TRIAD
Health Center

Patient Name: _____

Appointment Date: **M** ☐ **T** ☐ **W** ☐ **Th** ☐ **F** ☐ **S** ☐ **Date:** _____ **Time:** _____ **AM** ☐ **/ PM** ☐

FUNCTIONAL MEDICINE & NUTRITION PROGRAM

Welcome to Triad Health Center! We are excited to help you on your journey through natural healthcare.

Inside of this packet, you will find: instructions to prepare for your initial consultation and assessment with Dr. Schwartz, an outline of expectations, and a detailed intake paperwork questionnaire.

Prior to your consultation…

You will need to fill out the intake paperwork forms completely and as detailed as possible. You must complete the paperwork and either bring with you to your appointment or email it back to us **at least 2 hours prior to your appointment: staff@triadhealthcenter.com**. If you have any labs you think are relevant from the past 2 years, please bring copies of your test results with you.

What will occur?

Be sure to arrive at least 15 minutes early for your appointment to allow time for parking, check-in, and to complete any additional paperwork upon arrival.

>> Triad Health Center: 301 Pisgah Church Rd, Suite H, Greensboro, NC 27455

At your first appointment you will meet with Dr. Schwartz for an in-depth health history exam working through your intake paperwork, any past labs, and discussion of your needs and health goals.

You will also be given a few preliminary non-invasive exams that will help determine if you are in a state of inflammation, including:

- Body Composition Analysis
- Visual Contrast Sensitivity Test
- Orthostatic Blood Pressure Assessment
- In-depth Proprietary Analysis of your NeuroToxic Questionnaire

The length of the entire first appointment is typically 90-120 minutes.

Following your initial consultation, 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?

This packet of paperwork fully completed. If you wear glasses or contacts at all, make sure you have them with you. Copies of any labs, imaging, or treatment plans from the past two years. A notebook and pen. And we highly encourage your spouse attend this appointment with you.

What is the policy on rescheduling this appointment?

If you are more than 15 minutes late for your appointment or your paperwork is not 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 (see our Patient Policies).

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. The same can be for you.

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.

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 order to return 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, MS-HNFM, D.PSc

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.

Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (Drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

I have read and understand the above information:

Patient Signature **Date**

Sale of Nutritional Supplements at Triad Health Center, PLLC

You are under no obligation to purchase nutritional supplements at our clinic. As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or big box stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

As always, if you have questions or concerns, please discuss them with our staff.

I have read and understand the above information:

Patient Signature **Date**

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 our office policies. Initial each line item to indicate your understanding, then sign and date the bottom of this form as acknowledgement of our patient policies outlined below.

_____ **PAYMENT POLICY** 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 and debit cards for payment, as well as HRA, FSA, HSA and Christian Health Share.

We do not directly bill these services to health insurance. If you are seeking a method of reimbursement, you may request an itemized super bill receipt following each payment, and a super bill will be supplied by email within 72 business hours of receiving your request.

We may recommend natural and alternative supplements, which may be purchased from Triad Health Center. Most insurance companies do not cover the supplemental items that we recommend and sell. FSA, HRA, and HSA may or may not cover the supplemental items that we recommend and sell, and it is your (the client's) responsibility to research coverage and communicate with the FSA / HRA / HSA company regarding coverage.

_____ **SUPPORT POLICY** Any additional questions outside of scheduled consultations, including phone calls or emails from Dr. Schwartz or his support staff, are an extra charge, based in 15-minute increments at $60.

_____ **ARRIVAL POLICY** For all appointments, be sure to arrive and be ready at least 15 minutes early. Early arrival allows for a relaxed and unhurried experience, and ensures time to take care of any paperwork prior to appointment time. If late arrival is inevitable, your appointment may need to be shortened in order for the practitioner to stay on schedule. The original reservation fee will be charged.

_____ **LATE ARRIVAL POLICY** We regret that late arrivals will not receive extension of scheduled appointments. The original reservation fee will be charged.

_____ **RESCHEDULE & CANCELLATION POLICY** We require at least 24 hours notice if you need to reschedule or cancel an appointment. If a client fails to cancel within 24 hours, they will be asked to pay in full the amount of this missed appointment, and use it as a pre-payment for future services. An additional late/missed appointment charge of $75 will be assessed. **Cancellation and reschedule requests must be received via phone or email: 336-288-4677 or staff@triadhealthcenter.com.**

_____ **NO SHOW POLICY** Clients who fail to show for appointments will be asked to pre-pay for future services and an additional missed appointment charge of $75 will be assessed.

_____ **CONFIDENTIALITY POLICY** The discussions between the practitioner and the client is confidential and is protected by state laws and the Health Insurance Portability and Accountability Act (HIPAA).

_____ **BREAK IN CARE POLICY** Clients who we have not been seen at Triad Health Center for Functional Medicine services for a year or more will be asked to fill out this form again.

_____ **TERMINATION OF LONGTERM PROGRAM POLICY** If treatment is terminated prior to completing a long-term program option, financial responsibility to the patient is assessed at a per visit fee.

_____ **COMMUNICATION POLICY** I give permission for the staff at Triad Health Center to contact me via telephone, text or email and to leave me messages that may contain appointment or medical information if I am not available.

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

Patient Signature	**Date**

TRIAD
Health Center

FUNCTIONAL MEDICINE INTAKE PAPERWORK

Name: Date:

Address:

City: State: Zip Code:

Home #: Cell #:

Email:

DOB: Gender: ☐ Male ☐ Female

Age: Height: Weight:

SSN: Insurance Info:

Status:

☐ Married ☐ Widowed

☐ Separated ☐ Single

☐ Divorced ☐ Partnership

I live with (check all that apply):

☐ Spouse ☐ Children

☐ Partner ☐ Friends

☐ Parents ☐ Alone

Education:

Occupation: Hours / Week: ☐ Retired

Employer: Work Address:

Primary Care Provider: Phone #:

In case of emergency, whom should we contact?

Name	Relationship	Phone #

How did you hear about our Functional Medicine and Nutrition Program?

What are your major complaints? List when each symptom began and be as descriptive as possible:

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

What are your current medications?

Medication	Dose	Reason for Taking

What are your current vitamins / supplements?

Supplement	Dose	Reason for Taking

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

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

Please list your past or present Hobbies (these 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. (Check all that apply.)

☐ Adhesives	☐ Animals	☐ Aspirin	☐ Bee Stings
☐ Ceftin	☐ Chocolate	☐ Dairy	☐ Dust
☐ Eggs	☐ Flax / Linseed	☐ Food Dyes / Colors	☐ Gluten
☐ Grains	☐ Latex	☐ Meat	☐ Molds
☐ Oxytocin / Codeine	☐ Peanuts / Nuts / Seeds	☐ Penicillin	☐ Pollen / Ragweed
☐ Rubber	☐ Seasonal Allergies	☐ Shellfish	☐ Soaps / Cleansers
☐ Soy	☐ Thickeners / Carrageenan	☐ Wheat	☐ X-ray / CT Dye
☐ Other:	☐ Other:	☐ Other:	☐ Other:

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).

How well have things been going for you (check all that apply)?

	Very Well	Fair	Poorly	Very Poorly	Does Not Apply
At school	☐	☐	☐	☐	☐
In your job	☐	☐	☐	☐	☐
In your social life	☐	☐	☐	☐	☐
With close friends	☐	☐	☐	☐	☐
With sex	☐	☐	☐	☐	☐
With your attitude	☐	☐	☐	☐	☐
With your partner	☐	☐	☐	☐	☐
With your spouse	☐	☐	☐	☐	☐
With your parents	☐	☐	☐	☐	☐
With your children	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No

If yes: ☐ Currently ☐ Previously, from ____ to ____

What kind? ____

Comments: ____

Food Journal

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

	Day One	Day Two	Day Three
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			
SNACK			

Eating Habits

Are you following a special diet? ☐ Yes ☐ No *If yes, check which:*

☐ Paleo	☐ AIP	☐ Pescatarian	☐ Other (describe):
☐ Keto	☐ Ovo-Lacto	☐ Vegetarian	
☐ Whole30	☐ Blood Type Diet	☐ Vegan	

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 is your favorite food? _____

What is your favorite restaurant? _____

What time do you wake up in the morning? _____

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

Do you wake up hungry? _____

How much of the following do you consume each week?

Candy		Cups of Tea		Salty Foods	
Cheese		Cups of Hot Chocolate		Regular Sodas	
Chocolate		Bread/Bagels/Rolls/Pasta		Diet Sodas	
Cups of Coffee		Ice Cream		Processed Meats	

Is there anything special about your diet that we should know? *Please explain:*

Do you have symptoms immediately after eating (e.g. belching, bloating, sneezing, hives, etc)?

☐ Yes ☐ No

If yes, are these symptoms associated with any particular food or supplement? ☐ Yes ☐ No

If yes, please name the food/supplement and associated symptom(s)(e.g. Milk = gas and diarrhea):

Do you feel you have delayed symptoms after eating certain foods (symptoms which may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc? ☐ Yes ☐ No

Do you feel much **better** or much **worse** when you eat a lot of:

Food Type	**Better**	**Worse**
High Fat Foods	☐	☐
High Protein Foods	☐	☐
Refined Sugar (junk food)	☐	☐
1-2 alcoholic beverages	☐	☐
High Carb Foods (bread, pasta, potatoes)	☐	☐
Fried Food	☐	☐
Other:	☐	☐

Does skipping a meal greatly affect your symptoms? ☐ Yes ☐ No

Have you ever had a food that you craved or "binged" on over a period of time? ☐ Yes ☐ No

If yes, what food(s)?

Do you have an aversion to certain foods? ☐ Yes ☐ No

If yes, what food(s)?

Check all that apply regarding your Bowel Movements (BM):

BM Frequency	✓
More than 3x/day	
1-3x / day	
4-6x / week	
2-3x / week	
1 or fewer x / week	

BM Color	✓
Medium brown consistently	
Very dark or black	
Greenish	
Blood / red visible	
Varies a lot	
Dark brown consistently	
Yellow / light brown	
Greasy / shiny / oily	

BM Consistency	✓
Soft and well formed	
Often float	
Difficult to pass	
Diarrhea	
Thin, long or narrow	
Small and hard	
Loose but not watery	
Alternate between hard and loose	

Do you experience intestinal gas (check all that apply):

☐ Daily ☐ Excessive ☐ Present with pain
☐ Occasionally ☐ Foul smelling ☐ Little odor

Have you ever used alcohol? ☐ Yes ☐ No

If yes, how often do you drink alcohol?

No longer consume alcohol ☐
Average 1-3 drinks per week ☐
Average 4-6 drinks per week ☐
Average 7-10 drinks per week ☐
Average >10 drinks per week ☐

Have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No

If yes, number of years as a nicotine user: _____ years. Amount per day: _____ Year quit _____

What type of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Are you exposed to second hand smoke regularly? ☐ Yes ☐ No

Do you have artificial joints or implants? ☐ Yes ☐ No

Do you feel **worse** at certain times of the year? ☐ Yes ☐ No

If yes, when? ☐ Spring ☐ Summer ☐ Winter ☐ Fall

Do odors affect you? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

If yes:

How often?	✓
4 x / week or more	☐
3 x / week	☐
2 x / week	☐
1 x / week	☐
2 x / month	☐
1 x / month	☐

How long is each session?	✓
≤ 15 minutes	☐
16-30 minutes	☐
31-45 minutes	☐
> 45 minutes	☐

What type of exercise?	✓
Jogging / Walking	☐
Running	☐
Biking	☐
Other:	☐

Is there any family history we should know about?

If yes, please explain:

What is the attitude of those close to you about your illness? ☐ Supportive ☐ Non-supportive

THIS SECTION IS FOR MEN ONLY

Date of last Thermography Screening _____ Results: ☐ Normal ☐ Abnormal

Date of last Prostate Exam _____ Results: ☐ Normal ☐ Abnormal

Do you fatigue easily during or after a workout? ☐ Yes ☐ No

Are you on any hormone replacement therapy? ☐ Yes ☐ No

If so, what? _____

Do you experience (check all that apply):

☐ Discharge from penis ☐ Ejaculation problem ☐ Genital pain ☐ Impotence ☐ Infection

☐ Lump in testicles ☐ Poor libido (sex drive) ☐ Prostate enlargement ☐ Prostate infection

☐ Other: _____ ☐ Other: _____

Any other hormone-related comments we should know? _____

TRIAD Health Center

THIS SECTION IS FOR WOMEN ONLY

Age at first period: _____ years

Are you periods now: ☐ Regular ☐ Irregular ☐ Heavy ☐ Scanty ☐ Spotting ☐ No periods

Date of last Thermography Screening _____ Results: ☐ Normal ☐ Abnormal

Date of last Pap Smear _____ Results: ☐ Normal ☐ Abnormal

Date of last Mammogram _____ Results: ☐ Normal ☐ Abnormal

Have you ever used birth control pills? ☐ Yes, when: _____ ☐ No

Are you taking the pill now? ☐ Yes ☐ No

Are you in menopause? ☐ Yes ☐ No *If yes,* age of last period: _____

Do you take: ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin ☐ Progesterone ☐ Provera

☐ Other: _____ ☐ Other: _____

How long have you been on hormone replacement therapy (if applicable)? _____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS symptoms)? ☐ Yes ☐ No ☐ Not applicable

Have you ever been pregnant? ☐ Yes ☐ No

If yes:

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? ☐ Yes ☐ No

Have you had other problems with pregnancy? ☐ Yes ☐ No

If so, please comment: _____

Do you experience (check all that apply):

☐ Ovarian cysts ☐ Poor libido (sex drive) ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Vaginal pain

☐ Vaginal discharge ☐ Vaginal odor ☐ Vaginal itch ☐ Breast cysts ☐ Breast lumps

Have you had a Hysterectomy? ☐ Yes, Partial ☐ Yes, Total ☐ No

Any other hormone-related comments we should know? _____

Patient History

Answer the following questions to the best of your ability. If you do not know the answer, simply leave it blank.

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?
☐ 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?

MERCURY		
☐ Yes	☐ No	Do you have amalgam (silver) fillings in your teeth? *If Yes,* 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 Yes,* How many?
☐ Yes	☐ No	Have you ever worked in a dental office? *If Yes,* 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 any 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?

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? *If Yes*, Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors? Yes No
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)?

LEAD		
Yes	No	Does your occupation involve soldering or metal salvage?
Yes	No	Have you done any home repair or sandblasting? *If Yes,* 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?

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 or respiratory symptoms?
Yes	No	Does anyone in your family have chronic sinus infections or irritations?

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, household cleaning products, 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?
☐ Yes	☐ No	Do you get your hair colored? *If Yes,* is it on the scalp?
☐ Yes	☐ No	Do you use aerosol hairspray?
☐ Yes	☐ No	Do you get your nails done? *If Yes*, how often?
☐ Yes	☐ No	Do you use air freshener in your house, work or car?
☐ Yes	☐ No	Do you drink filtered water? *If Yes*, what type of filter do you have?
☐ Yes	☐ No	Do you drink bottle water? *If Yes,* what kind?
☐ Yes	☐ No	Do you have a water filtration system for your entire house or shower filtration? *If Yes*, 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? *If Yes,* explain:

MICROBIOME HEALTH		
☐ Yes	☐ No	Do you get distention, bloating, feeling full and / or a noisy gut after eating healthy carbohydrates such as lettuce, 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 delivered?
☐ Yes	☐ No	Were you breast fed? If so, how long
☐ Yes	☐ No	Does your gut temporarily feel better after a round of antibiotics?

NEUROTOXIC QUESTIONNAIRE

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**	**5 = Constantly have it, severe effect**

	Dyslexia or loss of place while reading, even as a child
	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
	Dry skin
	Indecisiveness
	Swelling eyelids
	Gout (arthritic pain, especially in big toes)
	Floaters, shadows or swimmers when you read or look into the sky
	Hair falls out (not normal male pattern baldness)
	Depression
	Peeling on top layer of skin (hands, feet)
	Anemia (low iron/hemoglobin on blood test)
	Twitching eyelids
	Pain in shoulders or upper back
	Wrist/ankle drop or weak extensor muscles
	Heart pain (angina) and you are under 45 years old
	Total of Section 1

	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
	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 Section 2

☐	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°)
☐	Insomnia (can't get to sleep or return to sleep)
☐	Dizziness
☐	Sound in ears (ringing or hearing your heart beat)
☐	Psychological symptoms / thoughts of suicide
☐	Sensitivity to sound
☐	**Total of Section 3**

☐	Sensitivity to light
☐	Fatigue after exercising (feeling worse)
☐	Blurred vision at times
☐	Shortness of breath, with very little effort
☐	Excessive thirst and/or frequent urination
☐	Red eyes or tearing
☐	Bad night vision or seeing halos around light
☐	Morning stiffness
☐	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
☐	Chronic fatigue or weakness
☐	Non-restful sleep
☐	**Total of Section 4**

☐	**TOTAL OF SECTIONS 1 + 2 + 3 + 4**

☐ **CHECK HERE if you have lab results, imaging, and/or treatment plans from the past 1-2 years for Dr. Schwartz to review. Please bring these to your appointment or send to us: staff@triadhealthcenter.com**

YOU HAVE COMPLETED YOUR INTAKE FORMS

Please bring these forms with you to your appointment or return your completed PDF file to us by email at least 2 hours prior to your scheduled appointment time: staff@triadhealthcenter.com