INTEGRATED
NUTRITION OF MOUNT KISCO

Thank you!

You are probably aware that Dr. Michael Wald is likely the most qualified clinical nutritionist in the United States, if not the most qualified (see last page for Dr. Wald's credentials). Not all clinical nutritionists are alike and we thank you for making the smart and informed choice by choosing Dr. Wald to help you get well. Dr. Wald is available to you 24-7 via email and cell phone. Let's get you on the road to health by starting with the attached important paperwork.

Please bring this paperwork with you to your first appointment with Dr. Wald.
We are looking forward to being of service!

Welcome!

Thank you for taking this first step towards improving your health naturally. Enclosed is important paperwork that will start you on your way to wellness.

- Please fill it out as completely as you can.
- Leave questions blank if you are uncertain of your answers.
- Mail this information to us prior to your first appointment if possible, or bring it with you. You may scan in and e-mail the completed document to: info@intmedny.com
- If you do not complete this paperwork for any reason prior to your first appointment, please arrive at our office 20 minutes earlier than your scheduled appointment time (unless your appointment is 9:00 AM) to complete or receive new paperwork. Due to scheduling difficulties, we can only provide you with your scheduled appointment time; therefore, if you are late or need to complete your paperwork, your appointment time will necessarily be adjusted (shortened) accordingly.
- 24-hour Cancellation notice is required - there will be a charge of $175 for cancellatioins and/or no shows if not cancelled within 24 hours of scheduled appointment. Each cancellation given with less than 24-hours notice will be charged an additional fee of $175. Your new patient deposit is non-refundable, but fully applied to your new patient visit if you cancel your new patient appointment, and reschedule within sixty days, your deposit will be fully applied to your new patient visit on a one-time basis only.

It is not necessary for you to fast before your appointment. Continue to take any prescription medication as prescribed, but inform the nurses at the time of your blood draw.

OVERALL GOAL

The overall goal of your first visit is to assess your health needs. To do this, Dr. Wald will conduct a thorough health history, possibly physical exam and testing. Based upon your first visit with Dr. Wald all agreed upon test will be performed after your visit in our office. We may refer you to an outside testing facility if needed. You are free to accept or deny any testing, testing companies or treatments.

WHAT TO EXPECT

During your initial visit you will meet with Dr. Michael Wald (the nutritional director) for nutrition work regarding weight loss, healthy weight gain, chronic and acute disease care and more. Dr. Wald is a doctor of chiropractic and clinical nutritionist. He is double-board certified in nutrition and licensed as a dietician-nutritionist. In addition he holds multiple certifications and diplomas in the areas of health and nutrition, including an MD degree. However, Dr. Wald is not a licensed medical doctor. Please

refer to our office website (www.intmedny.com) for further clarifications under the section Q&A (Schedule as a New Patient).

APPOINTMENT LENGTH AND COST

Your initial consultation and examination will take one to three hours and costs $430.00. Your second visit (follow- up) is forty-five minutes to one hour in length and the cost is $275. It is during the follow-up visit that most or all test results are reviewed and the bulk of recommendations are provided. The cost for future nutritional consultations (as necessary) are $125. Our office requires payment in full at the time services are rendered with the exception of covered laboratory tests (see below). Standard follow-up appointments are 30 minutes in length. If you should require extra time you will be charged $75 additional for each 30-minute interval and a minimum of $75 if your standard appointment exceeds or meets 45 minutes in length. We reserve the right to change our fees without notice. A new patient appointment deposit of $175 is fully applied to your new patient first appointment as described on our website at: www.intmedny.com on the contact page.

REGARDING LABORATORY TESTING

Laboratory testing is frequently recommended. Tests may include regular blood work if you have not had blood work within the last 3 months, but this decisions is based upon your specific needs. If you have had blood work performed within this time frame, we welcome you to bring it with you. Additional specialized tests may be recommended based upon your personal and family history as well as health goals. All testing requires you prior approval before blood is drawn. Depending upon your health concerns this may be permissible and our health care providers will make our best-educated efforts to improve your health in this instance. We are not responsible for lab tests costs not covered by your insurance company.

PAYMENT

We kindly request a payment of $175.00 to hold our first (new patient) appointment slot; the reason for this policy is to ensure that those that seek us out are the most serious of individuals. This down payment is NOT refundable, but it's fully credited in full towards your first visit fee. If you cancel your first appointment this fee is not refundable. If you re-schedule your first appointment within one month this fee is fully transferrable. Our office requires that payment be made for services rendered at the time of your visit. Please be prepared to pay for your visit fees with a check, credit card, or cash. Checks will not be held for future deposit. Our office cannot maintain a balance-due for services rendered. Our fee for bounced checks will be no less than $35. If paying by check, please bring more than one check since certain laboratory testing fees require separate payments directly to the laboratory. Some or all of your visit fees may be reimbursable to you by your insurance company. Our front desk will provide you with the receipts you need to submit to your insurance company. Our full policy regarding your new patient appointment can be found on our website at the point-of-sale on the contact page at www.IntMedNY.com. Dr. Wald is non-participating in insurance plans including Medicare (he has "opted out") which means he cannot submit services (charges) to Medicare for reimbursement.

MORE ABOUT OUR PAYMENT POLICIES: NEW PATIENT VISIT DOWNPAYMENT

Thank you for scheduling an appointment with Dr. Michael Wald of Integrated Nutrition of Mount Kisco and Blood Logic, Inc. We are happy to schedule your New Patient Appointment and require a deposit of $175.00; this downpayment is fully credited towards your new patient visit and is non-refundable* and is applied in full towards your new patient visit fee of $430.00 towards your New Patient Appointment scheduled within 60 days of your $175.00 down payment.

Dr. Michael Wald is a sought after health professional with limited time to see new patients. If you should cancel your appointment your down payment will be applied in full towards a rescheduled new patient appointment visit, on a one-time basis only, when you re-schedule your new patient visit within 60-days of your initial new patient down-payment; after 60 days your new patient downpayment will be forfeit entirely and will not be applied to a new patient visit if you should re-schedule after 60 days of your downpayment payment date.

Only one rescheduled new patient appointment is allowed, and it must occur within 60 days, from the date of your initial new patient downpayment. If you cancel a second new patient appointment your initial downpayment fee will be entirely forfeit even if we choose not to reschedule you for a new patient visit. Our office reserves the right not to reschedule a new patient appointment after your first cancellation. If we agree to re-schedule a new patient appointment for you after 60 days, or at anytime, you will be required to pay another new patient appointment down payment in the amount of $175.00.

NEW PATIENT VISIT

All payments for visits and services paid during your New Patient Appointment are non-refundable for any reason. Your payment is an acknowledgement of your complete satisfaction and agreement of our non-refund policy. Currently, the full New Patient Visit fee is $430.00, but is subject to change without prior notice.

FIRST VISIT INSTRUCTIONS

- ✔ Bring in all completed paperwork for your first appointment.
- ✔ Bring a list of vitamins, supplements and medications you are taking. It is not necessary to bring the bottles themselves.
- ✔ PLEASE drink liberal amounts of plain water prior to your appointment as you may be performing urine testing as well.
- ✔ Please do not wear perfume or cologne (as some of our patients and staff may be chemically-sensitive).
- ✔ Continue taking any prescription medication(s).

Thank You!

_____ _____

Patient's Acknowledgement Signature Required Today's Date

_____

Print First and Last Name Here

GENERAL INFORMED CONSENT

I have sought the medical and health care services of Integrated Nutrition of Mt. Kisco (INMK) for my personal healthcare or for my child or children who are minors. I understand that this practice uses some diagnostic and treatment methods that are known as complementary, alternative, or holistic, and may not be covered by my insurance plan, or generally accepted by mainstream medicine. The terms complementary, alternative, and holistic refer to therapies that may include, but are not limited to, dietary and nutritional supplement advice, and various diagnostic/testing procedures. Furthermore, the information gained from laboratory and other tests may be interpreted differently from mainstream medical doctors. Approaches for improving general health and nutrition may be based upon the tests/evaluations and philosophies of complementary medicine and may or may not be consistent with mainstream medical tests/evaluations and philosophies.

Foods, vitamins, minerals, enzymes, herbs, and other nutritional approaches may be advised as a stand-alone therapy or as adjunctive to medical therapies. Not all vitamin-drug (medication) reactions can be predicted, have been well-proven or may not apply to you; we reserve the right to apply our independent judgment regarding the use of vitamins, minerals, herbs and other nutritional products with or without medications that you may be taking or will take, or that may be recommended by us. It is your responsibility to follow our supplement (nutritional) advice exactly and to inform us of any changes you make on your own, or at the advice of health care providers as adverse or unintended or dangerous consequences may result.

Our office and its employees make no representations, claims, or guarantees regarding the efficacy of our treatment recommendations. The treatments we recommend are based upon a combination of our clinical experience and knowledge of scientific and medical literature. With this information, individualized treatments may be offered and applied as either adjunctive (complementary) or primary treatments for various symptoms and disease states.

By signing this informed consent you agree to hold harmless Integrated Nutrition of Mt. Kisco, Dr. Michael Wald and its employees from all professional and personal liability. You agree to be responsible for all legal costs and fees that may result from action(s) on your part or on the part of your representative(s) against us. If a legal case is brought against us, you agree that we shall be judged by the standards and principles of complementary, alternative, and/or holistic medicine and not the standards and principles of consensus conventional medicine. You have the right to have this consent reviewed by your lawyer before accepting any medical and/or nutritional services from this office. If you are investigating our office your are hereby requested to reveal your intensions at the beginning of your first appointment with Dr. Wald.

_____Initials

GENERAL INFORMED CONSENT (CONTINUED)

Our office makes available nutritional supplements and other health products. You are in no way obligated to purchase these products from our office or any other specific location or company. You may freely choose to purchase such products from any source(s) as you wish. INMK and its employees may profit from the sale of supplements and other products we make available to our patients.

Most insurance plans cover services that they consider medically necessary and/or reasonable and customary. Many of our services (nutritional consultations) are often not considered to be necessary by insurance companies based upon their own internal criteria. Our office does not accept insurance assignment and Dr. Wald has "opted out" of Medicare meaning that he cannot submit services to Medicare for reimbursement. By signing this form you accept full financial responsibility for all non-covered services; including consultations, blood and other laboratory tests and procedures.

SIGNATURE ON FILE: I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

Your signature verifies that you have not been told to discontinue treatments with any other medical specialists or other health care providers.

Your signature is being given prior to your accepting any services, advice, and/or recommendations whatsoever from IMMK, and your payment for services will serve as your unconditional acknowledgement of satisfaction with the services provided. This acknowledgement will serve as proof of our policy of no refunds of monies paid to this office in the form of cash, credit card, and personal check or by any other means.

It is the responsibility of the patient to follow-up with our office for results of all testing and laboratory procedures. It should not be assumed on the part of the patient that if they are not contacted by INMK, or its employees, or if the patient does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further medical treatments or advice. Health/medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations. Please schedule your follow-up appointment at the front desk after each and every consultation or visit to the office.

The patient is further notified that their insurance company may not cover some tests, or all. The patient assumes full responsibility for the costs of non-covered tests. IMMK does not assume responsibility for costs incurred regarding non-covered and/or potentially covered services, including procedures, laboratory tests (blood, urine, saliva, etc.) and consultations. If allowed by law, our office will not provide insurance collection services, but will commonly make reasonable attempts to provide letters of medical necessity and answer correspondences from your insurance company regarding your treatments.

By entering your signature below you are acknowledging that you understand all terms, verbiage (language) and concepts herein.

I understand this consent agreement and have executed it freely and willingly. If any portion of this new patient paperwork is considered unreasonable or non-enforceable in a court of law, all other aspects of this agreement shall remain in force.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY POLICY AND PRACTICES

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

• Payment means such activities as obtained reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health- related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other individual identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to health information.

This notice is effective as of April 14th, 2004, and we are required to abide by the terms of the Notice of Privacy

Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing such a complaint.

Please contact us, for more information. For more information about HIPAA or to file a complaint:
The US Department of Health and Human Services Office of Civil Rights
200 Independence Avenue, S.W. Washington, DC 20202
Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign and print your name and provide the date below to acknowledge that you have received, read, and understood our Notice of Privacy Practices. Please return it to our front office staff or mail it to:

Integrated Nutrition of Mt. Kisco, 86 Smith Avenue, Mt. Kisco, NY 10549

_____

Patient Name (Signed)

_____

Patient Name (Printed)

_____

Date

DEMOGRAPHICS

A. Identification

Name: _____Age: _____ Birth Date:___/___/ ___ Sex: M / F

Address: _____ City: _____ State/ZIP: _____

Phone (H): _____ (W): _____(C): _____

Occupation: _____

Email: _____ Fax: _____

Social Security # _____ How did you hear of us? _____

Family Status: Single / Divorced / Married / Widow(er) / Significant Other (circle one)

Emergency contact _____ Phone _____

B. Insurance Information

Insurance Company _____ Policy#: _____ Group name: _____

Insured's name (holder of policy): _____Insured's SS# _____

I authorize the release of medical information necessary to process this and related claims. I request payment to myself or to the party who provided the care.

Signature _____ Date: _____

C. Primary Care Provider

Do you have a primary care provider? Yes [ ] No [ ] If Yes, provider's information:

Name _____

Address _____

Address _____

Phone _____

HEALTH HISTORY

Please list your major problems and/or symptoms and the approximate date they began. If none, please write your reason for seeking this consultation. PLEASE RANK IN ORDER OF IMPORTANCE TO YOU.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

What are your expectations regarding what you would like our office to provide for you?

If you have seen other practitioners for these problems, indicate the results of these evaluations: Please indicate if you have had any of the following problems in the past. Please note years affected.

Alcoholism _____	Eating Disorder _____	Mental Illness _____
Allergies _____	Heart Disease _____	Migraine/Headache _____
Anemia _____	Herpes _____	Multiple Sclerosis _____
Arthritis _____	HIV _____	Pneumonia _____
Asthma _____	Hypoglycemia _____	Polio _____
Bleeding / Bruising _____	Hepatitis _____	Rheumatic Fever _____
Cancer _____	High Cholesterol _____	Stroke / TIA _____
Crohn's Disease /Colitis _____	High Blood Pressure _____	Seizures _____
Depression _____	Irritable Bowel _____	Stomach / Intestinal Ulcers _____
Diabetes _____	Kidney Disease _____	Tuberculosis _____
Digestive Disease _____	Lupus _____	Thyroid Disease _____
Drug Problems _____	Lyme Disease _____	Venereal Disease _____

Other _____

Hospitalizations and Surgeries (include dates) _____

Medications _____

Nutritional Supplements _____

EXERCISE ASSESSMENT

Do you currently participate in a resistance training program? _____

How long have you been following a regular (one or more times per week) resistance training program?

_____

How many times per week do you resistance train?

_____

How intense (or difficult) are your resistance training workouts?

_____

What types of resistance training exercises do you perform and how many of them can you perform with proper technique?

_____

NUTRITIONAL ASSESSMENT

Name:_____ **Date:** ____/____/____

Birthdate: _____ **Gender:** _____

Please list your five major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART I

Read the following questions and fill in the number that applies:

KEY: **0 (or leave blank) = Do not consume or use** **2 = Consume or use weekly**
1 = Consume or use 2-3 times/month **3 = Consume or use daily**

DIET

1. ____ Alcohol
2. ____ Artificial sweeteners
3. ____ Candy or other sweets
4. ____ Carbonated beverages
5. ____ Chewing tobacco
6. ____ Cigarettes
7. ____ Cigars/pipes
8. ____ Coffee
9. ____ Eat fast food regularly
10. ____ Fried foods
11. ____ Luncheon meats/ hot dogs
12. ____ Margarine
13. ____ Milk products
14. ____ Non-herbal tea
15. ____ Refined flour/ Baked goods
16. ____ Refined sugar
17. ____ Vitamins and minerals
18. ____ Water, distilled
19. ____ Water, Tap
20. ____ Water, well
21. ____ Diet often

LIFESTYLE

22. ____ Times you exercise per week (1 = once a week, 2 = 2-4 times/week, 3 = 5 times a week)
23. ____ Changed jobs (3= within last 2 months, 2= within last 6 months, 1= within last 12 months.)
24. ____ Divorced (3= within last 6 months, 2= within last year, 1= within last 2 years)
25. ____ Work over 60 hours/week (3= always, 2= usually, 1= occasionally, 0= never)

MEDICATIONS

Indicate with a checkmark or circle any medications you're currently taking or have taken in the last month:

26. ____ Antacids
27. ____ Antibiotics
28. ____ Anticonvulsants
29. ____ Antidepressants
30. ____ Antifungals
31. ____ Aspirin/Ibuprofen
32. ____ Asthma inhalers
33. ____ Beta blockers
34. ____ Chemotherapy
35. ____ Cortisone
36. ____ Diabetic medications
37. ____ Diuretics
38. ____ Estrogen/Progesterone
39. ____ Heart medications
40. ____ High blood pressure
41. ____ Hormone Therapy
42. ____ Laxatives
43. ____ Insulin
44. ____ Oral/implant contraceptives
45. ____ Radiation exposure
46. ____ Recreational drugs
47. ____ Relaxants/Sleeping pills
48. ____ Thyroid medication
49. ____ Tylenol/acetaminophen
50. ____ Ulcer medications

Other medications and dosages (if known): _____

PART II

Read the following questions and fill in the number that applies:

(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true.)

KEY: **0 (or leave blank) = No or Do not have the symptom, the symptom does not occur**
1 = Yes or It is a minor or mild symptom or it rarely occurs (once a month or less)
2 = It is a moderate symptom or it occasionally occurs (weekly)
3 = It is a severe symptom or it frequently occurs (daily)

Section 1

51. ____ Belching or gas within 1 hr. of a meal
52. ____ Heartburn or acid reflux
53. ____ Bloating shortly after eating
54. ____ Are you a vegan (no dairy, meat, fish or eggs)
55. ____ Bad breath (halitosis)
56. ____ Loss of taste for meat
57. ____ Sweat has a strong odor
58. ____ Stomach upset by taking vitamins
59. ____ Sense of excess fullness after meals
60. ____ Do you feel like skipping breakfast?
61. ____ Do you feel better if you don't eat?
62. ____ Sleepy after meals
63. ____ Fingernails chip, peel or break easily
64. ____ Anemia unresponsive to iron
65. ____ Stomach pains or cramps
66. ____ Diarrhea, chronic
67. ____ Diarrhea shortly after meals
68. ____ Black or tarry stools
69. ____ Undigested food in stool

Section 2

70. _____ Pain between shoulder blades
71. _____ Stomach upset by greasy foods
72. _____ Greasy or shiny stools
73. _____ Nausea
74. _____ Sea, car or airplane sickness, motion sickness
75. _____ History of morning sickness (1 = yes, 0 = no)
76. _____ Light or clay colored stools
77. _____ Dry skin, itchy feet and/or skin peels on feet
78. _____ Headache over the eye
79. _____ Gallbladder attacks (past or present)
80. _____ Gallbladder removed (1 = yes, 0 = no)
81. _____ Bitter taste in mouth, especially after meals
82. _____ Become sick if drinking wine
83. _____ If drinking alcohol, easily intoxicated
84. _____ Alcoholic beverages per week (0 = < 3/ week, 1 = < 7/ week, 2 = < 14/ week, 3 = > 14/week)
85. _____ Recovering alcoholic (1 = yes, 0 = no)
86. _____ Hangovers after drinking alcohol
87. _____ History of drug or alcohol abuse (1 = yes, 0 = no)
88. _____ History of hepatitis (1 = yes, 0 = no)
89. _____ Long term use of prescription medications (1 = yes, 0 =no)
90. _____ Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
91. _____ Sensitive to tobacco smoke
92. _____ Exposure to diesel fumes
93. _____ Pain under right side of rib cage
94. _____ Hemorrhoids or varicose veins
95. _____ Nutrasweet (aspartame) consumption
96. _____ Bothered by aspartame (Nutrasweet)
97. _____ Chronic fatigue or Fibromyalgia

Section 3

98. _____ Food allergies
99. _____ Abdominal bloating 1 to 2 hours after eating
100. _____ Specific foods make you tired or bloated (1= yes, 0= no)
101. _____ Pulse speeds after eating
102. _____ Airborne allergies
103. _____ Experience hives
104. _____ Sinus congestion, "stuffy head"
105. _____ Crave bread or noodles
106. _____ Alternating constipation and diarrhea
107. _____ Crohn's disease (1 = yes, 0 = no)
108. _____ Wheat or grain sensitivity
109. _____ Dairy sensitivity
110. _____ Are there foods you could not give up (1 = yes, 0 = no)
111. _____ Asthma, sinus infections, stuffy nose
112. _____ Bizarre vivid or nightmarish dreams
113. _____ Use over-the-counter pain medications
114. _____ Feel spacey or unreal

Section 4

115. _____ Anus itches
116. _____ Coated tongue
117. _____ Feel worse in moldy or musty place
118. _____ Taken any antibiotic for a combined time of (1 = < 1 mo., 2 = < 3 mos., 3 = > 3 mos.)
119. _____ Fungus or yeast infections
120. _____ Ring worm, "jock itch", "athletes foot", nail fungus
121. _____ Eating sugar, starch or drinking alcohol increases yeast symptoms
122. _____ Stools hard or difficult to pass
123. _____ History of parasites (1 = yes, 0 = no)
124. _____ Less than one bowel movement per day
125. _____ Stools have corners or edges are flat or ribbon shaped
126. _____ Stools are not well formed (loose)
127. _____ Irritable bowel or mucus colitis
128. _____ Blood in stool
129. _____ Mucus in stool
130. _____ Excessive foul smelling lower bowel gas
131. _____ Bad breath or strong body odors
132. _____ Painful to press along outer sides of thighs (Iliotibial Band)
133. _____ Cramping in lower abdominal region
134. _____ Dark circles under eyes

Section 5

135. _____ History of Carpal Tunnel Syndrome (1 = yes, 0 = no)
136. _____ History of lower right abdominal pain (1 = yes, 0 = no)
137. _____ History of stress fractures
138. _____ Bone loss (reduced density on bone scan)
139. _____ Are you shorter than you used to be? (1 = yes, 0 = no)
140. _____ Calf, foot or toe cramps at rest
141. _____ Cold sores, fever blisters or herpes lesions
142. _____ Frequent fevers
143. _____ Frequent skin rashes and / or hives
144. _____ Have you ever had a herniated disc? (1 = yes, 0 = no)
145. _____ Excessively flexible joints, "double jointed"
146. _____ Joints pop or click
147. _____ Pain or swelling in joints
148. _____ Bursitis or tendonitis
149. _____ History of bone spurs (1 = yes, 0 = no)
150. _____ Morning stiffness
151. _____ Vomiting or nausea
152. _____ Crave chocolate
153. _____ Feet have a strong odor
154. _____ Tendency to anemia
155. _____ Whites of eyes (sclera) blue tinted
156. _____ Hoarseness
157. _____ Difficulty swallowing
158. _____ Lump in throat
159. _____ Dry mouth, eyes and / or nose
160. _____ Gag easily
161. _____ White spots on fingernails
162. _____ Cuts heal slowly and / or scar easily
163. _____ Decreased sense of taste or smell

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur
1 = **Yes** or Minor or mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

Section 6

164. _____ Aspirin is an effective pain reliever (1 = yes, 0 = no)
165. _____ Crave fatty or greasy foods
166. _____ Low or reduced fat diet (past or present)
167. _____ Tension headaches at base of skull
168. _____ Headaches when out in the hot sun
169. _____ Sunburn easily or suffer sun poisoning
170. _____ Muscles easily fatigued
171. _____ Dry flaky skin and or dandruff

Section 7

172. _____ Awaken a few hours after falling asleep, hard to get back to sleep
173. _____ Crave sweets
174. _____ Eat desserts or sugary snacks
175. _____ Binge or uncontrolled eating
176. _____ Excessive appetite
177. _____ Crave coffee or sugar in the afternoon
178. _____ Sleepy in afternoon
179. _____ Fatigue that is relieved by eating
180. _____ Headache if meals are skipped or delayed
181. _____ Irritable before meals
182. _____ Shaky if meals delayed
183. _____ Family members with diabetes (0 = none, 1 = 2 or less, 2 = Between 2 - 4, 3 = More than 4)
184. _____ Frequent thirst
185. _____ Frequent urination

Section 8

186. _____ Muscles become easily fatigued
187. _____ Feel worse, sore after moderate exercise
188. _____ Vulnerable to insect bites
189. _____ Loss of muscle tone, heaviness in arms / legs
190. _____ Enlarged heart, or heart failure
191. _____ Pulse slow / below 65 (1 = yes, 0 = no)
192. _____ Ringing in the ears / Tinnitus
193. _____ Numbness, tingling or itching in extremities
194. _____ Depressed
195. _____ Fear of impending doom
196. _____ Worrier, apprehensive, anxious
197. _____ Nervous or agitated
198. _____ Feelings of insecurity
199. _____ Heart races
200. _____ Can hear heart beat on pillow at night
201. _____ Whole body or limb jerk as falling asleep
202. _____ Night sweats
203. _____ Restless leg syndrome
204. _____ Cheilosis (cracks at corner of mouth)
205. _____ Fragile skin, easily chaffed, as in shaving
206. _____ Polyps or warts
207. _____ MSG sensitivity
208. _____ Wake up without remembering dreams
209. _____ Take birth control pills
210. _____ Small bumps on back of arms
211. _____ Strong light at night irritates eyes
212. _____ Nose bleeds and / or tend to bruise easily
213. _____ Bleeding gums especially when brushing teeth

Section 9

214. _____ Tend to be a "night person"
215. _____ Difficulty falling asleep
216. _____ Slow starter in the morning
217. _____ Keyed up, trouble calming down
218. _____ High blood pressure (normal 120/80)
219. _____ Headache after exercising
220. _____ Feeling wired or jittery if drinking coffee
221. _____ Clench or grind teeth
222. _____ Calm on the outside, troubled inside
223. _____ Chronic low back pain, worse with fatigue
224. _____ Become dizzy when standing up suddenly
225. _____ Difficult maintaining manipulative correction
226. _____ Pain after manipulative correction
227. _____ Arthritic tendencies
228. _____ Crave salty foods
229. _____ Salt foods before tasting
230. _____ Perspire easily
231. _____ Chronic fatigue, or get drowsy often
232. _____ Afternoon yawning
233. _____ Afternoon headache
234. _____ Asthma, wheezing or difficulty breathing
235. _____ Pain on the medial or inner side of the knee
236. _____ Tendency to sprain ankles or "shin splints"
237. _____ Tendency to need to wear sunglasses
238. _____ Allergies and / or hives
239. _____ Weakness, dizziness

Section 10

240. _____ Over 6' 6" tall (Mature height)
241. _____ Early sexual development (before age 10) (1 = yes, 0 = no)
242. _____ Increased libido
243. _____ Splitting type headache
244. _____ Memory failing
245. _____ Ability to tolerate sugar
246. _____ Under 4' 10" (Mature height)
247. _____ Decreased libido
248. _____ Abnormal thirst
249. _____ Weight gain around hips or waist
250. _____ Menstrual disorders
251. _____ Delayed (after age 13) sexual development (1 = yes, 0 = no)
252. _____ Tendency to ulcers or colitis

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur
1 = **Yes** or Minor or mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

Section 11

253. _____ Allergic to iodine
254. _____ Difficulty gaining weight, even with large appetite
255. _____ Nervous, emotional, can't work under pressure
256. _____ Inward trembling
257. _____ Flush easily
258. _____ Fast pulse at rest
259. _____ Intolerance to high temperatures
260. _____ Difficulty losing weight
261. _____ Mentally sluggish, reduced initiative
262. _____ Easily fatigued, sleepy during the day
263. _____ Sensitive to cold, poor circulation (cold hands and feet)
264. _____ Constipation, chronic
265. _____ Excessive hair loss and / or coarse hair
266. _____ Morning headaches, wear off during the day
267. _____ Loss of lateral 1/3 of eyebrow
268. _____ Seasonal sadness

Section 12 – Men Only

269. _____ Prostate problems
270. _____ Urination difficult or dribbling
271. _____ Difficult to start and stop urine stream
272. _____ Pain or burning with urination
273. _____ Waking to urinate at night
274. _____ Interruption of stream during urination
275. _____ Pain on inside of legs or heels
276. _____ Feeling of incomplete bowel evacuation
277. _____ Decreased sexual function

Section 13 – Women Only

278. _____ Depression during periods
279. _____ Mood swings associated with periods (PMS)
280. _____ Crave chocolate around periods
281. _____ Breast tenderness associated with cycle
282. _____ Excessive menstrual flow
283. _____ Scanty blood flow during periods
284. _____ Occasional skipped periods
285. _____ Variations in menstrual cycles
286. _____ Endometriosis
287. _____ Uterine fibroids
288. _____ Breast fibroids, benign masses
289. _____ Painful intercourse (dyspareunia)
290. _____ Vaginal discharge
291. _____ Vaginal dryness
292. _____ Vaginal itchiness
293. _____ Gain weight around hips, thighs and buttocks
294. _____ Excess facial or body hair
295. _____ Hot flashes
296. _____ Night sweats (in menopausal females)
297. _____ Thinning skin

Section 14

298. _____ Aware of heavy and / or irregular breathing
299. _____ Discomfort at high altitudes
300. _____ "Air hunger" and / or yawn frequently
301. _____ Compelled to open windows in a closed room
302. _____ Shortness of breath with moderate exertion
303. _____ Ankles swell, especially at end of day
304. _____ Cough at night
305. _____ Blush or face turns red for no reason
306. _____ Dull pain or tightness in chest and / or radiate into right arm, worse with exertion
307. _____ Muscle cramps with exertion

Section 15

308. _____ Pain in mid back region
309. _____ Dark circles under eyes and / or puffy eyes
310. _____ History of kidney stones (1 = yes, 0 = no)
311. _____ Cloudy, bloody or darkened urine
312. _____ Urine has a strong odor

Section 16

313. _____ Runny or drippy nose
314. _____ Catch colds at the beginning of winter
315. _____ Mucus producing cough
316. _____ Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)
317. _____ Frequent colds or flu
318. _____ Never get sick (3 = not in last 7 yrs., 2 = not in last 4 yrs., 1 = not in last 2 yrs.)
319. _____ Acne (adult)
320. _____ Itchy skin / dermatitis
321. _____ Cysts, boils, rashes
322. _____ History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition (1 = yes, 0 = no)

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DO OTHERS COMPARE TO DR. MICHAEL WALD'S CREDENTIALS?

Thank you for considering Dr. Michael Wald as your natural health care provider and clinical nutritionist. To help you make the most appropriate choice for your health concern(s) please compare other nutritionists' credentials to those of Dr. Wald.

DR. MICHAEL WALD	YES	OTHER NUTRITIONIST
· Masters Degree in Human Nutrition	✔	
· Double Board Certified in Nutrition	✔	
· Certified Dietician-Nutrition (CDN) recognition	✔	
· Certified Nutritional Specialist (CNS) recognition	✔	
· NSCA-CPT: Certified Personal Trainer	✔	
· Certified Sports Nutritionist (ISSN)	✔	
· PhD from the Holistic College of Nutrition	✔	
· Naturopathic degree (ND) from the Clayton School	✔	
· Post graduate degree in chiropractic	✔	
· Medical Degree earned*	✔	
· Director of clinic for 28 years	✔	
· Health expert for ABC, FOX, Channel 11, 12, 13, The Food Network and others	✔	
· Author of over 10 books	✔	
· Provides personalized attention to his patients	✔	
· Provides his cell phone number	✔	
· Provides a non-toxic treatment environment	✔	
· Inventor of the Blood Detective Software Technology that has him branded as someone who can find problems and natural solutions when others often fail	✔	

*See website for more details. Dr. Wald is not a licensed medical doctor.