HEALTHIER SHAPE WELLNESS CLINIC

Steps for your Appointment:

1. Please fill out all New Patient forms in their entirety.
2. If you have any recent labs (within 12 months), please bring them to your appointment.
3. If you are married or in a relationship, **please bring your spouse or significant other with you** to your appointment. (There will be much information covered concerning your unique condition as well as the fundamentals of the program.)
4. Please arrive on time.
5. We require a 24-hour notice to change or cancel your appointment.

Note: If these steps are not followed, it may compromise the full value of your consultation and therefore we will kindly reschedule your appointment.

Healthier Shape Wellness Clinic
20303 S. Crawford Ave., Suite 110
Olympia Fields, Il 60461
708.922.9170

Patient Introduction

Personal History:

Your Name: _____

Your Address: _____

_____

Telephone: (H) _____ ***(C)*** _____ ***(W)*** _____

Email Address: _____

Birth Date: _____/_____/_____

Marital Status: _____ ***Height:*** _____ ***Weight:*** _____

Occupation: _____

Employer: _____

Present MD: _____ ***City:*** _____

Referred to our Clinic or Presentation by: _____

Thank You!

10 Objections to Creating a Healthy, Abundant Life.

1. I don't have the personal knowledge to make the correct lifestyle choices.

a. You have the power to choose to learn. If you are open to learning, our personal mentoring program will guide you along an easy to follow path. Our programs our structured in a manner that gives each and every patient the information needed to bring independence to their life. You do have the choice to avoid the all too common dependency of a care-giver or assisted living environment.

2. I don't have the time to take appropriate care of myself.

a. We all live in a world that gives each of us 24 hours /day. What we do with that time is a personal decision based on values (real or perceived). If you do not take time to care for yourself, you will have to take time to try and repair yourself. Pro-activity and maintenance are required for optimized health. It takes no more time to eat correctly than poorly. Proper exercise requires no more than approximately 35 minutes 3-4 times / week. If you're honest with yourself, you recognize it really is based on what you judge as a valuable use of your time. Hum? TV, or a thriving, abundant life.

3. My family won't be on board with the changes I will need to make.

a. I recognize this sounds like a silly thought, but also realize it is a real concern for some. You would certainly think that all family members would be on board, however, in infrequent situations a spouse or family member may be negative toward your new enthusiasm. This usually comes down to a lack of understanding of what your lifestyle program entails, as well as some distrust of whether this approach will really work.
It may help to steer these family members to our site, www.healthiershape.com and view some of the incredible testimonials from our patients. Without taking the time to learn about our programs and proven success it is only human nature to be cautious. Once familiarizing themselves, you will not only get support, but an accountability partner to help ensure your success.

4. Eating right is too hard and expensive.

a. If you have not been eating right, you should already understand how expensive eating wrong can be. Health deteriorates and medical bills escalate with each year that these poor choices are made. Like any habits, there are good and bad. Once you develop a habit it can be a challenge to change or alter. Once the good or correct habit is developed it will be hard to break. I would challenge anyone to compare grocery bills of a cart full of

healthy food compared to one full of junk. And speaking of expense, this is not just a financial term. Losing out on the joys and experience in life because you're not feeding your body nutritious foods is a terrible, unnecessary expense.

5. I can't afford a lifestyle program or hire a health coach.

a. Most people recognize the importance of an education, whether this is a high-school, college or even an online education. It's widely accepted that this is an investment that must be made in order to have the best insurance of meeting our financial needs. The return on this financial investment can materialize into a very secure and abundant life. Although there are situations in life where funding higher education can seem impossible, we witness people every day finding solutions to "get it done". These individuals simply think differently. They do not accept anything less than their God given potential. I am suggesting that your health should be viewed as at least as valuable as your financial situation. What value is wealth if you do not have the health and vitality to enjoy it. At Imagine Wellness, we work with each individual to overcome any financial obstacles. We have solutions to allow those on fixed budgets and retired to easily move forward.

6. I'm afraid that proper lifestyle changes might isolate me from my friends and family.

a. It is true that not all of your friends will share your newly found optimism toward taking control of your health. Friends who do not place high priority on their health often play down healthy lifestyle choices. Although they may not mean any negative intent, this behavior is sabotaging. In one of my patient member video's I discuss this as being all too common and some tips to disarm this behavior in a non-confronting manner. The bottom line is those who truly care for you will support your decision to place your health as a priority.

7. My doctor may not approve.

a. I will always be open and willing to work with any doctor or health professional you currently have. They also, should be open and willing to do the same if the goal is to optimize health and improve lifestyle choices. This includes reducing and/or eliminating unnecessary medications. A doctor's main concern and intent should always be to aid in the optimization of health in his/her patients. This begins with "Do No Harm". I am always cautious of a physician that dismisses any holistic and natural approach to health. In summary, you are ultimately responsible for your health and therefore, the final decision and direction you wish to pursue.

8. I don't have the self-discipline to make permanent changes.

a. Self-discipline is not a trait that we are born with, but one that is developed over time through life experience. Discipline coincides with positive

experience. In other words, as your actions result in positive changes you will be inclined to continue these actions. One could look at this as positive habits or simply, discipline. Self-discipline is also strengthened thru accountability held by loved ones, a friend or a mentor.

9. What happens if I commit to a lifestyle program and then hate the experience and give up?

a. Life is a series of ups and downs. We do not always enjoy the duties required for the end result we are seeking. It's funny how these duties or actions can initially seem to be difficult or "no fun", but later take on an uplifting emotion. This is because we come to recognize the most meaningful successes, we have in life came from such actions. Having a successful marriage; raising children; optimizing our health and becoming financial independent all require discipline and actions that sometimes have us wanting to "give up and quit". Those of us who continue to play the game are allowed the pleasures of earned rewards.

10. I don't have the personal confidence to take action.

a. Very few of us have a natural born instinct of confidence. This comes from continually taking action even when we are fearful. The actual definition for this is courage. As we continue to develop skills from taking these bold steps, we become less fearful or confident. My son, Landon, has always lacked confidence as he enters a new sport. He is often hesitant to even giving it a try. Once he jumps in, regardless of the fear, he begins to develop skills that ultimately lead to enjoyment and yes, confidence! We are here to mentor you and support you. We do not judge or chastise. We offer an environment that anyone at any level can feel comfortable and genuinely cared for. As you become a veteran in the art of wellness, you too will become very confident.

Healthier Shape Wellness Clinic

Initial Consultation

Name: _____ Date: _____

Main Complaints:

1)_____ 2)_____

3)_____ 4)_____

How long have you suffered with this problem? _____

Any other complaints: _____

_____

Would you like improvement with any of the following?

☐ Digestion: Reflux, Gas, Constipation
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well Being
☐ Energy

What have you tried doing to resolve this problem that Did Not work?

Have you become discouraged or stressed about handling this problem?

When your problem is at its worst, how does it make you feel?

How does this problem interfere with the following areas in your life?
Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

_____

What effect does this have on your body functions? _____

Are you here visiting us to:

- ○ Resolve my immediate problem
- ○ Life style program for optimized living
- ○ Both
- ○ Other: _____

How have you taken care of your health in the past?

- ☐ Medications
- ☐ Routine medical
- ☐ Exercise
- ☐ Diet and Nutrition
- ☐ Holistic
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other: _____

How did the previous methods work for you?

What are you afraid this might be or will be affecting without change?

- ☐ Job
- ☐ Kids
- ☐ Marriage
- ☐ Sleep
- ☐ Freedom
- ☐ Future abilities
- ☐ Finances
- ☐ Time

Are there any health conditions you are afraid this might turn into?

- ☐ Diminished Future abilities
- ☐ Stress
- ☐ Weight gain
- ☐ Heart disease
- ☐ Depression
- ☐ Surgery
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific

What would be different or better without this problem?

- ☐ Diminished stress
- ☐ More energy
- ☐ Self esteem
- ☐ Confidence
- ☐ Sleep
- ☐ Work
- ☐ Outlook
- ☐ Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!

Metabolic Assessment Form

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

PART I

Please list your 5 major health concerns in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

PART II Please mark the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

Category II

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout the body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3
Abdominal intolerance to sugars and starches	0 1 2 3

Category III

Intolerance to smells	0 1 2 3
Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

Category IV

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables; undigested food found in stools	0 1 2 3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3
Use of antacids	0 1 2 3
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

Category VI

Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3

Category VII

Greasy or high-fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Burpy, fishy taste after consuming fish oils	0 1 2 3
Difficulty losing weight	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	0 1 2 3

Category VIII

Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalances	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul-smelling sweat	0 1 2 3

Category IX

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory/forgetful	0 1 2 3
Blurred vision	0 1 2 3

Category X

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category XI

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category XII

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under a high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category XIII

Edema and swelling in ankles and wrists	0 1 2 3
Muscle cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Frequent thirst	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel regularity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

Category XIV

Tired/sluggish	0 1 2 3
Feel cold—hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XV

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3

Difficulty gaining weight	0 1 2 3

Category XVI *(Males Only)*

Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel emptying	0 1 2 3
Leg twitching at night	0 1 2 3

Category XVII *(Males Only)*

Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Difficulty maintaining morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decreased physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XVIII *(Menstruating Females Only)*

Perimenopausal	0 1 2 3
Alternating menstrual cycle lengths	0 1 2 3
Extended menstrual cycle (greater than 32 days)	0 1 2 3
Shortened menstrual cycle (less than 24 days)	0 1 2 3
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal?	0 1 2 3
Since menopause, do you ever have uterine bleeding?	0 1 2 3
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness, or itching	0 1 2 3

PART III

How many alcoholic beverages do you consume per week? _____Rate your stress level on a scale of 1-10 during the average week: _____
How many times do you eat fish per week?_____ How many times do you work out per week?_____
How many caffeinated beverages do you consume per day?_____ How many times do you eat out per week?_____
How many times do you eat raw nuts or seeds per week?_____
List the three worst foods you eat during the average week:_____
List the three healthiest foods you eat during the average week:_____

PART IV

Please list any medications you currently take and for what conditions: _____
Please list any natural supplements you currently take and for what conditions: _____

Neurotransmitter Assessment Form™ (NTAF)

Name:_____Age:_____Sex:_____Date:_____

Please mark the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Section A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn new things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament generally getting worse? 0 1 2 3
- Is your attention span decreasing? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you become fatigued when driving compared to in the past? 0 1 2 3
- How often do you become fatigued when reading compared to in the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

Section B

- How high is your stress level? 0 1 2 3
- How often do you feel you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

Section C

- How often do you get irritable, shaky, or have light-headedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

Section C2

- How often do you get fatigued after meals? 0 1 2 3
- How often do you crave sugar and sweets after meals? 0 1 2 3
- How often do you feel you need stimulants, such as coffee, after meals? 0 1 2 3
- How often do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite increased? 0 1 2 3
- How often do you gain weight when under stress? 0 1 2 3
- How often do you have difficulty falling asleep? 0 1 2 3

Section 1

- Are you losing interest in hobbies? 0 1 2 3
- How often do you feel overwhelmed? 0 1 2 3
- How often do you have feelings of inner rage? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing your enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep, restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

Section 2

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested, even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

Section 3

- How often do you feel anxious or panicked for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

Section 4

- Do you feel your visual memory (shapes & images) has decreased? 0 1 2 3
- Do you feel your verbal memory has decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity decreased? 0 1 2 3
- Has your comprehension diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing a slower mental response? 0 1 2 3

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic & Specific Sertonergic Antidepressants (NaSSAas)

- ☐ Remeron®
- ☐ Norset®
- ☐ Zispin®
- ☐ Remergil®
- ☐ Avanza®
- ☐ Axit®

Tricyclic Antidepressants (TCAs)

- ☐ Elavil®
- ☐ Prothiaden®
- ☐ Endep®
- ☐ Adapin®
- ☐ Tryptanol
- ☐ Sinequan®
- ☐ Trepiline®
- ☐ Tofranil®
- ☐ Asendin®
- ☐ Janamine®
- ☐ Asendis®
- ☐ Gamanil®
- ☐ Defanyl®
- ☐ Aventyl®
- ☐ Demolox®
- ☐ Pamelor®
- ☐ Moxadil®
- ☐ Opipramol®
- ☐ Anafranil®
- ☐ Vivactil®
- ☐ Norpramin®
- ☐ Rhotrimine®
- ☐ Pertofrane®
- ☐ Surmontil®
- ☐ Thadentm

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil®
- ☐ Seromex®
- ☐ Zoloft®
- ☐ Seronil®
- ☐ Prozac®
- ☐ Celexa®
- ☐ Lexapro®
- ☐ Esertia®
- ☐ Luvox®
- ☐ Cipramil®
- ☐ Emocal®
- ☐ Seropram®
- ☐ Cipralex®
- ☐ Fontex®
- ☐ Priligy®
- ☐ Sarafem®
- ☐ Fluctin®
- ☐ Faverin®
- ☐ Seroxat®
- ☐ Aropax®
- ☐ Deroxat®
- ☐ Rexetin®
- ☐ Paroxat®
- ☐ Lustral®
- ☐ Serlain®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Norpramin®
- ☐ Cymbalta®

Acetylcholinesterase Reactivators

- ☐ Protopam®

Monoamine Oxidase Inhibitor (MAOI)

- ☐ Marplan®
- ☐ Aurorix®
- ☐ Manerix®
- ☐ Moclodura®
- ☐ Nardil®
- ☐ Adeline®
- ☐ Eldepryl®
- ☐ Azilect®
- ☐ Marsilid®
- ☐ Iprozid®
- ☐ Ipronid®
- ☐ Rivivol®
- ☐ Zyvox®
- ☐ Zyvoxid®
- ☐ Propilniazide®

Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)

- ☐ Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

- ☐ Thorazine®
- ☐ Prolixin®
- ☐ Trilafon®
- ☐ Compazine®
- ☐ Mellaril®
- ☐ Stelazine®
- ☐ Vesprin®
- ☐ Nozinan®
- ☐ Depixol®
- ☐ Navane®
- ☐ Fluanxol®
- ☐ Clopixol®
- ☐ Acuphase®
- ☐ Haldol®
- ☐ Orap®
- ☐ Clozaril®
- ☐ Zyprexa®
- ☐ Zydis®
- ☐ Seroquel XR
- ☐ Geodon®
- ☐ Solian®
- ☐ Invega®
- ☐ Abilify®

Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax®
- ☐ Lexotanil®
- ☐ Lexotan®
- ☐ Librium®
- ☐ Klonopin®
- ☐ Valium®
- ☐ ProSom®
- ☐ Rohypnol®
- ☐ Magadon®
- ☐ Dalmane®
- ☐ Ativan®
- ☐ Loramet®
- ☐ Sedoxil®
- ☐ Dormicum®
- ☐ Serax®
- ☐ Restoril®
- ☐ Halcion®

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lunesta®
- ☐ Imovane®

Acetylcholine Receptor Agonists

- ☐ Urecholine
- ☐ Salagen®
- ☐ Evoxac®
- ☐ Isopto®
- ☐ Anectine®
- ☐ Nicotine

Acetylcholine Receptor Antagonists Antimuscarinic Agents

- ☐ AtroPen®
- ☐ Atrovent®
- ☐ Scopace®
- ☐ Spiriva®

Acetylcholine Receptor Antagonists Ganglionic Blockers

- ☐ Inversine®
- ☐ Hexamethonium
- ☐ Nicotine(high dose
- ☐ Arfonad

Acetylcholine Receptor Antagonists Neuromuscular Blockers

- ☐ Atracurium
- ☐ Cisatracurium
- ☐ Doxacurium
- ☐ Metocurine
- ☐ Mivacurium
- ☐ Pancuronium
- ☐ Rocuronium
- ☐ Anectine®
- ☐ Tubocurarine
- ☐ Vecuronium
- ☐ Hemicholinium

GABA Antagonist Competitive Binder

- ☐ Romazicon®

Cholinesterase Inhibitors (reversible)

- ☐ Aricept®
- ☐ Razadyne®
- ☐ Exelon®
- ☐ Cognex®
- ☐ THC
- ☐ Carbamate insecticides
- ☐ Enlon®
- ☐ Prostigmin®
- ☐ Antilirium®
- ☐ Mestinon®

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Flexyx®
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

Family Health History

Patient Name: _____ Date:_____

Please review the conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Children		
	Age	Age	Age	Age	Age	Age
Allergies						
Anxiety						
Asthma						
ADHD						
Back trouble						
Bed wetting						
Cancer						
Colic						
Constipation						
Depression						
Diabetes						
Disc problems						
Ear infections						
Emotional issues						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
Heart burn						
High blood pressure						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scoliosis						
Sinus trouble						
Other						

Additional Comments: _____

_____

_____

Healthier Shape Wellness Clinic

Disclaimer

Optimized Living Programs

At Healthier Shape Wellness Clinic, we practice in a holistic manner, but believe in the science of appropriate testing. This type of practice is actually called "functional medicine".

We use testing, whether it is blood analysis, urine, saliva, stool, MRI and other means to give us objective evidence of your current state of health. We then can use these same tests to re-measure for positive functional changes.

All of our treatment is directed towards the *cause* of dysfunction and not to simply cover up your symptoms with medication. By no means do we claim to treat specific diseases, nor offer any cure. No doctor or medication can actually cure the body. Healing is the responsibility of your own body's intelligence.

We offer solutions to help balance the body using specific and customized nutritional and nutraceutical protocols, allowing the body to do what it is programmed to do…*Heal Itself*.

Dr. Oganwu is not able to and does not accept every case. Dr. Oganwu's schedule is extremely busy, therefore the number of patients is strictly limited to ensure a high quality of care.

If you are currently on prescription medication, we ask you not to make any changes or go off of these medications without first consulting with your doctor.

It is the responsibility of your prescribing doctor to make these changes and work with us toward helping you become as drug free as possible.

I have read this disclaimer and understand its content,

_____Date: _____
Signature

_____
Print Name

Please list below the name of your physician that you are currently under care.

_____Phone:_____

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I, _____ have received a copy of Dr. Oganwu's Medical and Wellness Notice of Privacy Practice

_____

(Signature of Patient or Guardian)

_____

Staff will fill out section if patient's Signature is Not Obtained

Our office made a good faith effort to obtain ***Acknowledgement of Receipt*** *of our Notice of Privacy Practices, but it could not be obtained for the following reason:*

___Patient refused to sign.
___Emergency situation kept us from obtaining the patient's signature.
___Language barriers kept us from obtaining the patient's signature.
___Other:_____

Rita N. Oganwu, M.D.
20303 S. Crawford Ave. Suite 110
Olympia Fields, IL. 60461
708-922-9170

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 20032, and will remain in effect until replaced

We reserve the right to change our privacy practices and the terms of this notice at any time.

We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose our protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected heath information to other physicians who may be treating you.

For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services that we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to your for protected health necessity, and

undertaking utilization review activities. For example, obtaining approval for a hospital stay ma require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities; employee review activities, training go students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will only share your protected health care information with third party business associates that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, they are required to sign a written contract that contains the terms that will protect the privacy of your protected health information.

We may use or disclose your protected health care information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities.

For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosure of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information, or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary, if we determine that it is In your best interest based on our professional judgement.

We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities.

Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value. You may opt out of receiving further such information by telling us in writing by using the contact information listed at the beginning of this notice.

Research, Death, Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health medical examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others.

We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Clinic Directions

20303 S CRAWFORD AVE SUITE 110

OLYMPIA FIELDS, IL 60461

708-922-9170

Heading North/South from I-57

Exit Vollmer Rd East

Take Vollmer down two lights

Turn right on Crawford/Pulaski

Make a left on 203rd St.

We are the first building on the right side

Heading West from Indiana

Take Route 30 west towards Illinois

Turn right on Governor's Hwy/Crawford Ave/Pulaski Rd

Turn right on 203rd St.

We are the first building on the right side