SYMMETRIA
INTEGRATIVE MEDICAL
RELIEF | REPAIR | RESTORE

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# Nutrition Patient Health History Intake

Dear Candidate,
Congratulations on taking your first step toward reaching your health goals. Today you will be qualified based on several factors, including medical history and your level of commitment to achieving your desired results. During today's consultation, we will evaluate your areas of concern and see if you qualify for one of our treatment programs. Your success relies on your dedication and compliance during your time with us.

## What to expect from your initial appointment?

Today's appointment will allow you to sit down with a licensed nutritionist and discuss all your health concerns, whether that be weight loss, hormonal concerns, allergies, food sensitivities, issues with fatigue, digestive and gut issues, frustrations with your a (thyroid, blood pressure, heartburn, diabetes, pain, etc.), or anything else! You will get to spend full-time with a licensed nutritionist. After taking a comprehensive history and reviewing all your concerns, the Provider will present you with a plan that will assist in healing you! That is the goal. You are not here because you want a 'bandage' fix. You are here because you care about your health and want to heal the issues once and for all. We want to be a part of that journey!

## What does the program look like?

Treatment protocols are individualized and specific; your program will be determined after an assessment to ensure maximum results. At the end of your appointment, a plan will be laid out for care. These plans are individualized per your concerns and evaluation at the exam. In general, you can expect a plan for nutrition, future treatments/exams, perhaps supplementation, perhaps lab studies, and perhaps a way to boost metabolism! Again, everything is based on the evaluation at the appointment and is individualized to you. Keeping this in mind, it is vital that you tell the Provider as much detail as possible about what has been done in the past, your full history, and disclose any treatments you are undergoing/have in the past, including medications, supplements, and other procedures. Often, patients seek us out after they feel they have exhausted other options or are at a point where they are done jumping from plan to plan without results. Let's stop that pattern at your appointment! The more you share, the better the Provider can assist you in this journey.

## Program Qualifications:

- Serious Candidates only.
- Must be at least 18 years of age or older.
- Agree to undergo a supervised program.
- Agree to scheduled evaluations.
- Agree to attend a minimum of 2- 3 visits per week.
- Agree to program requirements.

## If you qualify for the treatment, today you are (check the appropriate box):

☐ Prepared to start a program today.
☐ Prepared to start a program today and will need to discuss options for payment plans.
☐ Not prepared to start a program today.
Please explain why: _____

I consent to receive a health screening. I acknowledge that I may be receiving treatment utilizing the invisa-RED™ therapy and agree to hold harmless the facility, owners, employees, and any subsidiaries from any damage resulting from this treatment. I understand and accept that visual documentation (photo and/or video) is necessary for evaluation and program monitoring.

Signature: _____ Date: _____

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# METABOLIC COMPREHENSIVE HEALTH HISTORY FORM

## PATIENT INFORMATION

Patient Name:_____
*(last)* *(first)* *(middle initial)*

Address:_____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

Best Contact: □ Phone □ Text □ Email Can we leave a voicemail at your phone number? □ Yes □ No

SS#: _____ DOB: _____ __ Age: _____ Approx. Height _____ Approx. Weight _____

Sex: □ M or □ F What gender do you identify as? □ Man □ Woman □ Trans □ Other_____

What is your preferred pronoun? □ He □ She □ They □ Other_____

Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Minor

Are you the primary decision maker? □ Yes □ No

Occupation: _____ Employer:_____

## IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Home Ph:(_____) _____ Cell Ph:(_____) _____

## DISCLOSURE OF HEALTH INFORMATION

Name of person(s) who we can disclose or release medical information to: _____

_____

□ No one, besides yourself

## MEDICATIONS & SUPPLEMENTS

Please list all prescription medications, over-the-counter medications, vitamins, and or other supplements ***you are taking OR have taken in the past*** **(including hormonal and antibiotics).** Please also provide the condition which you are taking them for, as in example: Metformin for type 2 diabetes or Vitamin C for general health.

| Name of Medication/Supplement | Dose (example: 50 mg) | Frequency Taken (example: 2x/day) | Reason Taking | Current or Past Use, circle one. |
|---|---|---|---|---|
| | | | | **Current Past** |
| | | | | **Current Past** |
| | | | | **Current Past** |
| | | | | **Current Past** |
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| | | | | **Current Past** |

## BIRTH CONTROL

If you are using OR have used birth control, please check all that apply.

□ Implant □ Current □ Past
□ Nuva Ring □ Current □ Past
□ Pill □ Current □ Past
□ Vasectomy □ Current □ Past
□ Tubal Ligation □ Current □ Past

## MEDICAL CONDITIONS

**Do you currently have or have had history of the following? (Please check all that apply)**

□ Adrenal Disorder
□ Anemia
□ Anxiety
□ Arthritis/Joint Disorder
□ Asthma
□ Bloating
□ Brain Fog
□ Constipation
□ Cancer
□ COPD
□ Crohn's Disease
□ Diverticulitis
□ Diarrhea
□ Depression
□ Diabetes Type 1
□ Diabetes Type 2
□ Endometriosis
□ Fatigue
□ Heart Disease
□ Hair loss/thinning
□ Hair on face/chest
□ Hyperlipidemia
□ Hypolipidemia
□ Hypertension
□ Inflammatory Bowel Disease (IBD)
□ Irregular menstrual cycle
□ Irritable Bowel Syndrome (IBS)
□ Kidney Disease
□ Liver Disease
□ Painful menstrual cycles
□ PCOS
□ Problems with digestion
□ Skin issues
□ Sleeping difficulties
□ Sex drive decreased
□ Stress
□ Stroke
□ Thyroid: Hyperthyroidism
□ Thyroid: Hypothyroidism
□ Other _____
□ Other _____

## SURGERIES & HOSPITALIZATIONS

Please list all surgeries and hospitalizations that have occurred in your life.

_____

_____

_____

## SOCIAL HISTORY

Do you or have you smoked? □ Yes □ No □ Past smoker. If you smoke, are you ready to quit? □ Yes □ No

Do you or have you used any recreational/street drugs?
□ Yes □ No

## GUT HEALTH QUESTIONNAIRE

It is important to look at the whole body when we are determining a treatment plan. You are probably here because you have tried everything else it seems and are tired of masking the symptoms. Please answer the following questions to give the provider a better understanding of your whole health.

| | | | |
|---|---|---|---|
| Approximate number of times antibiotics were used during childhood? | □ 0-1 times | □ 2-3 times | □ 4 or more times |
| Do you experience any bloating? | □ Yes | □ No | □ Sometimes |
| If yes, when is your bloating the worst? | □ Only before meals | □ Only after meals | □ All the time |
| If yes what time of day are your symptoms the worst? | □ When you wake up | □ End of day | □ All the time |
| Do you experience indigestion or heartburn? | □ Yes | □ No | |

Do you experience any abdominal pain, cramping, or discomfort?
□ Yes
□ No

**If yes, please answer the following questions:**

| | | |
|---|---|---|
| Is the pain worse after eating? | □ Yes | □ No |
| Is the pain better after eating? | □ Yes | □ No |
| Is the pain constant? | □ Yes | □ No |
| Do you wake up with abdominal pain? | □ Yes | □ No |
| Do you experience abdominal pain at least once a week? | □ Yes | □ No |
| Do you notice your abdominal pain improves with passage of stool? | □ Yes | □ No |
| Do you experience any flatulence (passing of gas) or belching? | □ Yes | □ No |
| Have you found your symptoms triggered by any foods? | □ Yes | □ No |
| Do you experience brain fog or forgetfulness in the middle of a thought? | □ Yes | □ No |

## QUESTIONS ABOUT WEIGHT

| | | |
|---|---|---|
| Your weight 1 year ago: | Your weight 5 years ago: | What is stopping you from losing weight on your own? |
| How much did you weigh when you were most comfortable with yourself? How many years ago was this? Why is this the number you were most comfortable? | | |
| What has had the most significant impact on your current weight/health condition? | | |
| Over your lifetime, how many diets/exercise programs have you tried? | | |
| How many times a year do you diet? | | |
| What have you tried in the past that has not worked, related to getting healthy or weight loss? | | |
| What do you remember most about being at your ideal weight and health goals? | | |

## QUESTIONS ABOUT YOUR CURRENT NUTRITION

| |
|---|
| Do you binge eat? □ Yes □ No |
| Do you suffer from cravings? □ Yes □ No If yes, what do you crave the most? |
| Do you feel that food controls you? □ Yes □ No |
| Do you eat because of your emotions? □ Yes □ No |
| How many meals a day do you eat? _____ |
| Do you have any food allergies/intolerances? □ Yes □ No If yes, please list? |
| Do you feel that you eat a well-balanced diet? □ Yes □ No |
| Are you aware of your body fat percentage? □ Yes □ No |

## QUESTIONS ABOUT YOUR CURRENT WELLBEING

| |
|---|
| Is your current health effecting your quality of life? □ Yes □ No |
| How many hours of sleep do you get per night, on average? _____ |
| Please describe any major current or past stress/depression/anxiety: |

## QUESTIONS ABOUT YOUR CURRENT WELLBEING

| |
|---|
| How will accomplishing these goals change your life? |
| Please list potential obstacles (time constraints, budget, commitment, partner, etc.). |
| How long have you been thinking about achieving your goals? □ 1 month □ 3 months □ 6 months □ 1 year or more |
| How fast do you want to lose weight, realistically? _____ |
| How serious are you about accomplishing your goals on a scale from 1 to 10, with 10 being the most serious?<br>_____ |

**The following is to be completed during your consultation with a member of the team.**

**invisa-RED ™ Consent and Release**

**Procedure**
Once you have been determined to be a candidate for the invisa-RED ™ Therapy, you will have the opportunity to ask questions and/or voice concerns you may have regarding the treatment. If it is determined that you are a candidate and you consent to receive treatment, there are a few preliminary steps that include paperwork, measurements, and photos. After this, you will be taken to the treatment area and lie down. From here the treatment will be administered by placing 680nm x 980nm low-level laser paddles, which use both red and infrared lasers, to the desired area that will penetrate to a depth of about 40nm. After the treatment you will be taken to a vibration platform, where you will complete up to a 20-minute session of standing vibration to aid with circulation. It is recommended that you complete this treatment in conjunction with a diet and exercise regimen for best results. You should consult your doctor before beginning any treatment, including diet and exercise if it is determined you are a candidate for this treatment.

**Risks and Discomfort**
There are a few risks associated with this low-level laser therapy. This treatment is non-invasive and does not have any of the side effects or adverse reactions of invasive treatments. There may be burning, spotting, and/or a warming sensation that is felt. It is possible to have spots or hyperpigmentation of the skin on the treatment area. The treatments are quick ranging between 15-30 minutes and relaxing. Light will be visible during treatment. Depending on the area being treated, you may be asked to wear protective eye gear. Please inform us if you are pregnant, or may be pregnant, as this will need to be determined before you can begin treatment. Although no detrimental risks exist, potential unknown risks may exist. If you have a pacemaker, this treatment may not be right for you. Please inform us if you have any metal in your body, including that in piercings and tattoos. There may be unknown risks associated with low-level therapy.

**_____ Initial**

**Alternatives**
This is a strictly voluntary cosmetic procedure. No treatment is necessary or required. Alternative therapies, which vary in sensitivity, effect, duration, and invasiveness can be considered.

**Consent**
I have reviewed the consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form, I grant authority for Symmetria Integrative Medical to provide treatment with invisa-RED ™. The purpose of this procedure, risks, complications, and alternative methods of treatment have been fully explained to me to my satisfaction.

Cosmetic indications for these procedures include but are not limited to cellulite reduction, treatment of problem fat areas, skin tightening, contouring, and stretch mark reduction. You may experience redness and spotting in the area for up to 12 hours. You will be able to return to most normal activities following the treatment.

I have been informed of potential risks and side effects of invisa-RED ™, including but not limited to redness, swelling, heat sensitivity, pain, increased bowel movement, increased urination, increased menstrual flow, and flu-like symptoms. The nature of the procedure, the risks, potential damages, and adverse side effects have been explained to me and I fully understand.

**_____ Initial**

I understand that the recommended treatments will vary with a minimum of 3 at a frequency of 2 to 3 times per week. I will be evaluated throughout the treatment to determine if more sessions are needed to achieve realistic goals. I understand that the treatment is most successful if I also maintain a diet that is nutritionally aligned with my weight loss or aesthetic goals along with exercise. I know that if after the treatment program I gain weight, the results of the invisa-RED ™ may be reversed.

**_____ Initial**

No guarantee has been given as to the results that may be obtained from this treatment. I have read the informed consent and certify that I understand its contents in full. I have had enough time to consider the information and I feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to have this procedure. If at any time during the procedure I experience discomfort or pain of any kind, I agree to inform the staff immediately and/or terminate the session at my discretion.

By signing below, I state that I am 18 years of age and older. I have read the contents of this form. I understand the information on this form and give my consent to what has been explained to me. I authorize Symmetria Integrative Medical to provide me with treatment.

Print name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____