

Welcome !



Welcome to Empower Healing where our goal is for all people to experience the most optimal health and well being possible through utilization of nature's vast resources. We believe travelling the road of life is complicated enough without worries of one's personal health.

Inside this Client Profile Packet you will find a series of questions designed to provide vital information to your Doctor which is necessary to individualize a program specific to your health goals. Carefully read the directions for each section and complete the entire packet prior to your first session with your Doctor and bring it with you. With out this information or with only a partial amount of the information completed, your Doctor will be unable to individualize your program thus resulting in a delay in your progress.

Included in your Client Profile Packet are the following:

1. New Patient Information
2. HIPPA (Health Information Patient Privacy Act) Notice of Privacy Practice
3. General Patient Information
4. Client Consent
5. Health History Questionnaire
6. Case History

NEW PATIENT INFORMATION

Appointments

We encourage you to schedule your appointments in advance to ensure that you receive and retain the time slot most desired. It is your responsibility to cancel any existing appointments which are made in advance. When the office has abbreviated hours or may be closed for Holiday observation, we will inform our patients of such changes in advance.

Parking

We recommend allowing extra time for travelling as the availability of parking can be unpredictable. You may park in any of the available parking spaces in the parking structure.

Cancellation Policy

Our Centre requires a minimum of 24 hours courtesy notice when cancelling an appointment. If you have missed or rescheduled an appointment with less than 24 hours notice, you will be responsible for the full charge of the office visit. We do understand that occasionally unforeseeable circumstances arise that prevent you from being on time for your scheduled appointment. Unfortunately, we have time constraints that do not permit for patients being more than 15 minutes late. If you are running late, please telephone the office prior so that you may avoid making an unnecessary trip and we will make every effort to accommodate your circumstances, if possible.

Payment & Insurance

Our Centre is set up for direct pay and accepts payment at the time of your visit. Check, Cash, Visa and Mastercard are acceptable forms of payment. If a check is returned, a fee of \$25.00 will be applied to your account.

Needles

Our Centre uses sterile, disposable needles.

Personal Property

Please keep your valuables with you while visiting the Centre. Our Centre are not responsible for your personal property while on the premises.

Welcome !

Attire

Please wear loose, comfortable clothing, as acupuncture therapy involves palpation and treatment of various parts of the body. Draping will be provided to ensure modesty. Please refrain from wearing excessive jewellery, as some metals may interfere with the efficacy of the therapy. In consideration of our environmentally sensitive patients, we ask that you refrain from wearing perfume, strongly scented oils or lotions on the days you visit the Centre.

Additionally, for your safety and comfort, we kindly ask that you turn off cell phones and pagers while at the Centre.

WHAT TO EXPECT ON YOUR FIRST VISIT

- Allow yourself at least an hour and 15 minutes for your first treatment. Please keep your schedule open or very light after your appointment; providing yourself the gift of focusing on your health.
- Have an agenda. Please have any and all notes and questions written down prior to your appointment in relation to your goals. Be as specific as possible and share these goals with your practitioner.
- You will be required to sign the following forms prior to receiving treatment:
- Please do not wear any perfume, perfumed powder, strong smelling deodorant, hair spray, or after shave. Do not eat strong smelling herbs like raw garlic when you come to the clinic for treatments. If you suspect a food as an allergen, you may bring the food to the doctor's office in a baby food jar or any thin glass container with a lid, wrapped with brown paper or a brown paper bag. Please do not bring the food in plastic containers. Plastic containers cannot be used in testing with MRT.
- Always eat before you come for the treatment. You should not take NAET treatments and acupuncture when you are hungry. If you have a long wait in your Doctor's office, please bring a snack with you, leave it in the car or outside the office. Five to ten minutes before your treatment, please go outside the clinic and eat your food, wash your hands, and rinse your mouth before you return to the clinic for the treatment.
- Please wash your hands before and after treatment. Wash with soap and water before the treatment. After the treatment if you cannot wash or rinse your hands, vigorously rub your hands interlacing your fingers for 30 seconds.
- Please take a shower before your treatment, and wear freshly washed clothes to avoid smells of herbs, spices, perspirations, etc., from your body or clothes. This can cause irritation and reactions in other sensitive patients in the office. Additionally, you will be required to NOT bathe until 6 hours after your treatment.
- Drink a glass of water before the NAET treatment. Energy moves better in a well hydrated body. Drink lots of water (4-6 glasses/day) after NAET and acupuncture treatments to help flush out the toxins produced or eliminated during the treatment.
- NAET treatment will not interfere with any other treatment. In fact, if you can keep your body free of toxin accumulation (stool softeners, laxatives, to prevent constipation, and colonics or high enemas once or twice a month to eliminate the toxic build up), and keep your symptoms under control with whatever method you are using, NAET will be easier.
- For your relaxation and comfort; we have a Patient lounge with an assortment of herbal teas while you await your visit.
- Once escorted into a treatment room, please make yourself comfortable. The Doctor will arrive shortly to begin your evaluation by asking you many questions. Some of your questions will be directly related to your chief complaint; many will not seem to be related at all. Please be patient during this process as all questions are necessary to make an accurate Oriental Medicine Diagnosis.
- Depending upon your health complaint, the Doctor may take your pulse, look at your tongue, palpate specific points, check your range of motion, or do muscle testing.

Welcome !

What to expect.....(cont.)

- Upon conclusion of your first visit, the Doctor will make a treatment recommendation/ This may include a certain number of treatments within a certain amount of time. Your Doctor may recommend herbal medicine, nutritional and lifestyle changes, or refer you to another healthcare provider. Please take these suggestions seriously as they are based on years of experience as well as your individual circumstances, and are important to your health and well-being.
- Please utilize this time to ask ANY questions that you may have of the Doctor.
- Having a feeling a relaxation after the treatment is normal and you should use the time in the treatment room to enjoy this experience for yourself.

What To Expect AFTER Your First Visit

- Please wash your hands immediately after your treatment.
- Keep your schedule open or very light after your appointment. Give yourself the gift of focusing on your health.
- Take note on how you feel, physically, mentally, and emotionally until the next treatment. Please make certain to inform your Doctor of your progress at your next treatment so they can modify your treatment if at all necessary.
- After the treatment, please do not exercise vigorously for 6 hours. A mild walk is fine.
- Please avoid exposure to extreme hot or cold temperature after the treatment.
- NAET treatment will not interfere with any other treatment. In fact, if you can keep your body free of toxin accumulation (stool softeners, laxatives, to prevent constipation, and colonics or high enemas once or twice a month to eliminate the toxic build up) and keep your symptoms under control with whatever method you are using, NAET will be easier.
- Your Doctor will ask you to avoid the treated allergen for 25 hours or more as indicated by their testing after the completion of the treatment in the office.
- On the evening of the treatment and for a few days after:

Do	Do Not
•Drink Plenty Of Water	•Drink Alcohol
•Get Plenty Of Rest	•Overdo Anything (especially if you feel energized)
•Eat Lightly; But Well (small portions of meat)	•Drink Too Much Coffee Or Energy Drinks
•Take A Hot Shower Or Epsom Salt Bath	
- Your practitioner will request that you avoid the treated allergen for 25 hours or more as indicated by their testing after the completion of the treatment in the office.
- If you have any additional questions or concerns after your treatment, please do not hesitate to telephone the Centre.

HIPPA (Health Information Patient Privacy Act)

Empower Healing

HIPPA Notice Of Privacy Practices

The majority of society feel that their health, medical and personal information is private and should be protected. We understand that importance and are equally committed to protecting that information. As providers of quality care and health services, we create a record of the care and services you receive from us. We require this information to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Dr. Roya Nikzad, whether made by your family practitioner or other agents working with Dr. Roya Nikzad. This notice will inform you about the ways in which we may use and disclose health information about you. This notice will also describe your rights pertaining to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your information. The following policy will be followed by every one of our employees to ensure your information is confidentially maintained. This notice will explain the ways we use information about you in order to make sure that you receive all the care you need.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 08/01/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, health care operations and payment. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you. We may disclose medical information in the form of a patient status report to your worker's compensation carrier or insurance company representative so that they may monitor how you are progressing.

Health care Operations: We may use and disclose your health care information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

HIPPA (Health Information Patient Privacy Act) *cont.*

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse Or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six(6) years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by reasonable alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Today's Date: _____/_____/_____

General Patient Information

Last Name		First Name		Middle Initial	How Do You Prefer To Be Addressed?	
Address			City	State		Zip
Home Phone # () -	Cellular Phone # () -	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced		D.O.B. ___/___/___	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Work Phone # () -	Employer			Occupation		
Emergency Phone # () -	Emergency Contact Name (Last, First)			Relationship To You		
E-Mail Address			Referred By:		Social Security #: - - -	
Physician's Phone () -	Primary Care Physician's Name			Physician's Speciality		
Address			City	State		Zip

Insurance Information

Insurance Company			Phone # () -	Insurance Group #:		
Address			City	State		Zip
Insured's: Last Name		First Name		Middle Initial	D.O.B. ___/___/___	Insurance ID #:
Address			City	State		Zip
Insured's Employer:		Relationship To Insured:	Insurance Plan Name:		Social Security #: - - -	

Note On Insurance:

Payment for treatment is due in full at the time services are rendered. Upon request a Superbill will be provided. A Superbill is a receipt that you may submit directly to your insurance company to seek reimbursement for payments made. You may call your Insurance Company to inquire if acupuncture services are covered under your policy.

SUPERBILL REQUESTS: No Thank you! Once a Month Each Visit

MISSED APPOINTMENT POLICY:

If you need to change or cancel your appointment please do so with 24 hours Notice. Failure to do so will result in being charged for your visit.

Please Initial: _____ I understand the cancellation policy

Diagnosis Code #: _____ Diagnosis Name: _____

Client Consent

By signing this consent, you are agreeing to the stipulations and requirements of Dr. Roya Nikzad's Office as outlined below. Please read the information carefully, sign your name at the bottom and date it with today's date.

I _____ certify that Dr. Roya Nikzad does not claim to cure any illness or disease with NAET (Nambudripad's Allergy Elimination Techniques).

I understand that NAET is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. NAET uses various, standard medically proven diagnostic measures and modalities (Allopathic, chiropractic, kinesiological, and acupuncture) to diagnose the patient's condition. The premise behind NAET is to desensitize a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional, and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I am (my dependent) to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the Doctor who prescribed them. During the 25 hours of after if I (my dependent) get a life-threatening reaction from the allergen I (my dependent) was treated or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by telephoning 911 emergency services or attending an emergency room at the local hospital. If I (my dependent) am/are suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my dependent's) symptoms under control while I (my dependent) am/are being treated with NAET treatments. This way essential NAET treatments can be completed without interruption and once I (my dependent) complete the essential NAET treatments for my (my dependent's) condition, I (my dependent) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my dependent) am to avoid eating, touching, breathing and coming within 5 feet of the substance(s) for which I (my dependent) have received treatment. If I (my dependent) comes in contact with the substance(s) for which I (my dependent) am being treated for; I realize that the treatment may not work and I (my dependent) may have a sensitivity reaction.

I understand that I (my dependent) must return after my 25 hours avoidance period preferably within 24 hours but at least within 7 days, to see if I (my dependent) have cleared for the substance(s). I fully understand that I (my dependent) may still experience a reaction to the substance(s) of unknown severity if I (my dependent) come in contact with them if I (my dependent) did not clear them completely. If I (my dependent) did not clear them completely, I (my dependent) may require to repeat the procedure (more office visits my cost) until I (my dependent) clear them satisfactorily.

I have read or have had read to me the above statements and have had an opportunity to ask questions about it's content and by signing below I agree to the terms and procedures.

X _____ /_____/_____
(Patient's Signature) (Date)

(Name Of Minor) (Relationship to the ward i.e.: Mother/Father)

X _____ /_____/_____
(Witness's Signature) (Date)

Financial Policy

FEES:

The fees charged at this office are comparable to those charged by other specialists with similar qualifications in this geographic area. The fees for office services are payable at the time of the visit. We accept Master Card & Visa, personal checks and cash for payment of services.

INSURANCE BILLING:

Your health insurance coverage represents a contract between you and your insurance company. You are responsible for your bill including any co-pays, co-insurance amounts or non-covered services. We will provide you with a super-bill (receipt with insurance codes) which you may submit directly to your insurance carrier for reimbursement. We will provide a reasonable amount of assistance to you should your insurance company request further information, but reserve the right to bill \$50/hr. for any significant requests.

BENEFIT REVIEW:

We suggest that you carefully review your insurance coverage prior to your office visit. Policies are often confusing, misleading, and rarely pay 100% of billed charges. Insurance benefits are a matter between the patient (the insured) and his or her insurance company.

DELINQUENT ACCOUNTS:

In those cases where your account becomes past due, we reserve the right to make a late charge of one and one half percent (1.5%) per month of the account balance for every month that an account remains overdue, after 30 days.

Health History Questionnaire

Personal History:

1. What is your reason for seeking our services? _____
_____.

2. How long have you had the above symptoms/condition? _____

3. How many occurrences of this symptom / condition? _____

4. What position exacerbates the condition? _____

4. Have you sought treatment elsewhere for your condition?

If so, where & when? _____ / _____ / _____

If so, what kind of success was obtained? _____

5. Do you feel this condition to be:

Improving

Getting Worse

Unchanged

Other: _____

6. How is your condition interfering with daily living? _____

7. What do you believe caused this condition? _____

8. Were you overweight as a child?

Yes No

9. Have you experienced a history of excess weight?

_____ Lbs. -Lowest _____ Lbs- Highest

4. Please list all surgeries you have had within the past 2 years: _____
_____.

5. Please list all Hospitalizations other than surgeries you have had in the past 2 years: _____
_____.

6. Are you now or have you ever been under any other practitioner's care for any reason: Yes No

If YES, please describe: _____.

7. Please list all medications including over-the-counter medications:

Aspirin

Antacids

Blood Thinners

Ibuprofen

Fiber/Laxatives

Blood Pressure Pills

Acetaminophen (Tylenol)

Tranquilizers

Sleeping Pills

Oral Contraceptives

Allergy Medication

Anti-depressants

Insulin

Weight loss/Diet

Other: _____

8. Please indicate whether you have experienced a significant problem with any of the symptoms or conditions listed below: (check all that apply)

Unexplained Weight Loss

Unexplained Shortness Of Breath
During Physical Activity

Migraines Or Recurring
Headaches

Chronic Fatigue

Asthma

Chronic Or Recurring
Cough

Change In Appetite

Chronic Joint Or Muscle Pain

Difficulty Sleeping

Chest Pain Or Pressure

Arthritis Or Rheumatic Condition

Anxiety Or Restlessness

Chest Pain With Exertion

Lightheadedness, Dizziness
Or Fainting

Anemia

Rapid Or Irregular
Heartbeats

Epilepsy Or Seizures

Emphysema

Low Blood Pressure

Back Pain

Bronchitis

High Blood Pressure

Swollen, Stiff Or Painful Joints

Pneumonia

Health History Questionnaire

Personal History: *(continued)*

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Hypoglycemia/Low Blood Sugar | <input type="checkbox"/> Cold Hands Or Feet | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack, Coronary <input type="checkbox"/> Stroke, Bypass Or Other Cardiac Surgery | | |

Please explain briefly any items checked: _____

1. Recent tests and results:

Cholesterol: _____ Blood Pressure: _____ Mammography: _____
Prostate: _____ Blood Work: _____ STD Check: _____
HIV/AIDS: _____ Other: _____

2. Please list any (known) allergies to medications: _____

Water Element

- Hearing Loss
- Dizziness
- Lower Back/Neck Pain
- Sinus Congestion
- Edema
- Darkness Under Eyes
- Emotional Instability
- Aversion to Cold
- Hair Thinning or Loss
- Pre-mature Aging
- Frequent Urination
- Kidney Stones
- Perspire Very Easily
- Weakness of Legs/Knees
- Asthmatic Cough
- Rapid Weight Change
- Loose Teeth
- Reduced Sexual Energy
- Thyroid Problems
- Diabetes

Wood Element

- Headaches
- Migraines
- Ringing In The Ears
- Poor Eyesight
- Eye Infections
- Dry Eyes
- Eczema
- Shingles
- Herpes simplex
- Warts
- Nervousness

Wood Element (cont.)

- Hepatitis
- Hemorrhoids
- Constipation
- Irritability
- Convulsions, Spasms
- Vomiting
- Gallstones
- Indecisive
- Fullness Below Ribs
- Shoulder/Neck Tension
- Insomnia

Fire Element

- Dry Scalp
- Skin Eruptions, Rashes
- Cysts, Tumors
- Ear Infections
- Sore Throat, Tonsillitis
- Lymphatic Swelling
- Hot Palms & Soles
- Heart Palpitations
- Aversion to Heat
- Bitter Taste in Mouth
- Gum Problems
- Nose Bleed
- Facial Redness
- Itching/Burning Skin
- Hot Hand & Feet
- Thirst
- Vivid Dreaming
- Dark Urine
- Night Sweats

Earth Element

- Indigestion
- Flatulence
- Food Allergy
- Stomach Ache/Ulcer
- Diarrhea
- Anemia
- Halitosis
- Sores In Mouth
- Heartburn
- Strong Appetite
- Weak Appetite
- Nausea
- Abdominal Bloating
- Low Body Weight

Metal Element

- Bronchitis
- Asthma
- Shallow Breathing
- Cough
- Sinus Congestion
- Nasal Infections

Other

- Fatigue
- Arthragia
- Sciatica/Nerve Pain
- Cold Hands & Feet
- Tendonitis
- Bursitis

Health History Questionnaire

Nutritional

1. Do you now or have you ever smoked? Yes No
 If YES, how many packs/day _____ Since what age? _____
2. Do you consume alcohol? Yes No
 If YES, how many glasses per day _____ week _____
3. Do you consume caffeinated beverages? Yes No
 If YES, enter glasses per day in the appropriate box Coffee Tea Soda
 1 2 3 4 5
4. On a scale of 1-5 please rate your Nutrition (1=Poor 5=Excellent)
5. Do you currently follow any special diet or eating plan? Yes No
 If YES, explain: _____
6. Are you currently taking any type of nutritional supplements, vitamins, herbs, performance enhancing aids and/or weight loss products? Yes No
 If YES, what type?: _____
7. What types of restaurants do you frequent?
 Fast Food Sit-down/Casual Sit-down/Formal Cafeteria Deli Diner Other
8. Please briefly describe your daily diet:
 Breakfast: _____ Morning Snack: _____
 Lunch: _____ Afternoon Snack: _____
 Dinner: _____ Evening Snack: _____

Family History:

1. Is there a history of excess weight in your family? Yes No
2. Have any of your blood relatives experienced any of the following: (check all that apply)

Father, Mother, Siblings, Children & Grandparents				Relationship To You
Gender	Age	Age At Death	Significant Health Problem Or Cause Of Death	
<input type="checkbox"/> M <input type="checkbox"/> F			Heart Attack	
<input type="checkbox"/> M <input type="checkbox"/> F			Stroke	
<input type="checkbox"/> M <input type="checkbox"/> F			Coronary Disease	
<input type="checkbox"/> M <input type="checkbox"/> F			Congenital Heart Disease	
<input type="checkbox"/> M <input type="checkbox"/> F			Diabetes	
<input type="checkbox"/> M <input type="checkbox"/> F			Cancer	
<input type="checkbox"/> M <input type="checkbox"/> F			Emphysema	
<input type="checkbox"/> M <input type="checkbox"/> F			Cholestistitis (Gall bladder disease)	
<input type="checkbox"/> M <input type="checkbox"/> F			Other (please specify)	