____

MSQ – MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help 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 completing this after first time, the record your symptoms for ONLY the last 48 hours.

Point Scale

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

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.
*Optimal is less than 10 *Mild Toxicity: 50-100 *Severe Toxicity: Over 100

DIGESTIVE TRACT
___Nausea or vomiting
___Diarrhea
___Constipation

ENERGY/ACTIVITY
___Fatigue, sluggishness
___Apathy, lethargy
___Hyperactivity

HEART
___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
___Chest pain

___Bloated feeling
___Belching or passing gas
___Heartburn
___Intestinal/Stomach pain
Total _____

EARS
___Itchy ears
___Earaches, ear infections
___Drainage from ear
___Ringing in ears, hearing loss
*Total*_____

EMOTIONS
___Mood swings
___Anxiety, fear, or nervousness
___Anger, irritability, or aggressiveness
___Depression
*Total*_____

___Restlessness
*Total*_____

EYES
___Watery or itchy eyes
___Swollen, reddened or sticky eyelids
___Bags or tunnel vision (does not include near or far-sightedness)
*Total*_____

HEAD
___Headaches
___Faintness
___Dizziness
___Insomnia
*Total*_____

*Total*_____

MSQ – MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE (CONTINUED)

NAME: _____ DATE: _____

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
___Difficult breathing
*Total*_____

NOSE
___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus formation
Total _____

SKIN
___Acne
___Hives, rashes, or dry skin
___Hair loss
___Flushing or hot flashes
___Excessive sweating

MIND

___Poor memory
___Confusion, poor comprehension
___Poor concentration
___Poor physical coordination
___Difficulty in making decisions
___Stuttering or stammering
___Slurred speech
___Learning disabilities
*Total*_____

MOUTH/THROAT

___Chronic coughing
___Gagging, frequent need to clear throat
___Sore throat, hoarseness, loss of voice
___Swollen/discolored tongue, gum, lips
___Canker sores
*Total*_____

*Total*_____

WEIGHT

___Binge eating/drinking
___Craving certain food
___Excessive weight
___Compulsive eating
___Water retention
___Underweight
*Total*_____

OTHER

___Frequent illness
___Frequent or urgent urination
___Genital itch or discharge
*Total*_____

GRAND TOTAL: _____

ADDITIONAL NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. PLEASE TRACK YOUR SYMPTOMS FOR 3 DAYS AND DOCUMENT BELOW. DO NOT WAIT AND BRING THIS FORM WITH YOU TO YOUR APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

3 DAY SYMPTOM DIARY

DAY 1:

AWAKE (document when you woke up): _____

_____

MIDDLE DAY: _____

_____

EVENING: _____

_____

BEDTIME (include time): _____

_____

MIDDLE OF THE NIGHT (wake up times included): _____

_____

_____

DAY 2:

AWAKE (document when you woke up): _____

_____

MIDDLE DAY: _____

_____

EVENING: _____

_____

BEDTIME (include time): _____

_____

MIDDLE OF NIGHT (wake up times included): _____

BLEU RX SOLUTIONS

_____

DAY 3:

AWAKE (document when you woke up): _____

_____

MIDDLE DAY: _____

_____

EVENING: _____

_____

BEDTIME (include time): _____

_____

MIDDLE OF THE NIGHT (wake up times included): _____

_____

_____

ADDITIONAL NOTES: _____

_____

_____

_____

_____

_____

_____

_____