
FACSIMILE TRANSMITTAL SHEET

TO:

FROM:

Dr. Bryan P. Walsh

COMPANY:

DATE:

VIS Vitality and Wellness

FAX NUMBER:

TOTAL NO. OF PAGES, INCLUDING COVER:

734-468-8573

PHONE NUMBER:

SENDER'S REFERENCE:

443-458-8307

RE: PATIENT INTAKE FORM

Instructions

1. Fax in this entire intake form to 734-468-8573.
2. Within one business day you will receive an email with the subject line "Confidential: Your Lab Requisition" that will contain the form to bring to the nearest LabCorp drawing station. Print out the form and bring it with you when you go to get your blood drawn.
3. The results of your intake form and blood work will be reviewed during your appointment, as will your diet diary, which you can bring to your appointment.

Name: _____

Address: _____

(street)

(suite/apt)

(city)

(state)

(zip)

Phone: _____

Fax: _____

Email: _____

Date of Birth: _____

Credit Card: _____

Expiration date: _____

I am interested in the:

Elite Wellness Package \$1995

Cardiac Risk Assessment \$395

Comprehensive Hormonal Panel

Wellness Starter Package + Adrenal Stress Test \$365

Male \$411

Wellness Starter Package \$269

Female Premenopausal \$469

Female Post-Menopause \$329



Patient Introduction and Informed Consent

Naturopathic doctors obtain a doctorate in naturopathic medicine after graduating from an accredited naturopathic medical institution. Naturopathic doctors complete training in the study of biological sciences and conventional medical diagnosis and treatment. In addition, naturopathic doctors receive extensive training in clinical nutrition, homeopathy, botanical medicine, physical medicine and counseling. Naturopathic doctors concentrate on whole-patient wellness. Recommendations are specific to each patient and emphasize prevention and self-care. Naturopathic doctors focus on the underlying cause of the patient's illness rather than focusing solely on symptoms. Naturopathic therapies may require more time to be effective, yet often provide long-lasting health improvements.

A Naturopathic Doctor (ND) is trained as a primary care provider and is a board-certified physician in states where licensure is applicable. Dr. Bryan P. Walsh is a licensed naturopathic physician in the District of Columbia. Currently licensure for naturopathic doctors is not available in Maryland. Therefore, Dr. Bryan P. Walsh does not practice medicine, and does not diagnose or treat diseases or medical conditions in the state of Maryland. Dr. Bryan P. Walsh focuses his practice on the enhancement of health. Dr. Bryan P. Walsh's services are not meant to substitute or replace those of a licensed physician and clients seeking his consultation are advised to be under the care of a licensed Maryland state physician. Dr. Bryan P. Walsh encourages open communication between a patient's current licensed medical professional and himself for any and all suggestions the patient receives.

I understand that Dr. Bryan P. Walsh functions as a health consultant. He uses his education and experiences to make suggestions and recommendations. I hereby request out of my own volition and consent to meet and consult with Dr. Bryan P. Walsh. I take full personal responsibility for taking any natural remedy that he may recommend. I do not hold the naturopathic doctor responsible or liable for any adverse effects or complications from the natural remedies that I consume. If I feel any adverse effects I agree to cease taking all natural remedies immediately. I take responsibility for informing my licensed medical practitioner about any and all natural remedies that I choose to consume. I request Dr. Bryan P. Walsh to make suggestions which he feels appropriate at the time, based on the facts known, in the interest of my overall well being. I will be given the opportunity to discuss with the Naturopathic Doctor, the nature and purpose of these recommendations.

I agree to pay my full account (in cash or check) at the time of each visit. **I understand that there is a \$75 dollar fee for missed and/or cancelled appointments not given 24 hours advanced notice.** I have read the above consent.

I have been given the opportunity to ask questions about this consent, and by signing below I agree to the terms above regarding my consultation(s) with Dr. Bryan P. Walsh. This consent form shall be in effect during the entire duration of consultations between Dr. Bryan P. Walsh and myself.

All therapies, including the naturopathic/acupuncture modalities described above have the potential to create both desirable and undesirable effects. Of the latter, such effects can include the following: allergic reactions/sensitivities/adverse effects to recommendations of natural supplements and adjustments to making lifestyle modifications.

VIS Vitality and Wellness, LLC

Dr. Bryan P. Walsh, ND • 443.458.8307 (phone) • bryan@drbryanpwalsh.com



Please Initial and Sign

____ I understand that Dr. Bryan P. Walsh is a Licensed Naturopathic Doctor

____ I understand that Naturopathic medical treatments and therapies may be different from those offered by other licensed health care providers and that I am at liberty to seek other care.

____ I understand that payment is expected at the time of service.

I have read and the understood the information on this consent form.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Bryan P. Walsh, ND, regarding cure or improvement of my condition. I understand that I am free to withdraw this consent and discontinue participation of these procedures at any time.

Date ____ / ____ /20 ____

Name _____

Signature _____

Adult Intake Form

Thank you for your interest in becoming a patient. This form is designed to help me get to know you better and your reasons for seeing health consulting. The more time you spend answering the questions on this form, more quickly we can get started on helping you achieve your health goals and in the most time-efficient manner possible.

Please take time to answer the following questions to the best of your knowledge. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Information

Name: _____ Date: ____/____/____
(Last name) (First name) (Middle name) (dd/mm/yyyy)

Age: _____ Gender: M F Height: _____ Weight: _____ Date of Birth: ____/____/____
(dd/mm/yyyy)

Address: _____
(Street)

(City) (State) (Zip Code)

(Home Number) (Work Number) (Mobile Number)

(email address) (Fax)

May we leave messages on your phone line? Y N Preference: Home / Work / Cell

Occupation: _____ How long at current job? _____

Do you work full-time? Y N Level of satisfaction at work: 10 9 8 7 6 5 4 3 2 1

Are you: Single Married Separated Divorced Widowed Living with a Partner Same Sex Other

Do you have any children: Y N If yes, how many? _____ Age(s): _____

Blood Type (if known): _____ How did you hear about us? _____

Emergency Contact Information

Name: _____
(Name) (Relationship)

(Home Phone) (Work Phone) (Mobile Phone)

Physician Information

Primary Care Physician: _____
(Name) (Phone Number) (Date of last exam)

Specialty Physician: _____
(Name) (Phone Number) (Type of Care)

Specialty Physician: _____
(Name) (Phone Number) (Type of Care)

Are you currently seeking the care of any other healthcare practitioners or have in the past year (please list reason)?

Chiropractor _____ Acupuncturist _____

Massage Therapist _____ Physiotherapist _____

Counselor _____ Homeopath _____

Health Information

What is your primary goal for today's visit? _____

Who diagnosed this condition? _____ When was it diagnosed? _____

How has it been treated? _____

Describe your symptoms, including when they feel better/worse, related symptoms, etc.

Other health concerns you would like to address. Please list any current or past treatments used.

1. _____
(Concern) (Treatment) (Outcome)

2. _____
(Concern) (Treatment) (Outcome)

3. _____
(Concern) (Treatment) (Outcome)

Medical History

Prenatal Influences (if known, e.g. alcohol, coffee, cigarettes, drugs, stress): _____

Nature of birth (if known, e.g. trauma, forceps, natural, etc.) _____

Breast Fed: _____ months Health as infant (colic, earaches, etc.): _____

Immunizations: Indicate if you were immunized (I), had the disease (D), or neither (N). Specify when, if known.

I	D	N		I	D	N		I	D	N	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flu
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mono	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rubella
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Roseola	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus

Reactions to vaccinations? _____

Chronic problems as a child (e.g. stomach, throat, lungs): _____

Do you have: Mercury dental fillings How many? _____ Dental implants Root canal

Have you ever had any accidents / fractures / falls / injuries? Y N

If yes, please explain: _____

List all past **surgeries** and **medical procedures**:

Year	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Tests: Have you had any of the following exams in the past year?

<u>Test</u>	<u>Yes/No</u>	<u>Result</u>
PAP Test	Y N	_____
Mammogram	Y N	_____
Colonoscopy	Y N	_____
Testicular/Prostate Exam	Y N	_____
Cholesterol check	Y N	_____
Blood pressure check	Y N	_____
Blood sugar check	Y N	_____

Medications:

Drug and other medication allergies: _____

Do you take currently or use recurrently: (Please indicate Yes, No or Past)

Yes	No	Past		Yes	No	Past		Yes	No	Past	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laxatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Relievers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appetite Suppressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antacids								

Please list all prescription, over the counter medications and supplements, including daily dose (e.g. Lanoxin 0.25mg) that you have used in the past 1 year:

Medication

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____
9. _____	10. _____

How many times have you been treated with antibiotics in the last 5 years? _____

Supplements

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____
9. _____	10. _____

Please note if you have ever had any of the following currently (C), intermittently (I), or in the past (P)

C	I	P		C	I	P	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism or Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injury (serious)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overweight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Candida (yeast)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism/Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (type ?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Family History

Has any **blood relative** had any of the following:

Yes	No	?		Yes	No	?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding (easily)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Issues
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure/Epilepsy
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type: _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

	Age (if alive)	Age(at death)	Health Problems
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Maternal			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____
Paternal			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____

Female Health

Age at onset of menstruation: _____ Date of last menstruation: _____ Period every _____ days

Do you have the following (check all that apply):

- | | | | | | |
|--|---|--|---|---|---|
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Irregularities | <input type="checkbox"/> Spotting | <input type="checkbox"/> Pain | <input type="checkbox"/> Discharge | <input type="checkbox"/> Blood in the urine |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Bloating | <input type="checkbox"/> Irritability | <input type="checkbox"/> Menstrual pain | |
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Libido (sex drive) | High/low/normal | |
| <input type="checkbox"/> Bladder, kidney or urinary tract infections | | | <input type="checkbox"/> Problems with control of urination | | |

Number of pregnancies: _____ Number of live births _____
 Miscarriages _____ Abortions _____ Stillbirths _____

Do you perform self breast exams? Yes No

Psychosocial History

List any important **life experiences**, in chronological order, especially traumatic events.

Age	Event	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly outline a typical week day. What do you do from waking to sleeping?

Time	Activity	Time	Activity
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who are the most **significant others** in your life and what, if any, are the challenges in each relationship?

Religious or spiritual beliefs: _____

What is your view of the present and your outlook for the future? _____

How do you feel about yourself? _____

Do you have a supportive environment at home and/or work for making lifestyle changes? Y N

Describe the emotional climate of your home? _____

What are your hobbies and interests? _____

What do you enjoy most about life? _____

If you had a choice to be doing anything else in your life, what would it be? _____

On average, how many hours a day do you sleep? _____ What time do you typically go to bed? _____

Do you have trouble falling asleep? Yes No Do you remember your dreams? _____

Do you wake up at night? Yes No If yes, why? _____

How many hours a day do you watch TV? _____

How much effort are you willing to put into your health? 1 2 3 4 5 6 7 8 9 10 (10= maximum effort)

Please rate from 1 – 10 how important are each of these things in your life?

Career _____ Money _____ Health _____ Romance _____
Fun & Recreation _____ Personal Growth _____ Family & Friends _____ Physical Environment _____

Fears/Phobias:

- Heights Crowds Insects Being alone The dark Thunderstorms
 Thieves/Robbers Death Dogs Financial Worries Snakes Closed-in-spaces
 Water Cats Mice Spiders Other _____

Stress:

Please list the three most significant, stressful events in your life, from the most recent to the most distant.

1. _____
(event) _____ *(date)* _____ *(does it still impact you?)* _____
2. _____
(event) _____ *(date)* _____ *(does it still impact you?)* _____
3. _____
(event) _____ *(date)* _____ *(does it still impact you?)* _____

What is the level of stress you are currently experiencing in your life? **1 2 3 4 5 6 7 8 9 10** (high)

How do you manage stress? _____

Food

Please list the foods that you typically eat for each meal. Make sure to include foods that are not eaten frequently. Please underline the foods that are eaten more frequently. For example, if you eat cereal almost every day for breakfast, but only have eggs once a week, then underline the cereal and make sure to include the eggs on the list.

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Dessert: _____

Do you have any cravings, if so, for what? _____

How would you describe your relationship with food? _____

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

_____, _____, _____

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

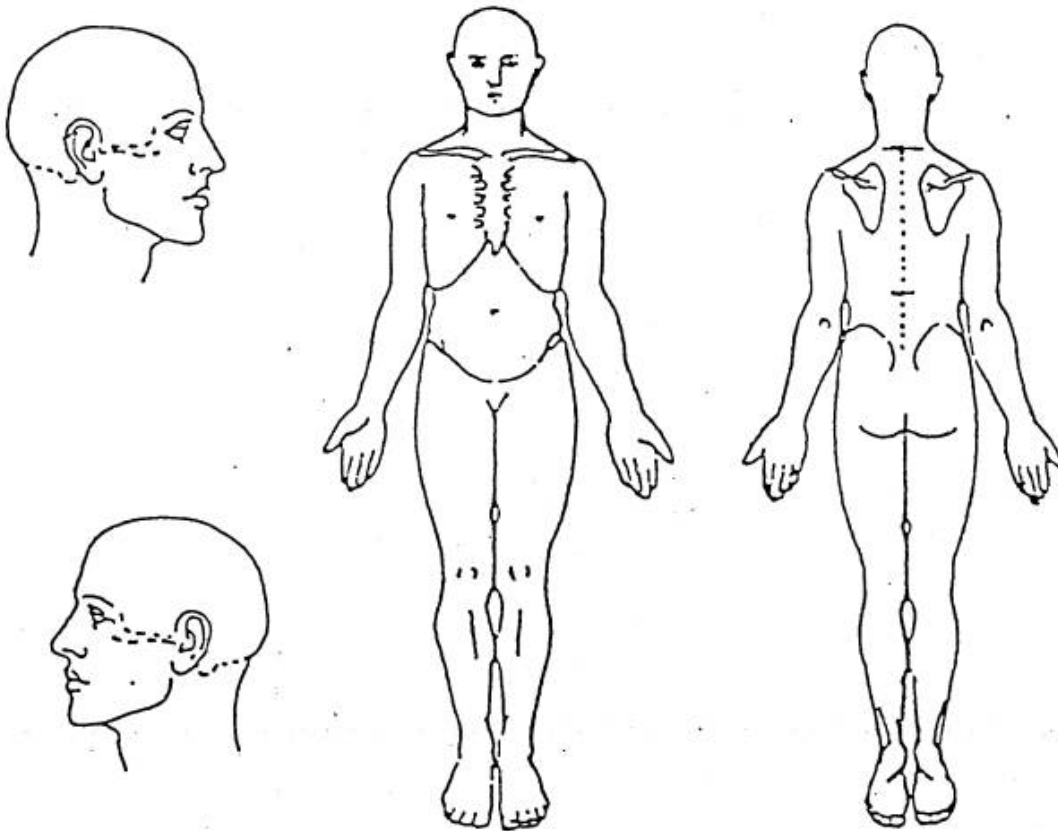
_____, _____, _____

Mental Health

- | | | | |
|------------------------------------|---|--|---|
| Is stress a major problem for you? | <input type="checkbox"/> Y <input type="checkbox"/> N | Do you have problems with eating or your appetite? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Do you feel depressed? | <input type="checkbox"/> Y <input type="checkbox"/> N | Do you cry frequently? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Do you panic when stressed? | <input type="checkbox"/> Y <input type="checkbox"/> N | Do you have trouble sleeping? | <input type="checkbox"/> Y <input type="checkbox"/> N |

Have you seen a psychotherapist in the past? Y N If so, please explain: _____

If experiencing chronic or acute pain, please indicate where and the approximate severity.



Health Habits

Alcohol (Includes wine, beer and liquor)

How often do you drink:

- Never
- Less than 1 time per week
- 2-5 times per week
- At least once daily

What do you drink? _____

Has drinking ever been a problem? Y N

Tobacco

Do you currently smoke? Y N

If yes, how much per day? _____

For how long? _____

Caffeine

How many cups of the following do you consume daily:

Coffee _____	Cola _____
Black Tea _____	Diet Cola _____
Green Tea _____	Chocolate _____

Recreational Drugs

Do you now or have you in the past used marijuana or other drugs? Y N

Please list: _____

If yes, have you developed any chronic problems from their use?

Chemical Exposures

Have you ever been exposed to toxic chemicals, solvents, flames, heavy metals or other possible toxins?

Y N

If yes, please explain: _____

Water Consumption

Are you thirsty? Y N

Amount of liquid/water you drink each day: _____

What temperature do you prefer to drink?

- Hot Cold Room Temp

Exercise

Do you exercise? Yes No

Which of the following do you do and how often?

- | | | |
|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Jog | <input type="checkbox"/> Bicycle | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Weight lifting | <input type="checkbox"/> Cardio |
| <input type="checkbox"/> Swim | <input type="checkbox"/> Walk | |
| <input type="checkbox"/> Other _____ | | |

Relaxation

Do you make time for rest, relaxation or meditation sometime during the day?

Yes No

How often? _____

How do you relax?

Sleep

Do you have trouble falling asleep? Yes No

If yes, what keeps you up? _____

Do you sleep through the night? Yes No

Do you wake feeling refreshed? Yes No

Do you have recurring dreams? Yes No

If yes, what is the theme? _____

What position do you sleep in? _____

Is there a position you cannot sleep in?

Yes No

Do you have nightmares, sleep walk, snore, or grind your teeth at night? Yes No

If yes, describe. _____

Please check “✓” any of the following that apply to you or write “P” beside the box if you have experienced any in the past.

General

- Fatigue
- Change in appetite
- Change in thirst
- Cravings
- Weight gain
- Weight loss
- Poor sleep
- Chills or fever
- Night sweats
- Sweat easily
- Allergies
- Cancer
- Diabetes

Skin and Hair

- Dryness
- Rash
- Itching
- Eczema
- Psoriasis
- Acne
- Recent moles
- Hives or allergic reactions
- Loss of hair
- Thinning hair
- Dandruff
- Other skin problem(s)

Eyes Ears Nose & Throat

- Eye pain
- Eye strain
- Blurry vision
- Impaired vision
- Cataracts
- Ear aches
- Ear infections
- Ringing in ears
- Vertigo or dizziness
- Sinus infections
- Nasal obstruction
- Post nasal drip
- Nosebleeds
- Loss of smell/taste
- Sores in mouth
- Mercury fillings
- Jaw pain or clicks
- Recurrent sore throat
- Tonsillitis
- Enlarged glands
- Enlarged thyroid

- Facial pain/tics
- Headaches

Cardiovascular

- Chest pain
- Palpitations
- High blood pressure
- Low blood pressure
- Heart attack
- Congestive heart failure
- Irregular heartbeat
- Pacemaker
- Artificial heart valve
- Stroke
- Fainting
- Varicose veins
- Deep leg pain
- Cold hands or feet
- Swelling of limbs
- Anemia
- Easy Bruising

Respiratory

- Difficulty breathing
- Shortness of breath
- Chronic cough
- Bronchitis
- Emphysema
- Asthma
- Wheezing
- Coughing blood
- Phlegm in throat

Muscle Bone & Joints

- Neck pain
- Back pain
- Arthritis
- Bursitis
- Joint pain or stiffness
- Artificial joint
- Muscle pain
- Muscle weakness

Gastrointestinal

- Nausea
- Vomiting
- Vomiting blood
- Reflux or heartburn
- Constant hunger

- Ulcer
- Indigestion
- Abdominal pain or cramping
- Bloating
- Gall stones
- Liver disease
- Jaundice
- Intestinal parasites
- Gas
- Constipation
- Diarrhea
- Chronic laxative use
- Rectal burning/pain
- Hemorrhoids
- Blood in stool

Neurological

- Anxiety
- Depression
- Irritability
- Emotional problems
- Loss of balance
- Poor memory
- Dizziness
- Seizures/Epilepsy
- Concussion
- Lack of coordination
- Extremity numbness
- Extremity tingling
- Paralysis

Infections

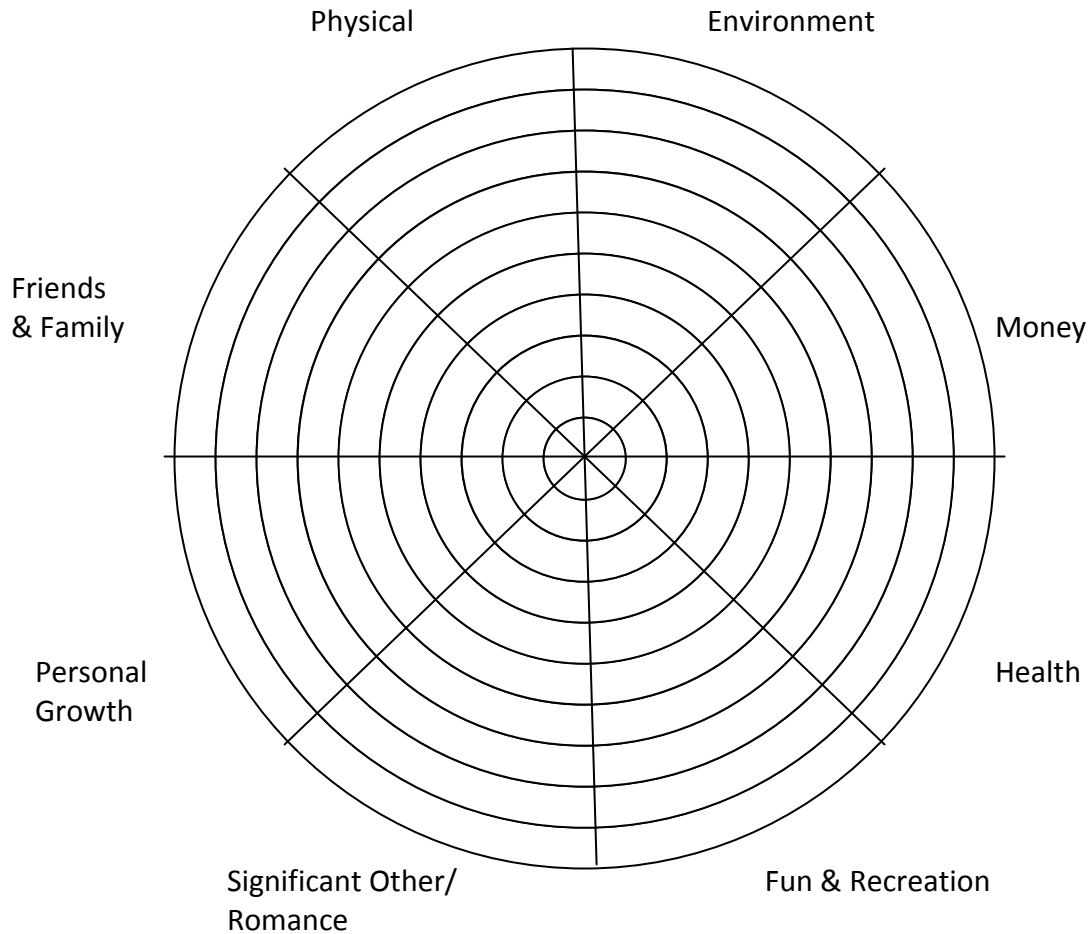
- Strep throat
- Mononucleosis
- Tuberculosis
- Hepatitis
- HIV/AIDS

Urinary

- Frequent urination
- Urgency to urinate
- Incontinence
- Pain on urination
- Waking at night to urinate
- Urinary tract infection
- Blood in urine
- Kidney stones

Wheel of Health

This is your wheel of health. Like any other wheel, in order for it to turn properly, it must be balanced. The same is true in life. Please shade the corresponding areas ranging from 0%, no satisfaction (center of wheel) to 100%, full satisfaction (outside rim of the wheel) representing your happiness with that area of your life.



This wheel will help you to recognize areas of your life that must be addressed in order to run your life smoothly and in balance.

Vis Vitality and Wellness, LLC

Metabolic Assessment Form

Answer the following questions on a scale of “0” (least/never) to “3” (often/always). Take your time and be honest with the answers; the more accurate you the better you will understand which systems are a priority for you.

Category A		Category E	
Feeling that bowels do not empty completely	0 1 2 3	Greasy or high fat foods cause distress	0 1 2 3
Lower abdominal pain relief by passing stool or gas	0 1 2 3	Lower bowel or gas or bloating several hours after eating	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3	Bitter, metallic taste in mouth, especially in the morning	0 1 2 3
Diarrhea	0 1 2 3	Unexplained itchy skin	0 1 2 3
Constipation	0 1 2 3	Yellowing cast to eyes	0 1 2 3
Hard dry or small stool	0 1 2 3	Stool color alternates from clay colored to normal brown	0 1 2 3
Coated tongue or “fuzzy” debris on tongue	0 1 2 3	Reddened skin, especially palms	0 1 2 3
Pass large amount of foul smelling gas	0 1 2 3	Pass large amount of foul smelling gas	0 1 2 3
More than three bowel movements daily	0 1 2 3	More than three bowel movements daily	0 1 2 3
Do you use laxatives frequently?	0 1 2 3	Do you use laxatives frequently?	0 1 2 3
	Total _____	Dry or flaky skin and/or hair	0 1 2 3
Category B		History of gallbladder attacks or stones	0 1 2 3
Excessive belching or burping	0 1 2 3	Have you had your gall bladder removed	Yes(3) No(0)
Gas immediately following a meal	0 1 2 3		Total _____
Offensive breath	0 1 2 3	Category F	
Difficult bowel movement	0 1 2 3	Crave sweets during the day	0 1 2 3
Sense of fullness during and after meals	0 1 2 3	Irritable if meals are missed	0 1 2 3
Difficulty digesting fruits and vegetables	0 1 2 3	Depend on coffee to keep yourself going or get started	0 1 2 3
Undigested foods found in stool	0 1 2 3	Get lightheaded if meals are missed	0 1 2 3
Pass large amount of foul smelling gas	0 1 2 3	Eating relieves fatigue	0 1 2 3
More than three bowel movements daily	0 1 2 3	Feel shaky, jittery, tremors	0 1 2 3
Do you use laxatives frequently?	0 1 2 3	Agitated, easily upset, nervous	0 1 2 3
	Total _____	Poor memory, forgetful	0 1 2 3
Category C		Blurred vision	0 1 2 3
Stomach pain, burning or aching 1-4 hours after eating	0 1 2 3		Total _____
Frequent use of antacids	0 1 2 3	Category G	
Feeling hungry an hour or two after eating	0 1 2 3	Fatigue after meals	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3	Craves sweets during the day	0 1 2 3
Temporary relief from antacids, food, milk, carbonation	0 1 2 3	Eating sweets does not relieve cravings for sugar	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3	Must have sweets after meals	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0 1 2 3	Waist girth is equal or larger than hip girth	0 1 2 3
	Total _____	Frequent urination	0 1 2 3
Category D		Increased thirst and appetite	0 1 2 3
Roughage and fiber cause constipation	0 1 2 3	Difficulty losing weight	0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3		Total _____
Pain, tenderness, soreness on left side under rib cage	0 1 2 3	Category H	
Excessive passage of gas	0 1 2 3	Cannot stay asleep	0 1 2 3
Nausea and/or vomiting	0 1 2 3	Crave salt	0 1 2 3
Stool undigested, foul smelling, mucous-like greasy or poorly formed	0 1 2 3	Slow starter in the morning	0 1 2 3
Frequent urination	0 1 2 3	Afternoon fatigue	0 1 2 3
Increased thirst and appetite	0 1 2 3	Dizziness when standing up quickly	0 1 2 3
Difficulty losing weight	0 1 2 3	Headaches with exertion or stress	0 1 2 3
	Total _____	Weak nails	0 1 2 3
			Total _____

Category I

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 six or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little activity	0	1	2	3

Total _____**Category J**

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amount 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
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Thinning of hair on scalp, face or genitals, or excessive falling hair	0	1	2	3

Total _____**Category K**

Heart palpitation	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

Total _____**Category L**

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

Total _____**Category M**

Increased sex drive	0	1	2	3
Reduced tolerance to sugars	0	1	2	3
“Splitting” type headaches	0	1	2	3

Total _____**Category N (Men)**

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

Total _____**Category O (Men)**

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
Increased 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

Total _____**Category P (Women – still menstruating)**

Are you perimenopausal	Yes(3)	No(0)		
Alternating menstrual cycle lengths	Yes(3)	No(0)		
Extended menstrual cycle, greater than 32 days	Yes(3)	No(0)		
Shortened menses, less than every 24 days	Yes(3)	No(0)		
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

Total _____**Category Q (Women – Menopausal)**

Since menopause, do you ever have uterine bleeding	0	1	2	3
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

Total _____**Category R**

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
Do you have a hard time remembering 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
Are you feeling down or sad more than normal?	0	1	2	3

Category R (con't)

Do you fatigue when reading sooner than in the past?	0	1	2	3
Do you fatigue sooner when driving than in the past?	0	1	2	3
Do you walk into rooms and forget why?	0	1	2	3
Do you pick up your cell phone and forget why?	0	1	2	3

Total _____**Category S**

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

Total _____**Category T**

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

Total _____**Category U**

Do you feel anxious or panic for no reason?	0	1	2	3
Do you have feelings of dread, or pending gloom?	0	1	2	3
Do you feel knots in your stomach?	0	1	2	3
Do you have feelings of being overwhelmed for no reason?	0	1	2	3
Do you have feelings of guilt about everyday decisions?	0	1	2	3
Does your mind feel restless?	0	1	2	3
Is it difficult to turn off your mind when you want to relax?	0	1	2	3
Do you have disorganized attention?	0	1	2	3
Do you now worry about things you were not worried about before?	0	1	2	3

Category U (con't)

Do you have feelings of inner tension and inner excitability?	0	1	2	3
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Total _____**Category V**

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 and faces?	0	1	2	3
Do you feel like your opinion about yourself is changed?	0	1	2	3
Are you experiencing excessive urination?	0	1	2	3
Are you experiencing slower mental response?	0	1	2	3

Total _____**Category W**

Does your skin look pale?	0	1	2	3
Do you feel tired or fatigued?	0	1	2	3
Do you feel weak?	0	1	2	3
Do you get short of breath?	0	1	2	3
Do you get dizzy?	0	1	2	3
Have you experienced a rapid heart rate?	0	1	2	3
Do you have numbness/coldness in your hands or feet?	0	1	2	3
Are you irritable?	0	1	2	3
Do you feel sad and depressed?	0	1	2	3

Total _____**Category X**

Pain or aches in joints	0	1	2	3
Pain, aches in muscles	0	1	2	3
Itchy ears	0	1	2	3
Belching, passing gas	0	1	2	3
Dark circles under eyes	0	1	2	3
Gagging, frequent need to clear throat	0	1	2	3
Swollen or discolored tongue	0	1	2	3
Headaches	0	1	2	3
Stuffy nose	0	1	2	3
Water retention	0	1	2	3
Craving certain foods	0	1	2	3
Excessive mucous	0	1	2	3
Frequent illness	0	1	2	3

Total _____



DIET DIARY INSTRUCTIONS

DATE

Write in the date of the diary entries for at least three days.

TIME

Write down, as accurately as possible, the time you eat.

FOODS EATEN

Be sure to include fluids, vitamins, and medications, as well as foods.

Write in the amount of food you eat, i.e. “bowl of Cheerios with a cup of milk and banana.” Among the measurements you may use are fluid ounce, ounce-weight, cup, gram, teaspoon (jam, butter), slice (bread), tablespoon, gallon, liter, or milliliters. If you list “cup” (as in coffee or tea), a “glass” (milk, beer, water, etc.), or a “bottle” or “can,” estimate the size of the container. You may also write in just the quantity of the food when the amount is obvious, like “1 hamburger, 2 apples, 3 cookies”, or a “serving of McDonald’s fries” (but write in whether it was a small or large order).

It is also important that you **write in brand names of foods that you eat**, as nutrient content will vary by manufacturer.

And finally, **write in the contents of foods where appropriate**. For example, instead of writing “vegetable soup”, write in “soup with carrots, vegetable broth, onion, garlic, etc.” for foods with multiple ingredients.

FEELINGS

Write in your emotions, as well as energy and physical stress levels. This is the place to chart your ups and downs during the day. Typical entries might include: “sad, depressed, high energy, low energy, very happy, tired, poor sleep last night, sleepy, runny nose, caught a cold, feeling very irritable, fighting with partner.” Do not limit yourself to just these entries. What is important is that you depict a picture of the ebbs and flows of your day. Try to correlate the entries as closely as possible with the times listed to the left on the diet diary form.

BOWEL, URINE HABITS, GAS

List your bowel movements, urine voids and any flatulence (gas). Again, try to correlate these entries with the times. Also, **note any changes or abnormalities** in bowel movements or urine, such as constipation, diarrhea, excessive quantity of urination, color changes, etc.

MAJOR ACTIVITIES

List your activity level (i.e., whether you are sedentary or active). Typical listings might include, “short walk, worked in the garden, ran three miles, sat in the office all day.”

If you have any questions, please contact Dr Bryan Walsh at bryan@drbryanpwalsh.com or 443-458-8307.

DIET DIARY

NAME: _____ START DATE: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Lunch							
Dinner							
Snacks							
Water Intake							