

Center for Wellness
1258 Mann Dr. Ste 100 Matthews NC 28105

Policy and Practices

Thank you for choosing The Center for Wellness to meet your medical needs. Dr. Speight and his staff are committed to providing you with best possible professional and compassionate care. Our goal is for you to receive optimal medical treatment so that you may have optimal health.

As a new patient, Dr. Speight has blocked 60 minutes for your appointment to review your history, medical records and to perform a physical exam. He will review your current supplements, medications and diet. For the most favorable treatment plan to be formulated it is important that all history information and lab results be available during the visit. Unlike traditional medical practices working within the confines of 10-15 minute time slots, Dr. Speight will build an in depth understanding of how to best treat you which requires taking time to listen and investigate your illness. Due to the extensive information that is provided and the complexity of the health issues seen in this office it is not uncommon for appointments to run behind schedule. Please take this information into consideration when booking your visits. Your new patient documents are to be completed prior to your appointment. Any forms requiring a dated signature we ask that you wait to do so at your appointment check-in time.

Practice Protocol: Office visits/ Scheduling/ Payment

Office hours are Monday thru Thursday 8:30-5:00. The fee structure is based on the consideration needed to effectively treat many chronic illnesses. Follow up visits are structured to provide you with the time you need. There is a one time administrative fee of \$50 at the initial visit. All visits are a fee for service and based on the time provided at \$5.90/minute. Adult follow up visits may be arranged with the Nurse Practitioner (NP) at \$5.00/min. Dr. Speight reviews all visit notes, supplement recommendations and prescriptions provided by the NP. *Payment in full is to be paid at the end of your visit.* We will accept Debit cards Flex spending cards, Visa, MasterCard, Discover and personal checks. No cash payments will be accepted. First time visits require a deposit to secure the one-hour appointment. Should the appointment need to be cancelled the office will need to be contacted Monday –Thursday with a minimum of 24hrs business hours prior to the appointment in order to receive a refund of the deposit. We are not contracted with any insurance companies; however a form will be provided to submit.

Once established, phone consults can be offered in lieu of office visits when appropriate and provided at least one annual office visit has occurred. Phone consults are billed at the same rate as office visits. A credit card number will be secured in your chart so that your fees can be handled at the end of the visit, just as office visit charges. This information is confidential and used only as you indicate on your "Record Confirmation". This policy was advised by the banking system.

If you choose to follow the treatment plan that is provided to you at your initial visit, we encourage you to plan on a follow up time with the physician or NP to review any testing that may have been ordered and to ensure your supplementation/medications are giving you the optimal benefit you deserve. Understand some specialty lab tests are complex and take up to 2 weeks to result. Additionally, due to the complexity of some tests and the questions that often arise, we may ask that you schedule an hour to review the results discussion.

Congratulations on your commitment to better health! We look forward to serving you. In addition, everyone one at the Center for Wellness would like to extend our invitation to you, to provide us with your input as to how we can continue to better serve you. Should you have any suggestions for improvement for our office that you would like to offer we encourage you to provide them in writing or email centerforwellness@gmail.com

Patient Signature

Date

Staff signature

A copy of this document has been provided to me _____ (initial)

As a courtesy to our patients with chemical sensitivities please do not wear any perfumes, body spray or scented lotions when visiting our office.

RECORD CONFIRMATION

The Center for Wellness, PA
1258 Mann Dr, Suite 100
Matthews, NC 28105

Neal Speight, MD
704-847-2022

Patient Last Name _____ First _____ MI _____

SS# _____ Birthdate _____ Home Phone# _____

Address _____ Cell Phone# _____

City/State _____ Zip Code _____

E-Mail Address _____

Who referred you to our office? _____

Marital Status _____ Sex _____ Is patient a minor? _____

Employer _____ Work Phone# _____

Address _____ City/State/Zip _____

Credit Card #(MC or Visa) _____ Exp Date _____

*I authorize the Center for Wellness to use this card for payment of office visit, phone consults, lab charges
And supplements. The number may be used in my physical absence for phone consults and supplement payment.
This card may also be used for the following family members*

Who is responsible for this account? _____

Spouse/Parent Last Name _____ First _____ MI _____

SS# _____ Birthdate _____ Home Phone _____

Address _____

City/State _____ Zip _____

Employer _____ Work Phone _____

Date _____ **Signature** _____

*****Center for Wellness is not a Medicare provider*****

The Center for Wellness
1258 Mann Drive Suite 100
Matthews, NC 28105
704-847-2022

COMMUNICATION PERMISSION RELEASE FORM

I, _____, give you permission to speak with the following persons on my behalf concerning my medical treatment, results of my medical tests or any other matter relating to my care at The Center for Wellness.

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____
4. _____ Relationship _____
5. No One but myself _____

NOTE: Information can be given to the above named individuals until it is revoked by you in writing.

Please wait to sign this until someone in the office can witness your signature.

Signed

Witness

Date

Date

Medicare Opt-Out Agreement

This agreement is between Dr. Mark O'Neal Speight, whose principal place of business is 1258 Mann Dr Matthews, NC, and patient _____ ("Patient"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on 01October2009 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient: Physical assessment, consultation and general medical management.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

Executed on _____ by

Patient _____ Signature _____

Print

Physician Mark O'Neal Speight, MD Signature _____

Mark O'Neal Speight, MD
1258 Mann Drive Ste 100
Matthews, NC 28105

The Center for Wellness
1258 Mann Drive Suite 100
Matthews, NC 28105
704-847-2022

INSURANCE INFORMATION

The practice of medicine at the Center for Wellness combines both traditional and alternative concepts in medical diagnosis and therapeutics, it is important that there be a clear understanding concerning fees for tests and therapies. You will always be informed of what tests and or treatments are, their intended purpose as well as the fees are before any are performed.

Insurance companies may reimburse for a portion of the diagnostic procedures and office visits, if the individual has out-of-network benefits. Traditional medical treatment modalities should be paid as any other medical facility; however, it is possible that your insurance company deems treatment as an alternative approach and will not pay for services.

We are not Medicare/Medicaid providers. As of July 2009 the Center for Wellness has filed the Opt-Out documents required in order to be able to treat those with Medicare; however you will be asked to sign a document of understanding that no Medicare claims will be filed, whether it be a primary or secondary coverage.

Individuals with commercial insurance will be provided with a HCFA form (regulated insurance form) to submit the services rendered directly to the appropriate provider. The individual is financially responsible for the sum of their services at the time of services.

By signing this form you acknowledge that you are responsible for payment of services rendered at the Center and there is no guarantee that your insurance company will reimburse you for these procedures and treatment.

Signature _____

Witness _____

Date: _____

**The Center for Wellness
1258 Mann Drive Suite 100
Matthews, NC 28105
704-847-2022**

LETTER OF UNDERSTANDING REGARDING INTEGRATIVE HEALTH PRACTICES

I have decided to choose an integrative treatment regimen to deal with my illness, rather than a traditional approach. I am requesting that Neal Speight, M.D. evaluate and/or treat my chronic illness. I understand that some of these approaches are considered experimental (investigational) in nature. They have been used in various centers throughout the world with much anecdotal success. I also understand that because some of these treatments are considered investigational from an insurance carrier perspective, they may not reimburse me for my expenses the Center for Wellness. I understand that each therapy may have side effects and that I will be informed of any potential side effects before I receive therapy. I agree to sign a separate consent form for any invasive therapy I receive. I understand that there is no guarantee of a cure for my illness. I want these treatments and evaluations. I am signing this statement of my own free will, effective as of my first day of treatment, understanding all of the above information.

Signed: _____ Date: _____

PRIMARY CARE UNDERSTANDING

I understand that the Center for Wellness, PA is not a "Primary Care Practice". While Dr. Speight is board certified in practice primary, his focus is on nutritional and environmental influences on illness. As such you will need to maintain your relationship with your primary care provider. By signing below you agree to this. We do not have an "on-call" physician and are not available for medical emergencies outside of office hours.

I understand that routine medical needs and my primary care physician must handle my medical emergencies.

My Primary Care Physician is: _____

City and Telephone #

Signature _____ Print _____ Date _____

Staff Witness _____

*The Center for Wellness
1258 Mann Drive Ste 100
Matthews, NC 28105
704-847-2022*

**Letter of Understanding Regarding Email Responses,
Prescriptions, and Emergencies**

Email

Email is becoming a more common and accepted method of exchange of information in the medical field. While we have utilized email in communicating with patients it is not the preferred method of communication.

By signing this letter of understanding, you acknowledge that you have been informed of this policy and that if you choose to email the centerforwellness@gmail.com and wait for a response you do so at your own risk and agree to hold the Center for Wellness, its employees and Dr. Speight harmless for complications that may arise indirectly or directly from an unanswered email.

Staff attempt to help patients via email with simple questions, but this is not the preferred method of communication for most issues. Should you choose to provide updates on your health so that the information may be address at your next scheduled appointment we will print your email, and the document will be considered a part of your legal chart. **Questions that require treatment changes are best addressed during scheduled phone consults or office visits.** Any questions requiring a rapid response the preferred communication is to call the office and speak with one of the staff. **Due to medical-legal constraints, advice pertaining to treatments and diagnosing are generally excluded from email responses.** In addition, technology limitations may compromise a response via email and it should not be relied upon for consistent communication. We prefer that if you desire a rapid response to your questions you call us and notify us that you need a response the day of your call.

If you have not received an answer to your email in what you would consider a timely fashion, you also acknowledge that if you feel your issue is urgent you will contact Dr. Speight's office directly.

Emergencies and Prescriptions

The Center for Wellness is not structured as an urgent care or emergency department (ED). By signing this form you acknowledge that you have been instructed to go to the ED or Urgent Care for emergent issues. You also understand that we do not have clinic hours on Friday except for scheduled Hyperbaric and Laser treatments performed by the technician. As such, any matters such as prescription refills, etc that are considered routine, should be made by 12 noon on Thursday in order to be refilled before Monday of the following week.

Insurance and Disability Forms

There are times when patients request a letter of justification to their insurance for the cost of evaluation and treatments. These requests are difficult to accommodate due to the time involved in generating a complete assessment and treatment rationale for each patient. You are unique! Many insurance companies state they are awaiting further records when in fact we have sent them or they have not sent the request. They then request a letter from the physician to justify treatment only to deny it anyway. We can generate these letters however **they will be billed at the same rate as an office visit.** We regret this policy, but due to the complex nature of most patient illnesses and the detail to which we evaluate these problems, it cannot be avoided.

Disability letters also are difficult and time intensive to craft for similar reasons and fall under the same policy: time spent = time billed. A simple yes/no form can generally be done in approximately 15 minutes, sometimes less. By signing below you acknowledge you have been informed of these policies and will abide by them when utilized.

Patient - Print

Signature Date

Witness - Print

Signature Date

CENTER FOR WELLNESS

Neal Speight, M. D.
1258 Mann Drive Suite 100
Matthews, NC 28105
704-847-2022
704-847-1830

Medical Records Release

To: _____

Address: _____

Phone _____

Name: _____

DOB: _____

SS# _____

I, _____ authorize the release of my medical record
to Neal Speight, MD of the Center for Wellness. Please include copies of office notes,
laboratory reports, radiology reports and surgical reports for dates:
_____ to current

Signature _____ Date _____

Relationship: ___self ___parent ___Power of attorney ___ Guardian

HIPAA Notice of Privacy Practices

CENTER FOR WELLNESS, PA
1258 Mann Drive, Suite 100
Matthews, NC 28105
704-334-8447

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

~~We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.~~

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

CENTER FOR WELLNESS

1258 Mann Drive · Suite 100 · Matthews, NC 28105

Tel: 704-847-2022 · fax: 704-847-1830

List the name and contact phone numbers to any councilors, specialists, chiropractors, and therapists physical, occupational, speech, behavioral that are contributing to your care

Name	Type of specialist	Phone

PLEASE DESCRIBE YOUR MAJOR PROBLEMS AND OR SYMPTOMS (If none, please write the reason for seeking this consultation.) Include when the symptoms first appeared. If you need additional space, please document on a separate piece of paper.

What habits, activities or attitudes do you consider to have contributed to any of your problems?

What do you want to achieve during your visit?

List household members of those currently living with you. Include family members, non-family and pets.

Name	Relationship	Age	Occupation

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Habits: Please be specific with your answers regarding types and quantities where requested.

Use of cosmetics?

Perfumes?

Aftershaves?

Scented soaps or lotions?

Do you currently smoke?

Previous smoker?

Year quit:

of packs per day

for how many years?

Alcohol use: specify what type, amount per day/week

--

Do you currently or have you in the past ever drank alcohol in excess?

--

Non-medicinal drug use? Specify type and frequency

--

Caffeine use: How much of each of the following do you consume?

Coffee

Tea

Chocolate

Colas

--

Exercise: type, length of sessions and frequency. Do you sweat?

--

Stress reduction: Describe type and frequency of any relaxation techniques you may engage in such as: meditation, yoga, prayer, self-hypnosis etc.

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Do you consider yourself to be under low, moderate or high levels of stress?

Your source of stress:

Sleep habits

Hours of sleep per night?	
Restless or restful?	
What time do you retire?	
Do you wake during the night?	
Do you dream?	

Hobbies or other life interests

--

Past history:

Did your mother have any problems during her pregnancy while carrying you, i.e. illness, stress, smoking, medications, alcohol?	
Were you bottle fed or breast fed?	
Was your home life: (circle appropriate terms) Add additional descriptive words here:	Loving, supportive, stressful, abusive, peaceful, loud, argumentative, educational, alcoholic, friendly, single-parent, lonely, numerous siblings

Circle any of the following childhood illnesses you may have had:

Colic, eczema, asthma, Polio, food allergies, seasonal allergies, bronchitis, Pneumonia, Meningitis, Rheumatic fever, Recurrent colds, Ear infections, Thrush, German Measles, Bedwetting, Tonsillectomy, Persistent diaper rashes, Learning disabilities, Hypersensitivity, Attention deficit, Depression. Other:
--

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Have you ever been hospitalized for illnesses or surgeries?

Hospitalization or surgery	Date admitted	Length of stay

Have you ever traveled out of the country?

Suffered traveler's diarrhea?	
Were you ever treated for parasites?	
Have you been tested for intestinal parasites?	

Immunizations

Test	Date	Test	Date
Smallpox		Polio	
Flu		Mumps	
Pneumonia		Pertussis	
Tetnus		Measles	
Diphtheria		other	

Family History of physical or mental illness Include Parents and Siblings

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Indicate for the following: C=current problem I= intermittent problem P=past problem

C/I/P		C/I/P		C/I/P	
	Headaches		High blood pressure		Weakness
	Neck lumps or swelling		Skipped heartbeats		Painful feet
	Loss of balance		Racing heart		Leg cramps
	Dizzy spells		Chest pain or pressure		Trembling or tremors
	Vertigo		Swollen feet or ankles		Seizures
	Vertigo		Swollen feet or ankles		Epilepsy
	Blackouts or fainting		Difficulty breathing at night		Numbness or tingling
	Blurry vision		Varicose veins or phlebitis		Skin tumors
	Double vision		Recurring indigestion		Dry skin
	Cataracts		Nausea or vomiting		Acne
	Watering eyes or redness		Belching		Skin rashes
	Hearing difficulties		Bloating		Psoriasis
	Earaches or drainage		Abdominal pain or cramps		Dandruff or seborrhea
	Noises or ringing in the ears		Constipation		Hives
	Recurrent ear infections		Diarrhea or loose stools		Itching or burning skin
	Sore or bleeding gums		Blood with stools		Hypothyroid (low)
	Dental problems/decay		Rectal itching		Easy bruising
	Sore tongue		Black stools		Hyperthyroid (high)
	Coated tongue		Pain in rectum		Weight gain
	Loss of taste or smell		Jaundice		Weight loss
	Sores in or around mouth		Hepatitis/pancreatitis		Feel excessively warm
	Difficulty swallowing		Crohn's disease		Loss of appetite
	Cold sores or fever blisters		Diverticulitis or diverticulosis		Constant hunger
	Sinus or nasal congestion				Fatigue or weariness
	Runny nose		Frequent urination		Night sweats
	Frequent colds		Brown or red urine		Diabetes
	Nasal polyps		Decreased force of urine		Low blood sugar
	Swollen glands		Involuntary escape of urine		Nervousness or anxiety
	Recurrent fevers or chills		Difficulty starting urination		Depression
	Recurrent fevers or chills		Difficulty stopping urination		Suicidal thoughts
	Hoarse voice		Kidney or bladder infection		Sought psychological help
	Shortness of breath		Herpes (oral or genital)		Painful testicles
	Wheezing or gasping		Osteoporosis		Hernia
	Coughing		Aching muscles or joints		Prostate problems
	Chest colds or pneumonia		Joint stiffness		Erectile dysfunction
	Heart murmur		Back or neck pain		Low sex drive

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GYNECOLOGICAL HISTORY FORM

Describe any current gynecological problem

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Pap smear information

Date of last pelvic exam	
Performed by	
Pap results	
Have you ever had abnormal pap Results? If so what was found and how long ago?	

Socially transmitted disease information

Have you ever had genital Herpes?	
Venereal warts or papilloma virus? If so, note your treatment and date(s).	
Have you ever been tested for Chylamdia? Did you receive treatment?	

Menstrual information

Your age at your first menstrual period	
Dates of last two periods	
Usual length of cycle	
Are they regular or irregular? Provide details if irregular	
Do you spot between periods?	
Usual number of days of menstrual bleeding	
Flow: Number of saturated pads or tampons.	
Do you pass clots?	
Type of pad or tampon used	
Do you use feminine hygiene sprays, deodorant pads or tampons?	

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Males only

Changes in erections or ejaculation?	
Fatigue?	
Weakness?	
Decreased sex drive?	
Difficulty sleeping?	
Mood swings or changes in decision making abilities?	
Weight changes?	
Annual prostate exams?	
Night time urination?	If yes note how many times wakened per night to void:

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Females only

MENSTRUAL CYCLE SYMPTOMS

In the column place the appropriate letter that applies to your cycle. P=premenstrual D=during A=after the menstrual bleeding.

P / D / A	Symptom	P / D / A	Symptom
	Intermittent abdominal cramps		Constant cramps
	Low back pain		Pressure sensations
	Headaches		Sugar cravings
	Depression		Irritability
	Breast tenderness		Acne
	Mood swings		Other symptoms:

Infection and yeast information

Have you had yeast or other vaginal infections? List frequency and treatments.	
Undiagnosed vaginal discharges? Describe	
What type of under-garment do you wear? (cotton, nylon, blend)	

Birth control and pregnancy

Do you use birth control? If so describe your method and for how long you have been using it.	
Note the birth control methods you have used in the past: Temperature/rhythm, diaphragm, foam, condoms, IUD, injectable, hormone ring, oral, patch. Give reason for discontinuation of methods previously used.	

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Birth control and pregnancy (continued)

Number of pregnancies and their dates.	
Outcome of pregnancies	
Describe infertility problems	
Have you ever breast fed? When and for how long?	
Have you ever had breast lumps? Describe if any:	
Fibrocystic breast disease?	
Do you do self breast exams? How often?	
Do you ever have nipple discharge? Describe if any:	
Have you ever had surgery, including biopsy, needle biopsy or implants to your breast? Provide details:	
Are you in menopause now? If so, are you still spotting or bleeding?	
Do you have hot flashes? If so, do they interfere with your activities of daily living?	
Are you post-menopausal? If so, when did you go through menopause?	
Have you ever had pelvic inflammatory disease? Describe.	
Describe any other problems and their treatments, such as endometriosis, fibroids, ovarian cysts, etc.	
Do you ever experience pain in the lower abdomen?	
Pressure in the vagina?	
Painful intercourse?	
Any change in sex drive or pleasure?	

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Living environment

Do you live in an urban, suburban, country, seaside or lakeside environment	
Type of heat	
Humidifier?	
Wood stove?	
Type of insulation?	
If there is a cellar is it: dry, damp, musty, dusty?	
Is the house old or new?	
Has it been treated for insects? If so Most recent treatment and date.	
Do you use feather or down bedding or jackets?	
Do you have an air filter or cleaner?	
Are there animals at home or places you visit frequently? What kind?	
Do you use strong chemical cleaners, solvents, paints at home or at work? Provide details if possible.	

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Diet Survey

What do you normally drink and eat **between** meals?

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Check which meals you eat daily: ___ Breakfast ___ Lunch ___ Dinner

Do you eat after 8pm? _____

Do you eat between meals? _____

Do you feel sick, weak or faint if you delay eating? _____

Do you eat protein with each meal? _____

Are you a vegetarian? _____

Do you crave carbohydrates? _____

Habits

Do you binge eat?	
Do you use foods for reward or escape? If so, what foods do you tend to eat?	
What foods would be most difficult for you to give up?	
Do you have specific food cravings? Describe	
What work or scheduling considerations might create difficulties for you in trying to change your eating or any other health habits?	
List any food sensitivities:	

Are you interested in Hcg injections for weight loss? ___yes ___no

Are you interested in nutritional supplements for appetite suppression? ___yes ___no

Are you interested in blood testing to assess your current nutritional status? ___yes ___no

CENTER FOR WELLNESS

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DIET SURVEY

Please indicate all the following statements, being care to use the appropriate box related to the frequency of your personal habits.

FREQUENT = at least once per day; **OFTEN** = several times/week; **OCCASIONAL** = once/week or less; **SELDOM** = once or twice/month or less; **NEVER** = almost total avoidance

Food item	Frequent	Often	Occasional	Never
Alcoholic beverages				
Eat at restaurants				
Eat at fast food restaurants				
Pastries, cookies, candies, ice cream, sweets				
Add sugar to coffee, tea, cola, chocolate				
Deep fried foods				
Margarine of any type				
Whole grain hot cereals (oatmeal, wheatena)				
Meat (beef, veal, pork, ham, lamb, liver)				
Chicken or turkey (circle free range or regular)				
Fresh fish				
Processed meat (bologna, sausage, hotdogs etc)				
Fresh raw fruit				
Fresh vegetables, raw or cooked				
Salads				
Whole grains or breads				
White bread or white flour products				
Beans and legumes (lentil, kidney, chickpea etc)				
Yogurt – circle: whole or low fat Plain or flavored				
Milk – circle: whole, low fat or skimmed				
Cheese				
Eggs – circle: regular or free range				
Salt				
Herbs, fresh and dried or spices				
Drink adequate water – circle: tap, filtered, bottled				
Eat excessively if bored or depressed				
Swallow food before chewing well				
Hurried or rushed meals				
Stuff yourself				
Read and understand food labels				
Sneak or hide foods				
Adequate fiber or roughage in the diet				
Artificial sweeteners (saccharin, Nutrasweet etc)				
Shop at health food stores				

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LIFE INDEX

Here is a list of feelings that people sometimes have. Please read each one carefully and select the number that best describes your feelings most recently. Write the number in the space provided.

0 = not at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; 4 = extremely

01234	Feeling or thought	01234	Feeling or thought
	Nervousness or shakiness in side		Repeated unpleasant thoughts
	Loss of sexual interest or pleasure		Feeling exuberant or enthusiastic
	The idea that someone can control your thoughts		Feeling others are to blame for your troubles
	Trouble remembering things		Feeling afraid in open spaces or outside
	Feeling critical of others		Feeling that your goals and aims are clear in life
	Thoughts of ending your life		Hearing voices that others do not hear
	Feeling easily annoyed or irritated		Crying easily
	Feeling happy and lighthearted		Feeling shy or uneasy with the opposite sex
	Feeling of being trapped or caught		Temper outbursts that you cannot control
	Blaming yourself for things		Feeling blocked in getting things done
	Feeling in control of your life		Feeling lonely
	Feeling blue or depressed		Facing daily tasks is a source of pleasure
	Worrying too much about things		Feeling no interest in things
	Feeling fearful or afraid		Your feelings are easily hurt
	Others are aware of your private thoughts		Others do not understand you
	Must do things very slowly to insure correctness		Feeling watched or talked about by others
	Difficulty making decisions		Feeling afraid to travel by bus, train or in a car
	Feeling your personal existence is valuable		Your mind is in a fog
	Having a lump in your throat		Feeling tense or keyed up
	Heavy feeling in your arms or legs		Thoughts of death or dying
	Feeling uneasy when people are watching you		Having to repeat the same actions over and over
	Having urges to break or smash things		Feeling self-conscious with other
	Having a good sense of humor		Feeling everything is an effort
	Spells of panic or terror		Getting into frequent arguments
	Feeling relaxed		Feeling nervous when you are left alone
	Feeling that others do not give you proper credit for your achievements		Feeling your life is filled with good things
	Feeling lonely even when you are with people		Never feeling close to another person
	Feeling at peace with your surroundings		Feeling of guilt
	Having the idea that something is wrong with your mind		Feeling very responsible for others
	Feeling able to turn to your family for help when something is troubling you		Feeling satisfied with your family's affection and responses to your emotional needs
	Feeling harmony in your personal world		Feeling angry
	Feeling that your ability to find meaning in life is very great		Being a very responsible person
	Feeling good about your personal relationships		

LIFE CHANGE INDEX

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This index, developed by Drs. Holmes and Rahe, indicates degrees of stress related to changes in life. Even enjoyable events can be stressful. Life change scores that are high are related to more illness. In studies, many people who scored over 300 became ill within a three to six month period. If an event has been true for you in the past year, or is about to happen, circle the associated point value. If an unlisted event has occurred, add it to the bottom of the list and assign it a point value. Add up all the points.

Event	Points	Your score	Event	Points	Your score
Death of a spouse or partner	100		Trouble with in-laws	29	
Divorce	73		Outstanding personal achievement	28	
Separation from spouse or partner	65		Spouse/partner begins/ stops work	26	
Jail term	63		Change in living conditions	25	
Death of a close family member	63		Revision of personal habits	24	
Personal injury or illness	53		Trouble with boss or employee	23	
Marriage/commitment to a partner	50		Change in work hours or conditions	20	
Fired at work	47		Change in schools	20	
Reconciliation with spouse or partner	45		Change in recreation	19	
Retirement	45		Change in church activities	19	
Change in health of family member	39		Change in social activities	18	
Pregnancy	40		Mortgage loan under \$100,000	17	
Sex difficulties	39		Change in sleeping habits	16	
Addition of new family member	39		Change in eating habits	15	
Business readjustment	39		Vacation	13	
Change in financial state	38		Christmas approaching	12	
Death of a close friend	37		Trouble with in-laws	11	
Change to a different line of work	36				
More arguments with a spouse or partner	35				
Mortgage over \$50,000	31				
Foreclosure of mortgage or loan	30				
Change in work responsibilities	29				
Child leaving home	29				