Client Name: ____

Appointment Date: M T W Th F S ______________ **Time:** ________________ **AM / PM**

CELLULAR DETOXIFICATION & CUSTOMIZED NUTRITION PROGRAM

What will occur?

Be sure to arrive 15 minutes early for your appointment, to finish additional paperwork.

At your first appointment you will be given a few preliminary non-invasive exams that will help determine if you are in a state of inflammation, including:

- Body Composition Analysis
- Meta Oxy Urine Analysis
- Vision Contrast Sensitivity Test
- Orthostatic Blood Pressure Test
- In-depth Proprietary Analysis of your NeuroToxic Questionnaire

The length of the entire first appointment is typically 50-60 minutes.

Following your initial visit, Dr. Schwartz will recommend any additional testing and customize a plan for you to get well! Future costs will depend on each individual's needs.

What do I need to bring?

We highly encourage you to bring your spouse to this appointment. Also bring the packet of intake paperwork completed. If you wear glasses or contacts at all, make sure you have them with you. If you have any labs you think are relevant from the past year, please bring copies of your test results to this appointment.

What is the policy on rescheduling this appointment?

If you are more than 15 min late for your appointment or do not have your paperwork completed or with you, the appointment is considered cancelled. You may reschedule this appointment up to 24 hours in advance. Outside of a catastrophic occurrence, you will be charged for any less-than-24 hour cancelations, late arrivals, or no-shows.

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Directions to Triad Health Center:

We are located at 2311 W Cone Blvd Suite 228, Greensboro, NC 27408

We are on the corner of W Cone Blvd and Battleground Ave. Our clinic is in the Northwestern Plaza office complex, which sits directly behind the All Pets Considered store and UPS Store. There is a McDonald's catty corner from our building.

If you need further directions, please call us: 336-288-4677

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EXPECTATIONS

"You didn't get sick over night, do not expect to get better over night."

The majority of patients who enter our office have been developing their illness for 20-30+ years. The process of getting well is much like the stock market; you will have good days and bad days. However, as you look back on your care you will realize you have always been progressing. I have been treating very sick people including myself for many years and I have never seen or experienced a progression to health in any other way.

My point is you are going to have bad days and that does not mean you are regressing. You will also have good days and those good days do not mean that you are cured.

True healing takes time. You can cover symptoms in hours or days but to remove a cause you will need to be patient and committed to the process. I can tell you from personal experience as it took 3-4 years to regain my complete health. With that said, after 6 months of treating the cause I was able to see the light at the end of the tunnel. My hope had returned.

What You Can Expect From Us:

1. **Our commitment** to get to the true cause of your illness.

2. **Our support**, as we are here to offer you not just hope but a path to follow.

3. **Encouragement** based on our experience of treating very sick patients and going from pain to purpose in our own health battles.

4. **Value,** we understand that the majority of our patients have financial burdens many of which occur because of their illness. Therefore, we created a health investment discount package to make it more affordable (based on the minimal amount of visits, testing and fees). We obviously have to charge for our services, as we are a business but by no means over charge in regards to today's medical fees. It is our goal to restore your health and life.

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What NOT To Expect From Us:

1. **Do not expect a "get fixed quick scheme"** or a **"magic bullet"**. Most illnesses do not occur overnight and true healing takes time.

2. **Do not expect to be coddled** - we are going to be tough because we have to be! We will not necessarily tell you what you want to hear but we will tell you what you need to hear to regain your health and life. Most of the patients that we treat are in the death zone. We have found the only way to pull them out of the death zone is to not coddle but to speak truth into their lives.

What We Expect From You:

1. **Commitment to lifestyle changes.** It's not easy but when getting to the cause lifestyle changes such as diet, exercise, toxin avoidance, and attitude are a must in to return someone back to a state of health.

2. **Commitment to the protocols** that we outline for your case. It is the individuals that stick closely to the protocols and that remain diligent that get the most consistent results.

3. **Patience**. REMEMBER you didn't get sick over night and you will not get better overnight.

We are excited to help you reach your optimal health potential!

Dr. David Schwartz, DC

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Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "*Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.*"

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above information:

_______________________________ _______________________

Client Signature **Date**

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- Patient Policy Form -

Welcome to Triad Health Center. We are excited to provide you with your health care needs and are honored to work with you to achieve your optimal health goals.

Please review the information below. Sign your initials next to each line item below to indicate you understand our office policies before moving forward, and please sign and date the bottom of this form as acknowledgement of the patient policy contents listed below.

_______ Payment for all services and products is due at the time of the visit. As the patient, you are responsible for the total charges incurred for each visit. We accept Visa, Mastercard, Discover and American Express credit cards, debit cards, checks, and cash for payment. There will be a charge of $25.00 for each returned check.

_______ I give permission for the staff at Triad Health Center and the staff of Triad Health Center to contact me via telephone or email and to leave me messages that may contain appointment or medical information if I am not available.

_______ **Cancellation Policy:** Any appointment time changes or cancellations must be received 24 hours prior to appointment time. Missed consultation without a 24 hour cancellation notification will result in a $75 fee being charged to the client. **Cancellations must be received via phone at 336-288-4677.**

_______ We may recommend natural and alternative supplements, which may be purchased at Triad Health Center. Most insurance companies, Flexible Spending Accounts, and Health Savings Accounts do not cover the supplemental items that we recommend and sell.

I have read and understand the above stated policies and will comply with them in all aspects.

IF TREATMENT IS TERMINATED PRIOR TO PROGRAM COMPLETION, FINANCIAL RESPONSIBILITY TO THE PATIENT IS ASSESSED AT A PER VISIT FEE IF PATIENT IS ON A LONGTERM PROGRAM OPTION. ANY PHONE CALLS OR EMAILS REGARDING ANY ADDITIONAL QUESTIONS OUTSIDE THE SCHEDULED CONSULT WOULD BE OF AN EXTRA CHARGE. ADMINISTRATIVE CHARGES ARE BASED ON 15 MINUTE INCREMENTS AT $25.00 each.

____ ______________________

Client Signature **Today's Date**

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Name: ___________________________________ Date: ________________

Plese list what you have eaten the last three days. If you cannot remember specifics, please list what 3 typical days of eating are.

	Day One	Day Two	Day Three
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			

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Please list how many days per week you are eating out (1-7) for each meal time, and give examples of your most frequented restaurants.

Breakfast: ___________ Days per week.

Where:____

____

____

Lunch: ___________ Days per week.

Where:____

____

____

Dinner: ___________ Days per week.

Where:____

____

____

What time do you wake up in the morning? _______________________

What time do you leave your house for work/school/errands?

____

What is your favorite food?

____

What is your favorite restaurant?

____

Do you wake up hungry? _______________________________________

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NEUROTOXIC QUESTIONNAIRE

Name:		**Date:**			
Address:					
City:		**State:**		**Zip code:**	
Home #:		**Cell #:**			
Email:					

DOB:		**Gender:**	☐ Male	☐ Female	
Age:		**Height:**		**Weight:**	

Status:

☐ Married	☐ Widowed
☐ Separated	☐ Single
☐ Divorce	☐ Partnership

I live with:

☐ Spouse	☐ Children
☐ Partner	☐ Friends
☐ Parents	☐ Alone

Education: ____

Occupation: _____________________________________ **Hours / Week:** _____________ ☐ **Retired**

Employer: ___________________________ **Work Address:** __________________________________

In case of emergency, whom should we contact:

Name	Relationship	Address	Phone

How did you hear about our Wellness and Nutrition Program?

____

____

____

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What is your major complaint? Please list when each symptom began and be as descriptive as possible:

____
____
____
____
____
____
____

What are your current medications?

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

What are your current vitamins / supplements?

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list your current and past health conditions (e.g. Diabetes Melitus, Fibromyalgia, etc.):

____
____
____
____
____
____
____

Is there anything else in your medical history that you consider to be relevant (even from childhood)?

____
____
____
____
____
____
____

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What is your employment history? Please provide brief summary including dates if possible.

____
____
____
____
____

Please list your past or present Hobbies that could be sources of toxicity or chemicals:

____
____
____
____

How often are you involved in these Hobbies currently?

____
____
____
____

Please list past or present allergies, including allergies to medications.

____
____
____
____
____

Please list all past surgeries and the condition each surgery was for, including dates.

____
____
____
____
____
____

Please explain your housing history (type of homes, where and when).

____
____
____
____
____
____
____

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Patient History:

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

MERCURY		
□ Yes	□ No	Do you have amalgam (silver) fillings in your teeth? If so, How many? _________
□ Yes	□ No	Have you ever had an amalgam removed? If Yes, How many?______ When? ___________
□ Yes	□ No	If you had amalgams removed, was it done by a biological dentist using a safe protocol?
□ Yes	□ No	Did your mother have amalgam when pregnant with you?
□ Yes	□ No	Do you have any dental crowns? If so, How many? ___________
□ Yes	□ No	Have you ever worked in a dental office? If so, how long? ________________
□ Yes	□ No	Have you had any dental crowns? If yes, how many? ___________
□ Yes	□ No	Have you had any bridges?
□ Yes	□ No	Have you had any root canals?
□ Yes	□ No	Have you had any tooth extractions?
□ Yes	□ No	Do you have any dental implants, retainers or other metal in your mouth? Explain:_______ ____
□ Yes	□ No	Did you wear contact lenses during the 1980's or early 1990's?
□ Yes	□ No	Did you take oral contraceptives during the 1980's or early 1990's?
□ Yes	□ No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
□ Yes	□ No	Have you noticed any adverse reactions to these shots?
□ Yes	□ No	Do you have any tattoos with red ink?
□ Yes	□ No	Do you eat large amounts (more than twice weekly) of tuna, shark, swordfish or Atlantic Salmon?

LEAD		
□ Yes	□ No	Does your occupation involve soldering or metal salvage?
□ Yes	□ No	Have you done any old home repair or sandblasting? If so, when_____________________
□ Yes	□ No	Do you do a lot of painting?
□ Yes	□ No	Was your home built before 1978?
□ Yes	□ No	Have you ever worn cosmetics containing kohl? (make-up with dark black or red pigment)
□ Yes	□ No	Are you around a lot of fake leather, or vinyl?
□ Yes	□ No	Do you get stomach aches in the morning?

GENERAL TOXICITY		
□ Yes	□ No	Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
□ Yes	□ No	Do you smoke or use tobacco?
□ Yes	□ No	Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
□ Yes	□ No	Do you have your house sprayed with pesticides for pest control?
□ Yes	□ No	Do you spray herbicide (weed killers) in or around your home?
□ Yes	□ No	Do you use conventional insect repellants on yourself or family?
□ Yes	□ No	Do you use conventional sunscreen?
□ Yes	□ No	Do you use conventional perfume or cologne every day?
□ Yes	□ No	Do you get your hair colored? If so, is it on the scalp?
□ Yes	□ No	Do you use aerosol hairspray?
□ Yes	□ No	Do you get your nails done? If so, how often? _____________
□ Yes	□ No	Do you use air freshener in your house, work or car?

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□ Yes	□ No	Do you drink filtered water? If so, what type of filter do you have? ____________________
□ Yes	□ No	Do you drink bottle water if so what kind?
□ Yes	□ No	Do you have a water filtration system for your entire house or shower filtration? If so, what type? ____
□ Yes	□ No	Does your spouse or other family members work around chemicals?
□ Yes	□ No	Can you think of any other toxic exposures you may have had?

MOLD		
How old is the house you are living in? _____________________ How long have you lived there? _________________		
Have you noticed any new symptoms since moving in? ___________ If so, what?______________________________		
□ Yes	□ No	Do you see mold growing at home, work or school?
□ Yes	□ No	Have you ever had water damage at home, work or school?
□ Yes	□ No	Does your home, workplace or school have a damp or mildew smell?
□ Yes	□ No	Does spending time in your basement cause or worsen your symptoms?
□ Yes	□ No	Does your basement ever get wet?
□ Yes	□ No	Do you have a crawl space?
□ Yes	□ No	Does your basement or crawl space have a sump pump?
□ Yes	□ No	Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
□ Yes	□ No	Does your car have a mildew smell?
□ Yes	□ No	Does anyone in your home have asthma like symptoms?
□ Yes	□ No	Does anyone in your family have chronic sinus infections or irritations?

LYME DISEASE		
□ Yes	□ No	Have you ever been diagnosed with Lyme Disease?
□ Yes	□ No	Have you had dry sockets or infected tooth extractions?
□ Yes	□ No	Do you have small joint pain?
□ Yes	□ No	Have you ever been bitten by a tick or recluse spider?
□ Yes	□ No	Have you ever seen a bulls-eye rash appear on any part of your body?
□ Yes	□ No	Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
□ Yes	□ No	Was your mother ever diagnosed with Lyme Disease?
□ Yes	□ No	Have you ever been diagnosed with Chronic Fatigues Syndrome, Fibromyalgia, Lupus, Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), or an Autoimmune condition?
□ Yes	□ No	Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

HEALTH HISTORY		
□ Yes	□ No	Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
□ Yes	□ No	Does anyone in your family experience similar symptoms to yours? What is your birth order (i.e. first born, second, third, etc.)? ____________________
□ Yes	□ No	Do you have any history of kidney dysfunction?
□ Yes	□ No	Do you or any immediate family member have a history with cancer?
□ Yes	□ No	Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
□ Yes	□ No	Are you currently having any thoughts of suicide?
□ Yes	□ No	Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
□ Yes	□ No	Do you have a history of strokes?

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□ Yes	□ No	Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?
□ Yes	□ No	Have you ever been in an auto accident, fallen or received a major physical injury?
□ Yes	□ No	Are you in menopause?

MICROBIOME HEALTH		
□ Yes	□ No	Do you get distention, bloating, feeling full and a noisy gut after eating healthy carbohydrates such as broccoli, Brussels sprouts or other vegetables?
□ Yes	□ No	Do you often have gas that has a sulfur or foul smell?
□ Yes	□ No	Are you sensitive to supplements?
□ Yes	□ No	Have you ever been vegan or vegetarian for any length of time?
□ Yes	□ No	Can you tolerate meat?
□ Yes	□ No	Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?
□ Yes	□ No	Have you taken birth control or Hormone replacement therapy for any length of time?
□ Yes	□ No	If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?
□ Yes	□ No	Have been on antibiotics for any extended period of time or often as a child or adult?
□ Yes	□ No	Were you caesarian de livered?
□ Yes	□ No	Were you breast fed? If so, how long ______________________
□ Yes	□ No	Does your gut temporarily feel better after a round of antibiotics?

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

POINT SCALE		
0 = Never had the symptom	2 = Occasionally have it, severe effect	4 = Frequently have it, severe effect
1 = Occasionally	3 = Frequently have it, mild effect	

COLUMN #1

	Anxiety
	Mood Swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5^{o})
	Insomnia (can't get to sleep or return to sleep)
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound
	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child

COLUMN #2

	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Bad night vision or seeing halos around light
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Blurred vision at times
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep
	Receive static shock more often and with more dramatic effect than normal (doorknobs, car, light switch, people)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night

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	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)
	Total of Column 1

	Joint pain-not necessarily true arthritis-can more from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)
	Total of Column 2
	TOTAL OF COLUMNS 1 + 2

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