



Dr. John R. Schmitt
Chiropractic Physician

182 Wind Chime Court
Raleigh, NC 27615
(919) 847-3555
Fax (919) 847-5338

Dear Valued Patients and Friends,

We at Triangle Wellness and Sports Center strive to provide the best health care available and bring you as close as possible to your optimal health. As you know, there are numerous factors that contribute to one's state of health, some that we can control, some that you must control and some that cannot be controlled at all. For our part, we evaluate and correct structural abnormalities and food and chemical sensitivities. We look for functional deficiencies in the digestive, elimination, endocrine, and immune systems. Nutritional needs are assessed, supplementation is suggested as needed, and dietary recommendations and other information are given to help you improve your own state of health. Of course, we do not claim to have the answer to every problem, but we do claim to give you the very best that we have to offer each time you are seen.

As many of you already know, the best that we have to offer is the system of Applied Kinesiology which is one of the best available health care systems anywhere in the world. Applied Kinesiology is a method of evaluation and treatment by which we can determine and then correct the cause of less-than-optimal health. We then tailor a program specific for you. The techniques utilized at Triangle Wellness and Sports Center are at the forefront of the profession, reflecting the latest research and highest level of knowledge available. Patients who have been with us for any period of time have seen our growth and development reflected in the constant improvements and innovations in our treatment protocol, ultimately affecting the impact we have on your health.

Much thought has been given as to how to best deliver our service. The enclosed material should give you a better understanding of our center. We expect and trust that our services will meet your highest expectations.

Triangle Wellness and Sports Center's doctors and staff are dedicated to serving you and we are proud of our reputation for putting you and your health first. We feel this awareness is one of the most important contributors to our success in improving the health of the people we serve. We look forward to your visit.

Yours in Health,

PLEASE COMPLETE THE ENCLOSED FORMS AND BRING THEM WITH YOU.....THANK YOU

Triangle Wellness and Sports Center P.A.

Date_____

Referred by_____

Name_____

Phone_____

Address_____

Age_____ Date of Birth_____

SS#_____

Sex_____ Marital Status S M W D sep

Spouses Name_____

Employer_____

Spouses Emp_____

Address_____

Address_____

City State Zip_____

City State Zip_____

Telephone_____

Telephone_____

Please give your card for photo copy:

Insurance information:

Spouse insurance information:

Company_____

Company_____

Policy #_____

Policy #_____

Group #_____

Group #_____

Phone #_____

Phone #_____

Payment Policy:

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that it is a service of this office to assist in the preparation of any necessary reports and forms in making collection from the insurance company and I may be charged clerical fees. I authorize this office to release any information needed upon request from the insurance carrier. Any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

The payment policy is as follows:

Payment in full is expected at the time of services rendered. The charge for professional time is up to \$180 an hour. Charges will be broken down on the bill along with diagnosis and treatment codes. You are responsible for filing your own insurance with the receipt provided to you. Reimbursement and allowance is determined by your insurance company.

Office policy:

This office retains the right to charge for missed appointments. Should I become inactive by discontinuing my care. I understand that any charges payable to this office will be due immediately. Outstanding balances not paid will be sent to a collection agency and 10% will be added to your account.

Patients signature_____

Date_____

Your appointments are as follows:_____

PLEASE BRING A URINE SPECIMEN FROM FIRST THING IN THE MORNING BEFORE EATING!

DR. JOHN R. SCHMITT

BS, University of Colorado, 1978
Doctor of Chiropractic, Logan College, 1982
Post Doctoral training: Applied Kinesiology
Research Chairman, NCCA, 1991-93
Alternate, North Carolina Board of Chiropractic Examiners, 1993-present
Practicing in the Triangle Area since 1983



Welcome to Triangle Wellness and Sports Center!

We offer an individually designed assessment and treatment giving you the opportunity to plan your goal of optimal health. Our doctors utilize the most advanced and current research techniques in Applied Kinesiology. I urge you to take advantage of the excellent resources available to you at Triangle Wellness and Sports Center and always welcome your comments for expanding our facets of care. It is our privilege to assist you in your quest for health.

Services offered at our center include:

- *Applied Kinesiology/Chiropractic Care
- *Dietary and Nutritional Assessment
- *Acupuncture
- *Massage Therapy
- *Yoga Classes
- *Health Lecture Series

Applied Kinesiology in Chiropractic

Chiropractic is the largest natural health care profession in North America. As primary health care providers, chiropractors provide portals of entry into the health care field. Traditional chiropractic is based on the relationship between spinal alignment and health. Applied Kinesiology (AK) utilizes specialized techniques to fine tune your spinal/structural alignment and to analyze the body's muscles, organs, acupuncture circuits, nutrition, and emotional state. By combining specific muscle tests and other AK procedures with traditional diagnostic methods, we can evaluate the status of your health and identify functional deficiencies often before the development of full blown symptoms of illness.

The Applied Kinesiologist's approach to health care is unique in the health care industry. Our typical patients have spent a long time unsuccessfully seeking relief with treatments from all types of health care professionals. Their chronic illnesses include neuromuscular-skeletal disorders, digestive disorders, allergies, hormonal imbalances, learning disabilities, and various recurring illnesses.

The ages of our patients extend from ten days old through 94 years old. Over 20% of our practice is comprised of preteen children. Our experience has shown that children who have the opportunity to benefit from AK have a high ability to achieve their full potential in all phases of growth and development.

We believe that early intervention is the key to you and your family's health and encourage you to take the first step at Triangle Wellness and Sports Center.

POLICIES
(Effective Date: February 1, 2007)

*Fee for Doctor's services is up to \$180.00 per hour. More or less time will be pro-rated.

*Payment is expected at the time services are rendered.

*Billing statements will be provided for you and your insurance carrier.

*Payment for supplements mailed is due within one week of receipt. If payment is not received by that time, payment for future supplements will be requested prior to shipping.

*If a billing statement for monies owed on your account must be sent to you, a \$10.00 administrative fee will be added to the outstanding balance per billing cycle.

*This office reserves the right to charge a minimum of \$25.00 to you, your insurance company for doctor's time in preparing reports, e.g.: disability forms, insurance requests.

*\$15.00 charge for returned checks.

If an appointment is cancelled without notice of within 24 hours, this office reserves the right to charge at least a minimum of an office visit (up to \$270.00)

Triangle Wellness Center P.A.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. Other than the uses and disclosures below, we will not sell or provide any of your health information to any outside marketing organization.

We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply for all of your health information in our files, and we will notify you in writing if/when you come in for treatment.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A correspondence should be addressed to:

Attn: HIPAA Compliance Officer, Triangle Wellness Center , 182 Wind Chime Court, Suite 203, Raleigh, NC 27615

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health information:

1. We may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run our practice.
4. We may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you(i.e. test results). 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you regarding your case at this office. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives and etc.)

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individual, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. We are providing health care services to you based on the orders (referral) of another health care provider.
2. We provide health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding how/where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

AMENDING YOUR HEALTH INFORMATION

You have the right to inspect the health information contained in your files while in our office and/or have a copy made for you. The health information is available up to seven years from the date that the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/or have them copied. There will be a charge of \$.50 per page copied.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- required for your treatment, to obtain payment for services, to run our practice, and/or made to you.
- necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- for national security, intelligence purposes, or law enforcement officers.
- that were made prior to the effective date of the HIPAA privacy law (April 14, 2003)

We will provide the first accounting within a 12 month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave S.W., Room 509F, HHH Bldg, Washington, D.C. 20201

This notice is effective as of January 1, 2003. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

Patient Name Printed

Date

Patient Signature

Authorized Staff Person

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient.

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Patients signature _____ Date _____

Your appointments are as follows: _____, _____, _____

PLEASE BRING A URINE SPECIMEN FROM FIRST THING IN THE MORNING BEFORE EATING!

DIRECTIONS TO:

**Triangle Wellness and Sports Center
182 Wind Chime Court, Suite 203, Raleigh, NC 27615
(919) 847-3555**

We are conveniently located off of Six Forks Road 2 1/2 miles north of I-440.

1. From Durham or from I-540: Take Highway 70-E (Glenwood Avenue). Continue east on Rt. 70 for about 3 miles after I-540. You will pass Pro Golf Shop, Eastman's Carpets, the Wicker Outlet and Capel's Carpets-all on your right. At the bottom of the hill, just past these businesses, is the stoplight for Lynn Road. Turn left on Lynn Road. Continue on Lynn Road for approximately 5 miles to the stoplight for Six Forks Road. Turn left on Six Forks Road. Go 1/2 mile to Wind Chime Court. Turn right at Wind Chime Court. **** (Just before Wind Chime court you will pass Wood Bend Road on your right) At the end of the Cul de Sac there are two driveway entrances to Wind Chime Plaza-one to the left, the other straight ahead. Go straight, then immediately turn right. We are in the second building on your left-Suite 203.

****You can now take I-540 from I-40 to Six Forks Road (Exit 11). Take Six Forks Road south. You will go through 5 stop lights: 1-New Road, 2-Strickland, 3-Forum, 4-Sawmill, and 5-Newton Road. After the light at Newton Road, you drive down a slight decline then up a hill. At the top of the hill on the left side, is Wind Chime Court. (Approx. 2 1/2 miles)

2. From Chapel Hill: Take I-40 E to Exit 283 I-540 to Highway 70 E. Directions continued in #1 above.

3. From I-85 South or I-40 West--West or Southwest of Raleigh: Stay on I-440 when these two interstates split. Take Exit 283 I-540 to Highway 70 E (Glenwood Avenue) Directions continued in #1 above.

4. From I-95 South or I-40 East of Raleigh: Take I-40 to Raleigh. Take I-440 N around Raleigh to Six Forks Road N. Take Six Forks Road 2 1/2 miles to Wind Chime Court. You will pass busy intersections at Millbrook Road and Lynn/Spring Forest Road. Turn right at Wind Chime Court. (Just before Wind Chime Court, you will pass Wood Bend Road on your right) At the end of the Cul de Sac there are two driveway entrances to Wind Chime Plaza - one to the left, the other straight ahead. Go straight, then immediately turn right. We are in the second building on your left- Suite 203.)

Triangle Wellness and Sports Center P.A.

Patient Name: _____

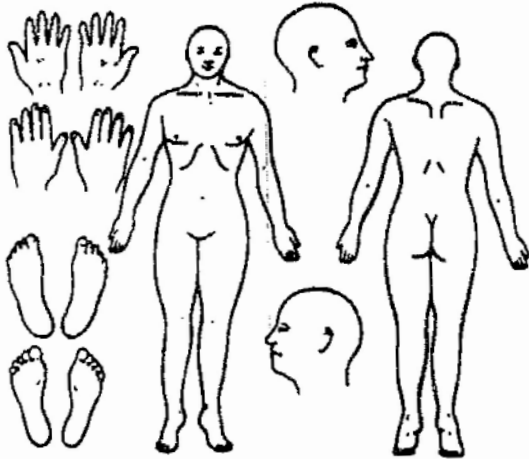
Date: _____

Age: _____ Date of Birth: _____

Referred by: _____

!!! leave no blanks please. If the question does not apply indicate N/A !!!

Please outline on the diagram the areas of discomfort and describe: (mark these symbols on diagram)



Sharp **XXX** Dull **000** Stabbing **VVV**
 Burning **///** Numbness **+++**

Chief complaint: _____

Indicate pain intensity on this scale with an x

0 _____ 10
 no pain mild moderate severe

Secondary complaint: _____

Describe injury / problem: _____

Indicate pain intensity on this scale with an x

0 _____ 10
 no pain mild moderate severe

Does pain radiate into arms or legs? _____

Have you had this before? describe : _____

Please indicate which factors affect your trouble: no effect worse better

Standing _____

End of day _____

Resting _____

Movement _____

Walking _____

Laying down _____

First thing in morning _____

Other _____

Describe other methods used to relieve discomfort ie. other doctors, medicine, heat ice etc., and result:

Describe other symptoms that you are currently suffering ie. headaches, nausea, intestinal distress, irritability etc.

Triangle Wellness and Sports Center P.A.

Patient Name: _____

Date: _____

Family History: indicate mother, father, sister, brother have had: (otherwise N/A)

Diabetes _____

High blood pressure _____

Cancer _____

Heart disease _____

Arthritis _____

Other _____

Past History:

Do you smoke? _____ years _____ packs day _____ around people who smoke? _____

Birth control pills? _____ how long? _____

List any Major diseases of which you have suffered or are currently suffering (give dates of diagnosis): _____

List all surgeries and hospitalizations (dates): _____

Date of beginning of last menstrual period (females): _____

Medications you are currently taking: _____

Circle if you use:

alcohol white bread caffeine deli meats sugar equal sweet&low tap water
margarine fast food sodas aspirin / Tylenol antacids laxatives hormone replacement

Known Allergies: _____

History of trauma:

Describe physical, emotional trauma and/or chemical exposures: _____

Please indicate any additional information that you feel useful here:

FOOD INTAKE

NAME: _____

DATE: _____

How many of each do you eat per week? Estimate as best as you can. Write number in each box.

	Srvgs/Wk
DAIRY	
Whole Milk	
Skim Milk	
Buttermilk	
Half & Half/Cream	
Yogurt	
Cheese	
Kind(s)	
Ice Cream	
Eggs	
MEAT/POULTRY/FISH	
Poultry	
Fish	
Other Seafood	
Beef	
Pork	
Bacon	
Liver	
Bologna or Cold Cuts	
Canned Meat	
NUTS & SEEDS	
Peanuts	
Peanut Butter	
Others: (Specify)	
GRAINS	
Cereals	
Sugar Coated Cereals	
Oatmeal	
Pancakes	
Waffles	
Crackers	
Rice	
Macaroni	
Spaghetti	
Slices of White Bread	
Slices of Wheat Bread	
Slices of Rye Bread	
Slices of Corn Bread	
Rolls	
Sweet Rolls & Muffins	
DESSERTS/SWEETS	
Pie	
Cake	
Cookies	
Doughnuts	
Jello	
Candy	
Chocolate	
Sweets most commonly eaten:	
VEGETABLES	
Asparagus	

Beans, Dried or String	
Brussel Sprouts	
Broccoli	
Cabbage	
Carrots	
Celery	
Cole Slaw	
Corn	
Green or Bell Peppers	
Green Peas	
Greens, Turnip etc.	
Lettuce	
Parsley/Cilantro	
Potatoes, White	
Potatoes, Sweet	
Squash, Summer	
Spinach	
Squash, Winter	
Onion	
Tomatoes	
Yams	
Others: (Specify)	
FRUITS	
Apples	
Applesauce	
Apricots	
Bananas	
Dates	
Figs	
Grapefruit	
Oranges	
Pears	
Pineapple	
Prunes	
Canned Fruits	
Dried or Frozen Fruit	
Type:	
Others: (Specify)	
BEVERAGES	
Colas	Glasses/wk
Uncolas	
Kool Aid, Etc.	
Orange Juice	
Grapefruit Juice	
Grape Juice	
Tomato Juice	
Others: (Specify)	
Alcoholic Beverages	
Type:	
Coffee	
Decaffeinated, Sanka	

Tea		
Herbal Tea		
Cream in coffee, tea, etc	Y	N
White sugar in coffee	Y	N
# Tsp/day		
Artificial Sweeteners	Y	N
Honey	Y	N
Water		
Tap Water	Y	N
FATS		
Pats of Butter		
Pats of Margarine		
What Vegetable oils, fats or other compounds do you use in cooking?		
What salad oil(s) do you use?		
Recent Meals & Habits		
What did you eat yesterday for Breakfast?		
What did you eat yesterday for Lunch?		
What did you eat yesterday for Dinner?		
What did you eat yesterday for Snacks?		
What beverages did you have yesterday?		
Do you use Salt (✓)		
Sparingly		
Moderately		
Freely		
Do you use Vinegar (✓)		
Sparingly		
Moderately		
Freely		
Is this your average diet for the past 3 or 4 years?	Y	N
What foods, if any disagree with you?		
Do you have/Are you:	Yes	No
Indigestion		
Fond of Bread		
Fond of Cereals/Grains		
Fond of Fried Foods		
Fond of Salty Foods		
Fond of Sweets		
Fond of Meats		
Fond of Fruits		
Fond of Vegetables		
Fond of (Specify)		

MSQ - Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale:

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Frequently have it, effect is not severe

3 = Occasionally have it, effect is severe

4 = Frequently have it, effect is severe

Digestive Tract	___ Nausea or vomiting	Total	Lungs	___ Chest Congestion	Total
	___ Diarrhea			___ Asthma, bronchitis	
Ears	___ Constipation	Total	Mind	___ Shortness of breath	Total
	___ Bloating Feeling			___ Difficulty Breathing	
Emotions	___ Belching or passing gas	Total	Mouth / Throat	___ Poor memory	Total
	___ Heartburn			___ Confusion, poor comprehension	
Energy & Activity	___ Itchy Eyes	Total	Nose	___ Difficulty in making decisions	Total
	___ Ear aches, ear infections			___ Stuttering or stammering	
Eyes	___ Drainage from ear	Total	Skin	___ Slurred speech	Total
	___ Ringing in ears, hearing loss			___ Learning disabilities	
Head	___ Mood Swings	Total	Weight	___ Chronic coughing	Total
	___ Anxiety, fear or nervousness			___ Gagging frequently; need to clear throat	
Heart	___ Anger, irritability or aggressiveness	Total	Other	___ Sore throat, hoarseness, loss of voice	Total
	___ Depression			___ Swollen or discolored tongue, gums, lips	
Joints & Muscles	___ Fatigue, sluggishness	Total	Grand Total	___ Canker sores	Total
	___ Apathy, lethargy			___ Stuffy nose	
Eyes	___ Hyperactivity	Total	Skin	___ Sinus problems	Total
	___ Restlessness			___ Hay fever	
Eyes	___ Watery or itchy eyes	Total	Weight	___ Sneezing attacks	Total
	___ Swollen, reddened or sticky eyelids			___ Excessive mucus formation	
Head	___ Bags or dark circles under eyes	Total	Skin	___ Acne	Total
	___ Blurred or tunnel vision [does not include near or far sightedness]			___ Hives, rashes, or dry skin	
Head	___ Headaches	Total	Weight	___ Hair loss	Total
	___ Faintness			___ Flushing or hot flashes	
Heart	___ Dizziness	Total	Other	___ Excessive sweating	Total
	___ Insomnia			___ Binge eating/ drinking	
Heart	___ Irregular or skipped heartbeat	Total	Weight	___ Craving certain foods	Total
	___ Rapid or pounding heartbeat			___ Excessive weight	
Joints & Muscles	___ Chest Pain	Total	Other	___ Compulsive eating	Total
	___ Pain or aches in joints			___ Water retention	
Joints & Muscles	___ Arthritis	Total	Other	___ Underweight	Total
	___ Stiffness or limitation of movement			___ Frequent illness	
Joints & Muscles	___ Pain or aches in muscles	Total	Other	___ Frequent or urgent urination	Total
	___ Feeling of weakness or tiredness			___ Genital itch or discharge	

HEALTH APPRAISAL - BRIEF

NAME _____

DATE _____

CIRCLE the number which best describes the **frequency** of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Point** box. The score for YES is the number inside the parenthesis ().

(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily or several times a day

PART I

Section A

1. Indigestion	0	1	2	3
2. Belching, burping	0	1	2	3
3. Gas immediately following a meal	0	1	2	3
4. Sense of fullness during meals	0	1	2	3
5. Poor appetite, picky eater	0	1	2	3
6. Difficult bowel movements	0	1	2	3
7. Difficulty swallowing	0	1	2	3
8. History of anemia, unresponsive to iron	N			Y (10)
9. Vegetarian (no eggs, dairy)	N			Y (5)
10. Spoon shaped nails	N			Y (3)
11. Unintentional weight loss	N			Y (3)
12. Partial loss of taste or smell	N			Y (3)

Total Points _____

Section B

1. Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
2. Pain, tenderness, soreness on left side under rib cage	0	1	2	3
3. Bloating	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Abdominal cramps, aches	0	1	2	3
6. Nausea and/or vomiting	0	1	2	3
7. Specific foods/beverages aggravate indigestion	0	1	2	3
8. Roughage and fiber causes constipation	0	1	2	3
9. Three or more large bowel movements daily	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Undigested food in stool	0	1	2	3
12. Mucus in stool	0	1	2	3
13. Dry, flaky skin, dry brittle hair	N			Y (3)
14. Difficulty gaining weight	N			Y (3)

Total Points _____

Section C

1. Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2. Feeling hungry an hour or two after eating	0	1	2	3
3. Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
4. Heartburn, especially when lying down, bending forward	0	1	2	3
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6. Difficulty or pain when swallowing	0	1	2	3
7. Chest pain or infections, difficulty breathing	0	1	2	3
8. For relief from carbonated beverages, cream/milk/food	0	1	2	3
9. Constipation	0	1	2	3
10. Black, tarry stool	0	1	2	3

Total Points _____

Section D

1. Lower abdominal pain, cramping and/or spasms	0	1	2	3
2. Lower abdominal pain relief by passing stool or gas	0	1	2	3
3. Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
4. Diarrhea (loose watery stool)	0	1	2	3
5. More than three bowel movements daily	0	1	2	3
6. Excessive gas and bloating	0	1	2	3
7. Painful, difficult, straining during bowel movements	0	1	2	3
8. Hard, dry or small stool	0	1	2	3
9. Extremely narrow stools	0	1	2	3
10. Alternating diarrhea/constipation	0	1	2	3
11. Mucus, pus in stool	0	1	2	3
12. Feeling that bowels do not empty completely	0	1	2	3
13. Bright red blood following bowel movement	0	1	2	3
14. Anal itching	0	1	2	3

Total Points _____

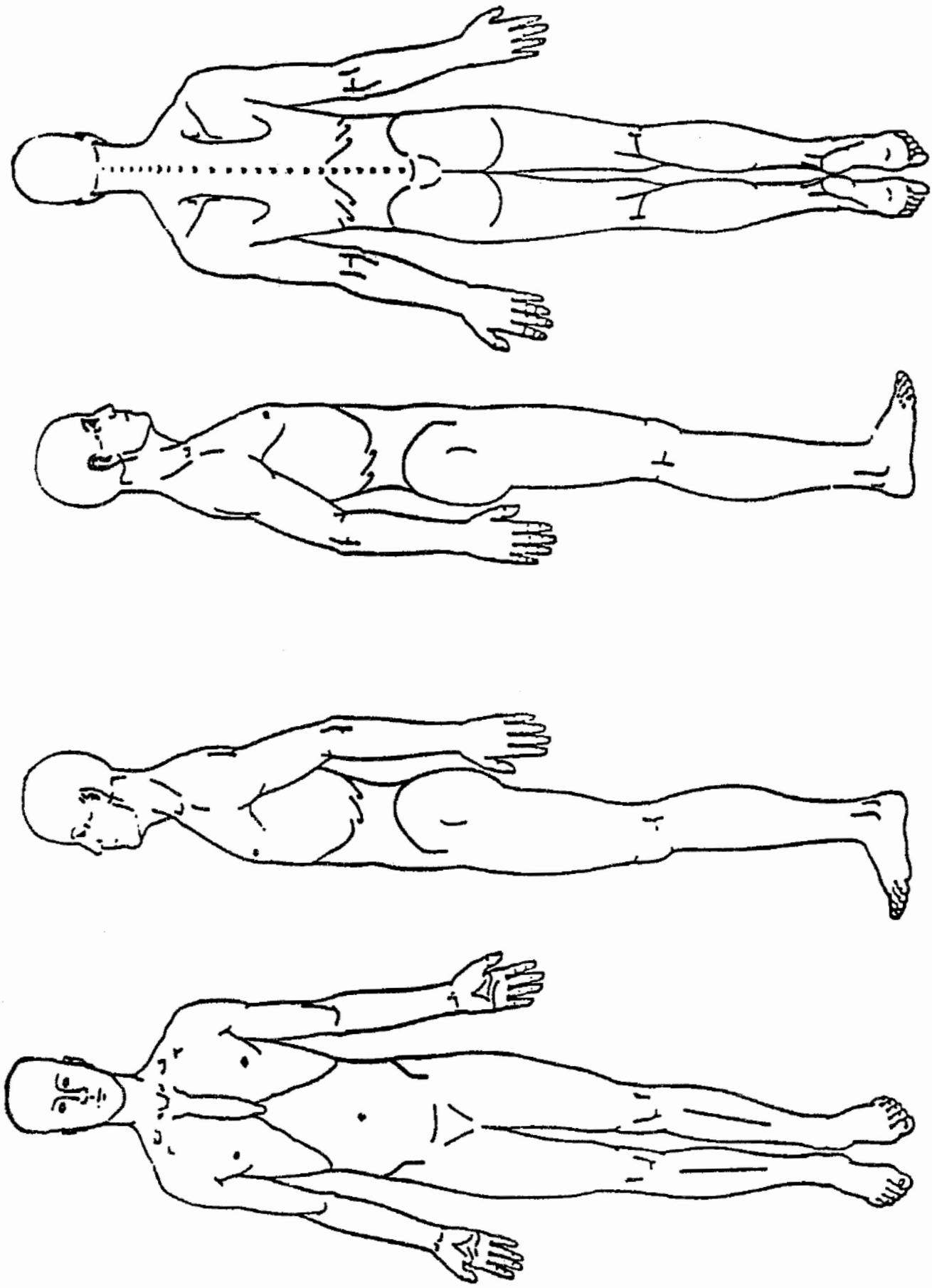
PART II.

Section A

1. Moderate to severe pain under right side of rib cage	0	1	2	3
2. Abdominal pain worsens with deep breathing	0	1	2	3
3. Regurgitate bitter fluid	0	1	2	3
4. Bloating, full feeling	0	1	2	3
5. Belching, heartburn, gas	0	1	2	3
6. Fatty foods cause indigestion	0	1	2	3
7. Nausea or vomiting	0	1	2	3
8. Feel restless, agitated	0	1	2	3
9. Unexplained itchy skin worse at night	0	1	2	3
10. Stool color alternates from clay colored to normal brown	0	1	2	3
11. Feeling of poor health	0	1	2	3

12. Fatigue, weakness, exhaustion	0	1	2	3
13. Unable to concentrate, irritable, confused	0	1	2	3
14. Swollen feet and/or legs	0	1	2	3
15. Easy bruising	0	1	2	3
16. Feeling of extreme dryness	0	1	2	3
17. Reddened skin, especially palms	0	1	2	3
18. Dark urine, diminished flow	0	1	2	3
19. Dry, flaky skin, hair	N			Y (3)
20. Yellowish cast to skin, eyes	N			Y (3)

Total Points _____



HISTORY OF INJURY

PLEASE MARK WITH AN "X" ALL THE PLACES ON YOUR BODY WHICH HAVE EVER BEEN INJURED
(SPRAINS, BROKEN BONES, SEVERE BRUISES, FALLS AND SURGICAL SCARS, ETC.)