Natural Medicine Center
4550 W. League City Pkwy #130
Phone: 281-286-6040 Fax: 281-286-4120

Dr. Robert Rakowski, DC, CCN, DACBN, DIBAK

Patient Information

Patients Name ..... **Date of Birth** .....

E-Mail .....

Address ..... **City** .....

ST ..... **Zip** .....

Primary Contact # .....**Home/Work/Cell (circle)**

Marital Status: (S)..... **(M)** .....**(W)** .....**(D)**..... **(Separated)** .....

Employer .....

Referred by: .....

Natural Medicine Center Cancellation Policies and Fees

Your appointment is reserved especially for you. We value your health and your business and ask that you honor the office's scheduling policies. We recognize that the time of our patients and staff is valuable and have implemented this policy to benefit everybody. When you miss an appointment with us, you not only sacrifice your own health progress, but it creates a gap in the schedule that another patient could have utilized, had we known in advance.
A credit card is required to hold your appointment. Should you need to cancel or reschedule, please notify us at least 24 hours in advance for chiropractic, and 48 hours in advance for nutrition/testing appointments. The cancellation fee is $125 for new patient testing. The fee for all other services is equal to half the cost of the scheduled service. This amount will be charged to the card provided if cancellations are not made in the time frame listed above. We understand that life emergencies and situations beyond your control arise and will take that into consideration if you're unable to keep the appointment that was reserved for you.
Your cooperation and understanding are greatly appreciated and will help us to be able to serve the needs of our patients more effectively.

CC number **Exp. Date** **Sec #**

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.
My signature below is proof that I have read and understand the financial/cancellation policy.

Signature **Date**

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Informed Consent for Chiropractic, Nutrition, and Acupuncture

The nature of Chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joints in a very specific way. You may feel a "click" or "pop" and you may feel movement of the joint. This is normal, but does not always occur with every adjustment.

The nature of Acupuncture treatment: The doctor may also use acupuncture as an adjunct, or in whole, during your care. Acupuncture involves the insertion of tiny needles into the body through the skin. It may also involve the use of pressure or electrical stimulation separately, or in conjunction with needling.

The nature of Nutrition treatment: The doctor may also advocate the use of specific nutrients during your care. This involves the prescription of brand name individual or combination products. Rest assured that the Natural Medicine Center uses only the highest quality products. Possible risks as with all health care, complications are possible following a chiropractic, acupuncture, and nutrition therapy.

---Chiropractic complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. These complications are extremely rare occurrences. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

---Acupuncture complications include infection at the needling site, organ perforation, bleeding, and pneumothorax. The style of acupuncture used at Natural Medicine Center is typically more superficial lessening the possibility of complications.

---Nutritional complications include the risk of adverse nutrient-reactions and hypersensitivity. Nutrients are in general well tolerated, however as with any medication, if any adverse symptoms occur with nutrient use, discontinue immediately and consult you treating doctor.

The risks of complications due to Chiropractic treatment have been described as “rare”. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. It is safer to get adjusted than it was to get in your car and drive to our clinic! The probability of adverse reaction due to acupuncture and nutrient therapy are also considered “rare”. They would be significantly less than the chance of adverse complications due to prescription medication use or surgery.

Risks of remaining untreated:
Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make further rehabilitation more difficult. Delaying treatment of nutrient therapy can lead to a variety of chronic diseases such as diabetes, heart disease, cancer, stroke, death etc.

Unusual risks:
I have had any unusual risks of my case explained to me. I have read the explanation above of Chiropractic, nutrition, and acupuncture treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment and understand that no guarantees of outcome have been made. I have also disclosed all medical information to the doctor.

By signing this document, I have freely decided to undergo the recommended treatment, and hereby give my full consent for treatment. I accept the risks and release Dr. Rakowski/Romportl of any liability for any injury or loss directly related to care I have received at this clinic.

Authorization to Release Information

I HEREBY AUTHORIZE THE NATURAL MEDICINE CENTER OR HIS BILLING AGENT TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY DIAGNOSIS OR TREATMENT TO MY INSURANCE COMPANY OR PERSONS REPRESENTING MY CASE.

.....
Patient Name:

.....
Patient Signature

.....
Date

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	**TOTAL** _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	**TOTAL** _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	**TOTAL** _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	**TOTAL** _____
MOUTH/ THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	**TOTAL** _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	**TOTAL** _____
HEART	_____	Chest pain	
	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	**TOTAL** _____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	**TOTAL** _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	**TOTAL** _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Feeling of weakness or tiredness	
	_____	Pain or aches in muscles	**TOTAL** _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Water retention	
	_____	Underweight	
	_____	Compulsive eating	**TOTAL** _____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	**TOTAL** _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
	_____	Poor concentration	
	_____	Poor physical coordination	**TOTAL** _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	**TOTAL** _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	**TOTAL** _____
GRAND TOTAL			**TOTAL** _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? _____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: _____

For Practitioner Use Only:

OVERALL SCORE TABULATION

Recommended protocols based on new detoxification questionnaire (MSQ and XTT)

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)

XTT SCORE _____ (High >10; moderate 5-9: Low <4)

MSQ Score	XTT Score	Description	Functional Medicine Protocol		
			Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance

Additional Symptom-Specific Support

Symptom	Nutraceutical Support
Water retention and/or frequent or urgent urination	Kidney support nutraceuticals
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

Identi-T™ Stress Assessment

Name _____ **Age** _____ **Sex** _____ **Date**_____

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:
Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I...

Section A:

1. Get wound up when I get tired and have trouble calming down 0 1 2 3
2. Feel driven, appear energetic but feel "burned out" and exhausted 0 1 2 3
3. Feel restless, agitated, anxious, and uneasy 0 1 2 3
4. Feel easily overwhelmed by emotion 0 1 2 3
5. Feel emotional — cry easily or laugh inappropriately 0 1 2 3
6. Experience heart palpitations or a pounding in my chest 0 1 2 3
7. Am short of breath 0 1 2 3
8. Am constipated 0 1 2 3
9. Feel warm, over-heated, and dry all over 0 1 2 3
10. Get mouth sores or sore tongue 0 1 2 3
11. Get hot flashes 0 1 2 3
12. Sleep less than seven hours a night 0 1 2 3
13. Have trouble falling asleep and staying asleep 0 1 2 3
14. Worry about high blood pressure, cholesterol, and triglycerides 0 1 2 3
15. Forget to eat and feel little hunger 0 1 2 3

Total points: _____

Section B:

1. Find myself worrying about things big and small 0 1 2 3
2. Feel like I can't stop worrying, even though I want to 0 1 2 3
3. Feel impulsive, pent up, and ready to explode 0 1 2 3
4. Get muscle spasms 0 1 2 3
5. Feel aggressive, unyielding, or inflexible when pressed for time 0 1 2 3
6. See, hear, and smell things that others do not 0 1 2 3
7. Stay awake replaying the events of the day or planning for tomorrow 0 1 2 3
8. Have upsetting thoughts or images enter my mind again and again 0 1 2 3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over 0 1 2 3
10. Worry a lot about terrible things that could happen if I'm not careful 0 1 2 3

Total points: _____

Section C:

1. Have muscle and joint pains 0 1 2 3
2. Have muscle weakness 0 1 2 3
3. Crave salt or salty things 0 1 2 3
4. Have multiple points on my body that when touched are tender or painful 0 1 2 3
5. Have dark circles under my eyes 0 1 2 3
6. Feel a sudden sense of anxiety when I get hungry 0 1 2 3
7. Use medications to manage pain 0 1 2 3
8. Get dizzy when rising or standing up from a kneeling or sitting position 0 1 2 3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason 0 1 2 3
10. Have headaches 0 1 2 3

Total points: _____

Metagenics™
Genetic Potential Through Nutrition

Section D:

1.	Have trouble organizing my thoughts	0	1	2	3
2.	Get easily distracted and lose focus	0	1	2	3
3.	Have difficulty making decisions and mistrust my judgment	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6.	Am forgetful	0	1	2	3
7.	Feel unsettled, restless, and anxious	0	1	2	3
8.	Wake up tired and unrefreshed	0	1	2	3
9.	Experience heartburn and indigestion	0	1	2	3
10.	Catch colds or infections easily	0	1	2	3

Total points: _____

Section E:

1.	Feel tired for no apparent reason	0	1	2	3
2.	Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3.	Find it difficult to concentrate and complete tasks	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Feel cold or chilled – hands, feet, or all over – for no apparent reason	0	1	2	3
6.	Have little or no interest in sex	0	1	2	3
7.	Sweat spontaneously during the day	0	1	2	3
8.	Feel puffy and retain fluids	0	1	2	3
9.	Sleep more than nine hours a night	0	1	2	3
10.	Have poor muscle tone	0	1	2	3
11.	Have trouble losing weight	0	1	2	3
12.	Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13.	Have no energy and feel physically weak	0	1	2	3
14.	Am susceptible to colds and the flu	0	1	2	3
15.	Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: _____

Add points from sections A, B & C	**Total for A, B & C:** _____
Add points from sections C, D & E	**Total for C, D & E:** _____

LIfestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   _____
3. I eat breakfast _____ times a week. My typical breakfast is: _____
4. I take a multiple vitamin/mineral _____ days per week. I take a fish oil supplement _____ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke _____ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

What types of therapy have you tried for this problem(s):

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather, etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m. – 9 a.m. ❑ 9 a.m. – 11 a.m. ❑ 11 a.m. – 1 p.m.
❑ 1 p.m. – 3 p.m. ❑ 3 p.m. – 5 p.m. ❑ 5 p.m. – 7 p.m.
❑ 7 p.m. – 9 p.m. ❑ 9 p.m. – 11 p.m. ❑ 11 p.m. – 1 a.m.
❑ 1 a.m. – 3 a.m. ❑ 3 a.m. – 5 a.m. ❑ 5 a.m. – 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. – 9 a.m. ❑ 9 a.m. – 11 a.m. ❑ 11 a.m. – 1 p.m.
❑ 1 p.m. – 3 p.m. ❑ 3 p.m. – 5 p.m. ❑ 5 p.m. – 7 p.m.
❑ 7 p.m. – 9 p.m. ❑ 9 p.m. – 11 p.m. ❑ 11 p.m. – 1 a.m.
❑ 1 a.m. – 3 a.m. ❑ 3 a.m. – 5 a.m. ❑ 5 a.m. – 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia (BPH)
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs
❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

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Notice of Financial Agreement

To our patients:

The Natural Medicine Center is very pleased to have you as a new patient. We are honored you have selected our clinic for your care.

We do not file Insurance claims however, we will work with you to insure that you have all the necessary documentation to file with your insurance carrier so they can process and pay your claims in a timely manner. Should you be covered by Medicare, you will not be eligible to submit your claims to them since we are not a Medicare provider.

If you are receiving treatment as a result of a motor vehicle accident, you are responsible for paying all costs at the time of treatment. A statement will be provided for you to file with the responsible party for reimbursement purposes.

If it is necessary to initiate action to collect any unpaid balance on your account, you agree to pay reasonable costs of collection, including necessary attorney fees and court costs.

Agreed:

*Patient Signature*_____ *Date* _____

Patient Name (print) _____

*Witness*_____

Natural Medicine Center
4550 W. League City Pkwy #130 - League City, TX 77573
Phone: 281-286-6040 Fax: 281-286-4120

Dr. Robert Rakowski, DC, CCN, DACBN, DIBAK

Pre-test Instructions

1. No lipstick or lip balm morning of test day. All other makeup and deodorant is ok.
2. No Food 12 hours before test appointment.
3. Nothing to drink 12 hours before test appointment, this includes water.
4. No Toothpaste, gum, mouth wash/spray - 12 hours before test. You may brush your teeth at the clinic after your appointment.
5. Collect the first morning urine after 4:00 A.M. on the morning of your test.
6. No skin lotions on your hands or feet.

Important reminder: *any appointments missed or cancelled less than 48 hours in advance will incur a missed appointment fee that will be charged to the credit card on file.*