



Patient Name: _____

Appointment Date: M T W Th F S Date: _____ Time: _____ AM / PM

FUNCTIONAL MEDICINE & NUTRITION PROGRAM

Welcome to your virtual Functional Medicine experience through Triad Health Center! We are excited to begin helping you further on your journey through natural healthcare.

Inside of this packet, you will find: instructions to prepare for your initial consultation and assessment with Dr. Schwartz, an outline of expectations, and a detailed intake paperwork questionnaire.

Prior to your consultation...

You will need to fill out the intake paperwork forms completely and as detailed as possible. You must complete the paperwork and email it back to us **at least 24 hours prior to your appointment**. If you have any labs you think are relevant from the past 2 years, please send copies of your test results to us. **Email your forms to staff@triadhealthcenter.com or Fax to us at 336-663-0263.** *If your forms are sent less than 24 hours before your appointment date, your consultation will be rescheduled.*

What will occur?

You will receive a private Zoom Meeting link sent to your email address separately prior to your appointment. Use that link to log-in to your appointment. You will need a device (computer/tablet/smart phone), camera, and microphone to complete your virtual appointment. Video is always the preferred method, however if this is not possible, telephone may be used. **Notify us at least 24 hours prior to your appointment time.**

Be sure to be at your phone or computer 10-15 minutes early for your appointment, to ensure enough time to get logged into the meeting or charge the battery.

At your first appointment you will meet virtually with Dr. Schwartz for an in-depth health history exam working through your intake paperwork, any past labs, and discussion of your needs and health goals.

The length of the entire first appointment is typically 90-120 minutes.

Following your initial consultation, Dr. Schwartz will recommend any additional testing and customize a plan for you to get well! Future costs will depend on each individual's needs.

What do I need to bring?

We highly encourage your spouse attend this appointment with you. A notebook for notes is recommended. Also have your copy of the completed intake paperwork in front of you to follow along.

What is the policy on rescheduling this appointment?

If you are more than 15 minutes late for your appointment or your paperwork arrives to us late, the appointment is considered cancelled. You may reschedule this appointment up to 24 hours in advance. Outside of a catastrophic occurrence, you will be charged for any less-than-24 hour cancelations, late arrivals, or no-shows.



EXPECTATIONS

"You didn't get sick over night. Do not expect to get better over night."

The majority of patients who enter our office have been developing their illness for 20-30+ years. The process of getting well is much like the stock market; you will have good days and bad days. However, as you look back on your care you will realize you have always been progressing. I have been treating very sick people, including myself, for many years and I have never seen or experienced a progression to health in any other way.

My point is you are going to have bad days, and that does not mean you are regressing. You will also have good days, and those good days do not mean that you are cured.

True healing takes time. You can cover symptoms in hours or days, but to remove a cause you will need to be patient and committed to the process. I can tell you from personal experience as it took 3-4 years to regain my complete health. With that said, after 6 months of treating the cause I was able to see the light at the end of the tunnel. My hope had returned. The same can be for you.

What You Can Expect From Us:

1. **Our commitment** to get to the true cause of your illness.
2. **Our support**, as we are here to offer you not just hope but a path to follow.
3. **Encouragement** based on our experience of treating very sick patients and going from pain to purpose in our own health battles.
4. **Value**, we understand that the majority of our patients have financial burdens many of which occur because of their illness. Therefore, we created a health investment discount package to make it more affordable (based on the minimal amount of visits, testing and fees). We obviously have to charge for our services, as we are a business, but by no means over charge in regards to today's medical fees. It is our goal to restore your health and life.

What NOT To Expect From Us:

1. **Do not expect a "get fixed quick scheme"** or a **"magic bullet"**. Most illnesses do not occur overnight and true healing takes time.
2. **Do not expect to be coddled** - we are going to be tough because we have to be! We will not necessarily tell you what you want to hear but we will tell you what you need to hear to regain your health and life. Most of the patients that we treat are in the death zone. We have found the only way to pull them out of the death zone is to not coddle but to speak truth into their lives.

What We Expect From You:

1. **Commitment to lifestyle changes**. It's not easy, but when getting to the cause, lifestyle changes such as diet, exercise, toxin avoidance, and attitude are a must in order to return back to a state of health.
2. **Commitment to the protocols** that we outline for your case. It is the individuals that stick closely to the protocols and that remain diligent that get the most consistent results.
3. **Patience**. REMEMBER you didn't get sick over night and you will not get better overnight.

We are excited to help you reach your optimal health potential!

Dr. David Schwartz, DC, MS-HNFM, D.PSc



Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a Drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and / or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (Drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

I have read and understand the above information:

Patient Signature

Date

Sale of Nutritional Supplements at Triad Health Center, PLLC

You are under no obligation to purchase nutritional supplements at our clinic. As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or big box stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

As always, if you have questions or concerns, please discuss them with our staff.

I have read and understand the above information:

Patient Signature

Date



Patient Policy Form

Welcome to Triad Health Center! We are excited to provide you with your health care needs and are honored to work with you to achieve your optimal health goals.

Please review our office policies. Initial each line item to indicate your understanding, then sign and date the bottom of this form as acknowledgement of our patient policies outlined below.

_____ **PAYMENT POLICY** As the patient, you are responsible for the total charges incurred for each visit. We accept Visa, MasterCard, Discover and American Express credit cards and debit cards for payment, as well as HRA, FSA, HSA and Christian Health Share. A payment invoice will be emailed to you following each appointment and payment is due within 24 hours.

We do not directly bill these services to health insurance. If you are seeking a method of reimbursement, you may request an itemized super bill receipt following each payment, and a super bill will be supplied by email within 72 business hours of receiving your request.

We may recommend natural and alternative supplements, which may be purchased from Triad Health Center. Most insurance companies do not cover the supplemental items that we recommend and sell. FSA, HRA, and HSA may or may not cover the supplemental items that we recommend and sell, and it is your (the client's) responsibility to research coverage and communicate with the FSA / HRA / HSA company regarding coverage. Payment for product or supplement orders is due at the time of placing the order. We will not ship out your order until payment is received. We offer discounted shipping rate of \$8.00 and free shipping on orders of \$150+.

_____ **SUPPORT POLICY** Any additional questions outside of scheduled consultations, including phone calls or emails from Dr. Schwartz or his support staff, are an extra charge, based in 15-minute increments at \$60.

_____ **ARRIVAL POLICY** For all appointments, be sure to arrive online and be ready at least 10-15 minutes early. Early arrival allows for a relaxed and unhurried experience, and ensures time to take care of any technology issues. If late arrival is inevitable, your appointment may need to be shortened in order for the practitioner to stay on schedule. The original reservation fee will be charged.

_____ **LATE ARRIVAL POLICY** We regret that late arrivals will not receive extension of scheduled appointments. The original reservation fee will be charged.

_____ **RESCHEDULE & CANCELLATION POLICY** We require at least 24 hours notice if you need to reschedule or cancel an appointment. If a client fails to cancel within 24 hours, they will be asked to pay in full the amount of this missed appointment, and use it as a pre-payment for future services. An additional late/missed appointment charge of \$75 will be assessed. **Cancellation and reschedule requests must be received via phone or email: 336-288-4677 or staff@triadhealthcenter.com.**

_____ **NO SHOW POLICY** Clients who fail to show for appointments will be asked to pre-pay for future services and an additional missed appointment charge of \$75 will be assessed.

_____ **CONFIDENTIALITY POLICY** The discussions between the practitioner and the client is confidential and is protected by state laws and the Health Insurance Portability and Accountability Act (HIPAA).

_____ **BREAK IN CARE POLICY** Clients who we have not been seen at Triad Health Center for Functional Medicine services for a year or more will be asked to fill out this form again.

_____ **TERMINATION OF LONGTERM PROGRAM POLICY** If treatment is terminated prior to completing a longterm program option, financial responsibility to the patient is assessed at a per visit fee.

_____ **COMMUNICATION POLICY** I give permission for the staff at Triad Health Center to contact me via telephone, text or email and to leave me messages that may contain appointment or medical information if I am not available.

I have read and understand the above stated policies and will comply with them in all aspects.

Patient Signature

Date



FUNCTIONAL MEDICINE INTAKE PAPERWORK

Name: Date:

Address:

City: State: Zip Code:

Home #: Cell #:

Email:

DOB: Gender: Male Female

Age: Height: Weight:

Status: Married Widowed Separated Divorced Partnership

I live with: Spouse Children Partner Friends Parents Alone

Education: _____

Occupation: _____ Hours / Week: _____ Retired

Employer: _____ Work Address: _____

Primary Care Provider: _____ Phone #: _____

In case of emergency, whom should we contact:

Name	Relationship	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

How did you hear about our Functional Medicine and Nutrition Program?

What are your major complaints? List when each symptom began and be as descriptive as possible:



Please list your current and past health conditions (e.g. Diabetes, Joint Pain, SIBO, Fibromyalgia, etc.):

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What are your current medications?

Medication	Dose	Reason for Taking

What are your current vitamins / supplements?

Supplement	Dose	Reason for Taking

Is there anything else in your medical history that you consider to be relevant (even from childhood)?

What is your employment history? Please provide brief summary including dates if possible.

Please list your past or present Hobbies (these could be sources of toxicity or chemicals):

How often are you involved in these Hobbies currently?

Please list past or present allergies, including allergies to medications. (Check all that apply.)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Adhesives | <input type="checkbox"/> Animals | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Bee Stings |
| <input type="checkbox"/> Ceftin | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Dairy | <input type="checkbox"/> Dust |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Flax / Linseed | <input type="checkbox"/> Food Dyes / Colors | <input type="checkbox"/> Gluten |
| <input type="checkbox"/> Grains | <input type="checkbox"/> Latex | <input type="checkbox"/> Meat | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Oxytocin / Codeine | <input type="checkbox"/> Peanuts / Nuts / Seeds | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Pollen / Ragweed |
| <input type="checkbox"/> Rubber | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Soaps / Cleansers |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Thickeners / Carrageenan | <input type="checkbox"/> Wheat | <input type="checkbox"/> X-ray / CT Dye |

<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
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Please list all past surgeries and the condition each surgery was for, including dates.

Please explain your housing history (type of homes, where and when).

How well have things been going for you (check all that apply)?

	Very Well	Fair	Poorly	Very Poorly	Does Not Apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your partner					
With your spouse					
With your parents					
With your children					
Other: _____					

Have you ever had psychotherapy or counseling? Yes No

If yes: Currently Previously, from _____ to _____

What kind? _____

Comments: _____



Food Journal

Please list what you have eaten the last three days. If you cannot remember specifics, please list what three typical days of eating are.

	Day One	Day Two	Day Three
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			
SNACK			

Eating Habits

Are you following a special diet? Yes No *If yes, check which:*

- Paleo AIP Pescatarian
 Keto Ovo-Lacto Vegetarian
 Whole30 Blood Type Diet Vegan

Other (describe):

Please list how many days per week you are eating out (1-7) for each meal time, and give examples of your most frequented restaurants.

Breakfast: # _____ Days per week.

Where:

Lunch: # _____ Days per week.

Where:

Dinner: # _____ Days per week.

Where:

What is your favorite food? _____

What is your favorite restaurant? _____

What time do you wake up in the morning? _____

What time do you leave your house for work/school/errands? _____

Do you wake up hungry? _____

How much of the following do you consume each week?

Candy	<input type="text"/>	Cups of Tea	<input type="text"/>	Salty Foods	<input type="text"/>
Cheese	<input type="text"/>	Cups of Hot Chocolate	<input type="text"/>	Regular Sodas	<input type="text"/>
Chocolate	<input type="text"/>	Bread/Bagels/Rolls/Pasta	<input type="text"/>	Diet Sodas	<input type="text"/>
Cups of Coffee	<input type="text"/>	Ice Cream	<input type="text"/>	Processed Meats	<input type="text"/>

Is there anything special about your diet that we should know?

If yes, please explain:

Do you have symptoms immediately after eating (e.g. belching, bloating, sneezing, hives, etc)?

Yes No

If yes, are these symptoms associated with any particular food or supplement? Yes No

If yes, please name the food or supplement and accompanying symptom(s) (e.g. Milk = gas and diarrhea):

Do you feel you have delayed symptoms after eating certain foods (symptoms which may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc? Yes No

Do you feel much **better** or much **worse** when you eat a lot of:

Food Type	Better	Worse
High Fat Foods	<input type="checkbox"/>	<input type="checkbox"/>
High Protein Foods	<input type="checkbox"/>	<input type="checkbox"/>
Refined Sugar (junk food)	<input type="checkbox"/>	<input type="checkbox"/>
1-2 alcoholic beverages	<input type="checkbox"/>	<input type="checkbox"/>
High Carb Foods (bread, pasta, potatoes)	<input type="checkbox"/>	<input type="checkbox"/>
Fried Food	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Does skipping a meal greatly affect your symptoms? Yes No

Have you ever had a food that you craved or "binged" on over a period of time? Yes No

If yes, what food(s)? _____

Do you have an aversion to certain foods? Yes No

If yes, what food(s)? _____

Check all that apply regarding your Bowel Movements (BM):

BM Frequency	✓
More than 3x/day	
1-3x / day	
4-6x / week	
2-3x / week	
1 or fewer x / week	

BM Color	✓
Medium brown consistently	
Very dark or black	
Greenish	
Blood / red visible	
Varies a lot	
Dark brown consistently	
Yellow / light brown	
Greasy / shiny / oily	

BM Consistency	✓
Soft and well formed	
Often float	
Difficult to pass	
Diarrhea	
Thin, long or narrow	
Small and hard	
Loose but not watery	
Alternate between hard and loose	

Do you experience intestinal gas (check all that apply):

- Daily
 Excessive
 Present with pain
 Occasionally
 Foul smelling
 Little odor

Have you ever used alcohol? Yes No

If yes, how often do you drink alcohol?

- No longer consume alcohol
 Average 1-3 drinks per week
 Average 4-6 drinks per week
 Average 7-10 drinks per week
 Average >10 drinks per week

Have you ever used recreational drugs? Yes No

Have you ever used tobacco? Yes No

If yes, number of years as a nicotine user: _____ years. Amount per day: _____. Year quit _____

What type of nicotine have you used? Cigarette Smokeless Cigar Pipe Patch/Gum

Are you exposed to second hand smoke regularly? Yes No

Do you have artificial joints or implants? Yes No

Do you feel **worse** at certain times of the year? Yes No

If yes, when? Spring Summer Winter Fall

Do odors affect you? Yes No



Do you exercise regularly? Yes No

If yes:

How often?	<input checked="" type="checkbox"/>
4 x / week or more	<input type="checkbox"/>
3 x / week	<input type="checkbox"/>
2 x / week	<input type="checkbox"/>
1 x / week	<input type="checkbox"/>
2 x / month	<input type="checkbox"/>
1 x / month	<input type="checkbox"/>

How long is each session?	<input checked="" type="checkbox"/>
≤ 15 minutes	<input type="checkbox"/>
16-30 minutes	<input type="checkbox"/>
31-45 minutes	<input type="checkbox"/>
> 45 minutes	<input type="checkbox"/>

What type of exercise?	<input checked="" type="checkbox"/>
Jogging / Walking	<input type="checkbox"/>
Running	<input type="checkbox"/>
Biking	<input type="checkbox"/>
Other:	<input type="checkbox"/>

Is there any family history we should know about?

If yes, please explain:

What is the attitude of those close to you about your illness? Supportive Non-supportive

THIS SECTION IS FOR MEN ONLY

Date of last Thermography Scan _____ Results: Normal Abnormal

Date of last Prostate Exam _____ Results: Normal Abnormal

Do you fatigue easily during or after a workout? Yes No

Are you on any hormone replacement therapy? Yes No

If so, what? _____

Do you experience (check all that apply):

Discharge from penis Ejaculation problem Genital pain Impotence Infection

Lump in testicles Poor libido (sex drive) Prostate enlargement Prostate infection

Other: _____ Other: _____

Any other hormone-related comments we should know? _____

THIS SECTION IS FOR WOMEN ONLY

Age at first period: _____ years

Are you periods now: Regular Irregular Heavy Scanty Spotting No periods

Date of last Thermography Scan _____ Results: Normal Abnormal

Date of last Pap Smear _____ Results: Normal Abnormal

Date of last Mammogram _____ Results: Normal Abnormal

Have you ever used birth control pills? Yes, when: _____ No

Are you taking the pill now? Yes No

Are you in menopause? Yes No *If yes, age of last period:* _____

Do you take: Estrogen Ogen Estrace Premarin Progesterone Provera

Other: _____ Other: _____

How long have you been on hormone replacement therapy (if applicable)? _____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS symptoms)? Yes No Not applicable

Have you ever been pregnant? Yes No

If yes:

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes No

Have you had other problems with pregnancy? Yes No

If so, please comment: _____

Do you experience (check all that apply):

Ovarian cysts Poor libido (sex drive) Endometriosis Fibroids Infertility Vaginal pain

Vaginal discharge Vaginal odor Vaginal itch Breast cysts Breast lumps

Have you had a Hysterectomy? Yes, Partial Yes, Total No

Any other hormone-related comments we should know? _____

Patient History

Answer the following questions to the best of your ability. If you do not know the answer, simply leave it blank.

HEALTH HISTORY		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does anyone in your family experience similar symptoms to yours? What is your birth order (i.e. first born, second, third, etc.)? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any history of kidney dysfunction?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you or any immediate family member have a history with cancer?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently having any thoughts of suicide?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a history of strokes?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been in an auto accident, fallen or received a major physical injury?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you in menopause?

MERCURY		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have amalgam (silver) fillings in your teeth? If Yes, How many? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had an amalgam removed? If Yes: How many? _____ When? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you had amalgams removed, was it done by a biological dentist using a safe protocol?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did your mother have amalgam when pregnant with you?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any dental crowns? If Yes, How many? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever worked in a dental office? If Yes, How long? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any dental crowns? If Yes, How many? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any bridges?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any root canals?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any tooth extractions?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any dental implants, retainers or other metal in your mouth? Explain: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did you wear contact lenses during the 1980's or early 1990's?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did you take oral contraceptives during the 1980's or early 1990's?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you noticed any adverse reactions to any shots?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any tattoos with red ink?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat large amounts (more than twice weekly) of tuna, shark, swordfish or Atlantic Salmon?

LYME DISEASE		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been diagnosed with Lyme Disease?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had dry sockets or infected tooth extractions?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have small joint pain?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been bitten by a tick or recluse spider?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever seen a bulls-eye rash appear on any part of your body? <i>If Yes, Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was your mother ever diagnosed with Lyme Disease?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been diagnosed with Chronic Fatigues Syndrome, Fibromyalgia, Lupus, Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), or an Autoimmune condition?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

LEAD		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your occupation involve soldering or metal salvage?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you done any home repair or sandblasting? <i>If Yes, when?</i> _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you do a lot of painting?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was your home built before 1978?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever worn cosmetics containing kohl? (make-up with dark black or red pigment)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you around a lot of fake leather or vinyl?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you get stomach aches in the morning?

MOLD		
How old is the house you are living in? _____ How long have you lived there? _____		
Have you noticed any new symptoms since moving in? _____ <i>If so, what?</i> _____		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you see mold growing at home, work or school?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had water damage at home, work or school?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your home, workplace or school have a damp or mildew smell?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does spending time in your basement cause or worsen your symptoms?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your basement ever get wet?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a crawl space?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your basement or crawl space have a sump pump?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your car have a mildew smell?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does anyone in your home have asthma-like or respiratory symptoms?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does anyone in your family have chronic sinus infections or irritations?

GENERAL TOXICITY		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever lived near, on or by a golf course, freeway or tension wires? <i>If Yes, please explain:</i> _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you smoke or use tobacco?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, household cleaning products, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have your house sprayed with pesticides for pest control?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you spray herbicide (weed killers) in or around your home?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use conventional insect repellants on yourself or family?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use conventional sunscreen?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use conventional perfume or cologne?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you get your hair colored? <i>If Yes, is it on the scalp?</i> _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use aerosol hairspray?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you get your nails done? <i>If Yes, how often?</i> _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use air freshener in your house, work or car?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you drink filtered water? <i>If Yes, what type of filter do you have?</i> _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you drink bottle water? <i>If Yes, what kind?</i> _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a water filtration system for your entire house or shower filtration? <i>If Yes, what type?</i> _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your spouse or other family members work around chemicals?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can you think of any other toxic exposures you may have had? <i>If Yes, explain:</i> _____

MICROBIOME HEALTH		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you get distention, bloating, feeling full and / or a noisy gut after eating healthy carbohydrates such as lettuce, broccoli, Brussels sprouts or other vegetables?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you often have gas that has a sulfur or foul smell?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you sensitive to supplements?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been vegan or vegetarian for any length of time?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can you tolerate meat?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you taken birth control or Hormone replacement therapy for any length of time?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have been on antibiotics for any extended period of time or often as a child or adult?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Were you caesarian delivered?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Were you breast fed? <i>If so, how long</i> _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your gut temporarily feel better after a round of antibiotics?

NEUROTOXIC QUESTIONNAIRE

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

POINT SCALE		
0 = Never had the symptom	2 = Occasionally have it, severe effect	4 = Frequently have it, severe effect
1 = Occasionally	3 = Frequently have it, mild effect	5 = Constantly have it, severe effect

COLUMN #1

	Anxiety
	Mood Swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5°)
	Insomnia (can't get to sleep or return to sleep)
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms / thoughts of suicide
	Sensitivity to sound
	Dyslexia or loss of place while reading, even as a child
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Dry skin
	Indecisiveness
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Floaters, shadows or swimmers when you read or look into the sky

COLUMN #2

	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Blurred vision at times
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Bad night vision or seeing halos around light
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep
	Receive static shock more often and with more dramatic effect than normal (doorknobs, car, light switch, people)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain-not necessarily true arthritis-can more from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athlete's foot, warts, jock itch, candidiasis

	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)
	Total of Column 1

	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)
	Total of Column 2

	TOTAL OF COLUMNS 1 + 2
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CHECK HERE if you have lab results, imaging, and/or treatment plans from the past 1-2 years for Dr. Schwartz to review. Please send this paperwork to us: staff@triadhealthcenter.com

YOU HAVE COMPLETED YOUR INTAKE FORMS

Please return your completed PDF file to us by email at least 24 hours prior to your scheduled appointment time: staff@triadhealthcenter.com