Preparing for Your Appointment

Dear Patient:

Welcome!

We look forward to helping you with our specialized, therapeutic lifestyle program called FirstLine Therapy (FLT). It is very different from today's common medical approach. The FLT program works to more clearly identify and overcome the cause of ill health, and then improve total body function naturally by nourishing, balancing and revitalizing the whole individual. It is powerful, effective, and rewards you with improved health and function that is long lasting!

Get Maximum Benefit From Your Appointment

Our consultation time with you is important! We analyze your personal and family health history, appropriate test results, current lifestyle and state of health, and clarify your health goals. We then guide you through a comprehensive, highly personalized, step-by-step program to achieve those goals. You can **get maximum benefit from the time reserved for your consultation by being prepared!**

How To Prepare

1. Please fill out any requested paperwork before coming to our office, or arrive 15 minutes early and fill it out here.

2. Prepare for your Bioimpedance Analysis (BIA Test) by adhering to the following guidelines:

a. Do not eat for 4 hours prior to testing.
b. Do not exercise for 12 hours prior to testing.
c. Do not consume alcohol for 24 hours prior to testing.
d. Drink your usual amount of water the night before and the day of your appointment. You will be asked to empty your bladder just before the test.
e. Do not drink caffeine the day of your test.
f. Insure access to your right foot with removable footwear (no pantyhose).

3. Please value the time reserved for you by being punctual so as to benefit fully from your consultation.

IMPORTANT: There is a <u>$100 NO SHOW fee</u> if cancellation is not made at least 24 hours prior to your appointment. Due to the popularity of the FirstLine Therapy program all appointment times are often filled several weeks in advance with no openings for those desiring earlier appointments. Cancellation made at least 24 hours in advance allows us to accommodate others. We thank you in advance for your cooperation.

Appointment Reminder

Your appointment is scheduled for:

Date_____, _____/_____/_____ Time_____ AM / PM

Patient Signature_____Date_____

Thank You! We look forward to helping you successfully achieve your personal health goals!

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Health History

Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Email _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit Date began

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health overall:

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs

☐ Other _____

Do you experience any of these general symptoms on a regular basis?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

Current medications (prescription or over-the-counter): _____

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

_____

Outcome: _____

_____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): _____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Healthy weight Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)?

_____

What are your current health goals: _____

_____

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Health History

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other _____

Date of last GYN exam_____

Mammogram ☐ + ☐ –

PAP ☐ + ☐ –

Form of birth control _____

# of children _____

# of pregnancies _____

☐ C-section _____

Age of first period _____

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles

_____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

_____

Health Habits

- ☐ Tobacco:

Cigarettes: # /day _____

Cigars: # /day _____

- ☐ Alcohol:

Wine: # glasses/d or wk _____

Liquor: # ounces/d or wk _____

Beer: # glasses/d or wk _____

- ☐ Caffeine:

Coffee: # 6 oz cups/d_____

Tea: # 6 oz cups/d _____

Soda w/caffeine: # cans/d _____

Other sources_____

- ☐ Water: # glasses/d _____

Exercise

- ☐ 5-7 days/wk
- ☐ 3-4 days/wk
- ☐ 1-2 days/wkk
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk: #days/wk _____
- ☐ Run, jog, other aerobic - #days/wk

_____

- ☐ Weight lift: #days/wk _____
- ☐ Stretch: #days/wk _____

Other _____

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables_____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ☐ Skip meals (which ones) _____

_____

- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals (describe) _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other _____

I Would Like to:

Energy, Vitality

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

Body Composition

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress: Mental and Emotional

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

Life Enrichment

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

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FirstLine Therapy® Health Profile

Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for: ☐ Past 30 days ☐ Past 48 hours

Point Scale

0 — Never or almost never have the symptoms
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

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **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 farsightedness) **Total** _____

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total** _____

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **Total** _____

Mouth/ Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores **Total** _____

Skin
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total** _____

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total** _____

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total** _____

Digestive Tract
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach 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** _____

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total** _____

Energy/ Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total** _____

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total** _____

Emotions
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **Total** _____

Other
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **Total** _____

Grand Total _____

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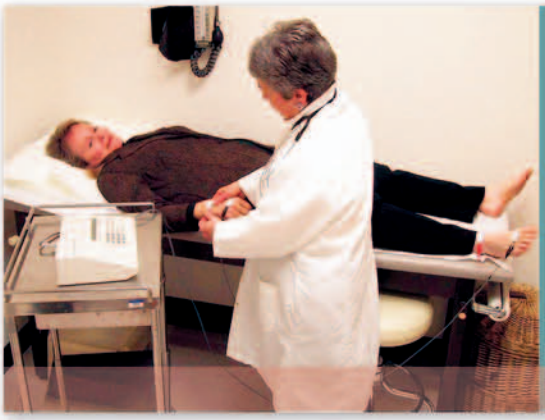

What Is a **BIA?**
(And why do you need one?)

Bioelectrical Impedance Analysis or Bioimpedance Analysis (BIA) is a method of assessing your "body composition"—the measurement of body fat in relation to lean body mass. It is an integral part of a health and nutrition assessment.

Why Is Body Composition Important to My Health?

Research has shown that body composition is directly related to health. A normal balance of body fat is associated with good health and longevity. Excess fat in relation to lean body mass, known as altered body composition, can greatly increase your risks to cardiovascular disease, diabetes, and more. BIA fosters early detection of an improper balance in your body composition, which allows for earlier intervention and prevention. BIA provides a measurement of fluid and body mass that can be a critical assessment tool for your current state of health.

BIA also measures your progress as you improve your health. Improving your BIA measurement, or maintaining a healthy BIA measurement, can help keep your body functioning properly for healthy aging. Your BIA results can help guide us in creating a personalized dietary plan, including nutritional supplements when appropriate, and exercise to help you maintain optimal health and well-being for a lifetime.

How Does a BIA Work?

BIA is much more sophisticated than your bathroom scale, but just as simple—and almost as quick. BIA is performed in our office with the help of a sophisticated, computerized analysis.

This analyzer "calculates" and estimates your tissue and fluid compartments—using an imperceptible electrical current passed through pads placed on your hand and foot as you lie comfortably clothed on an exam table. In just minutes, we'll have detailed measurements to help create an effective, personalized program for you.

Follow-up Tests

We can conduct a series of follow-up BIA tests to monitor your health and measure your progress.

Guidelines for Assessment

For the most accurate results, the following guidelines should be followed:

1. **Do not eat for 4 hours prior to testing.**
2. **Do not exercise for 12 hours prior to testing.**
3. **Do not consume alcohol for 24 hours prior to testing.**
4. **Drink at least 1 quart of water one hour before your test.**
5. **Do not drink caffeine the day of your test.**
6. **Do not wear pantyhose.**
7. **Do not put lotion on your hands and feet.**

Follow-up Appointment:

FirstLineTherapy®

Metagenics®
Genetic Potential Through Nutrition
www.metagenics.com

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Health Goals

Name _____ Date _____ Age _____ Sex _____

Column 1: List health goals based on priority.

Column 2:Does this goal require adding or eliminating a behavior?

Column 3: What is the most important action step to accomplish this goal?

Column 4: What is your timeframe for taking action?

Health Goals	Yes/No	Action Step	Timeline
1.			
2.			
3.			
4.			
5.			

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