



Office Use Only

Thank you note

Practitioner: _____

CC
 Eclipse

Name		DOB		Age		Date	
Address		City		State	Zip	Email/Newsletter	
Ph: H ()		W ()		M ()		Height	Weight
Cell Phone Carrier							
Preferred Contact		<input type="radio"/> Ph: (Home)		<input type="radio"/> Ph: (Work)		<input type="radio"/> Ph: (Mobile)	
		<input type="radio"/> Email		<input type="radio"/> Text			
Do you have Medicare coverage? <input type="radio"/> Yes <input type="radio"/> No							

Emergency Contact Information

Name		Relationship to patient		Ph ()	
How were you referred to our office?				<input type="radio"/> Single	<input type="radio"/> Married
				<input type="radio"/> Divorced	<input type="radio"/> Widowed

Additional Information

Language	Ethnicity	Race
<input type="radio"/> English	<input type="radio"/> Hispanic or Latino	<input type="radio"/> White <input type="radio"/> Hispanic or Latino
<input type="radio"/> Spanish	<input type="radio"/> Not Hispanic or Latino	<input type="radio"/> Asian <input type="radio"/> Black or African American
<input type="radio"/> Other	<input type="radio"/> Decline to answer	<input type="radio"/> Decline to answer <input type="radio"/> Other

HIPAA acknowledgement of receipt of notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Valeo Health & Wellness Center's Notice of Privacy Practices. Valeo is permitted to revise its Notice of Privacy Practices at anytime. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at anytime.

Client Name _____ Signature _____ Guardian _____ Date _____

Goals for my care: People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will evaluate your needs and desires when recommending your program of care. Please check the type of care desired, so that we may be guided by your wishes.

- Relief Care: Symptomatic relief of pain or discomfort.
- Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.
- Comprehensive Care: Address the entire system and bring whatever is malfunctioning in the body to the highest state of health possible.

Please list health concerns according to their severity. Rate from... 1 (Mild) to 10 (Unbearable)

Health Concern	Severity	Episode start date?	Had this before? When?	Constant or intermittent?

Since the problem started, is it: Same Improving Worse

Does it travel/radiate anywhere? No Yes Where _____

What makes it better? _____ What makes it worse? _____

Do you have a family history of this or similar symptoms? No Yes / Explain _____

If you are experiencing pain, is it: Sharp A Dull Ache Stabbing

Have other doctors seen you for this condition? No Yes / Diagnosis _____

Medical Chiropractor Other What was done? _____

Are you allergic or sensitive to fragrances or oils? Yes No

List all past accidents (auto or work), injuries, surgeries, X-rays, trauma - physical or emotional, procedures.

Type	Date	Doctor / Hospitalization / X-Rays

List all prescription drugs, over-the-counter-drugs, and all supplements you are currently taking.

Name of drug or supplement	Taken for how long?	For what purpose?	How much?

List any known allergies

Physical scars?

Do you have any scars? No Yes Where _____

The Beginning Years

Birth to 17 years of age	Yes	No	Unsure
Did you have any serious childhood illness? If yes, what?			
Did you have any serious falls as a child?			
Was there prolonged use of medicine such as antibiotics or an inhaler?			
Were you vaccinated?			
Adult: 18 to present	Yes	No	Unsure
Are you pregnant? If yes, when due?			
Do you have a pacemaker?			
Do you have any metal in your body? If yes, where?			

Please circle all that apply.

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

A - Medications B - Emergency room C - Routine medical D - Exercise E - Nutrition/Diet F - Holistic care G - Vitamins H - Chiropractic
I - Other (Please specify.) _____

2. How did the previous method(s) work out for you?

A - Bad results B - Some results C - Great results D - Nothing changed E - Did not get worse F - Did not work very long G - Still trying
H - Confused

3. Are you concerned that this condition is negatively affecting or will negatively affect any of the following?

A - Job B - Kids C - Future ability D - Marriage E - Self-esteem F - Sleep G - Time H - Finance I - Freedom

4. Are you concerned that your health condition(s) might turn into any of the following?

A - Family health problems B - Heart Disease C - Cancer D - Diabetes E - Arthritis F - Fibromyalgia G - Depression H - Chronic fatigue
I - Need surgery

5. Has your health condition affected your job, relationships, finances, family or other activities? No Yes (If yes, please explain.)

6. If you have health issues, what have they cost you? (time, money, hope, happiness, freedom, sleep, etc)? Please describe.

7. What do you think the time frame will be to regain your health?

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

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

* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

SECTION: GENERAL

- Does your child have any food sensitivities or allergies? (please list)

- List your child's 4 healthiest foods eaten regularly.

_____, _____,

- List your child's 4 unhealthiest foods eaten regularly.

_____, _____,

- How many times a week does your child eat candy? _____

- How many times a week does your child drink soda pop? _____

- Please list the top 4 foods your child craves regularly?

_____, _____,

- List the medication(s) your child is currently prescribed and over the counter.

- Do you find it difficult as a parent to have your child on a special diet?

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3

- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? 0 1 2 3

- Does your child eat dairy products? 0 1 2 3

- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? 0 1 2 3

SECTION: B (K53)

- Does your child eat fried fish? 0 1 2 3

- Does your child eat roasted nuts or seeds? 0 1 2 3

- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocados, flax seeds, olives) (mark "0" if present, "3" if missing) 0 1 2 3

- Does your child eat *fried* foods? 0 1 2 3

SECTION: C (K34)

- Is your child's mental speed slow? 0 1 2 3

- Does your child have difficulty with learning or memory? 0 1 2 3

- Does your child have difficulty with balance and coordination? 0 1 2 3

SECTION: D (K16)

- Does your child have stress? 0 1 2 3

- Does your child **not** have enough sleep and rest? (mark "3" if not enough) 0 1 2 3

- Does your child **not** have regular exercise? (mark "3" if no exercise) 0 1 2 3

- Does your child feel overly worried and scared? 0 1 2 3

SECTION: E (K16, K51)

- Does your child have temper tantrums? 0 1 2 3

- Does your child exhibit wild behavior? 0 1 2 3

- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3

- Does your child have an **inability** to nap or sleep when physically exhausted? (mark "3" if unable) 0 1 2 3

- Is your child overly talkative? 0 1 2 3

- Does your child fidget and squirm when seated? 0 1 2 3

- Does your child run and climb excessively when it is inappropriate? 0 1 2 3

- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION: F (K51)

- Does your child get excited easily? 0 1 2 3

- Does your child have anxiousness and panic for minor reasons? 0 1 2 3

- Does your child feel overwhelmed for minor reasons? 0 1 2 3

- Does your child find it difficult to relax when she/he is awake? 0 1 2 3

- Does your child have disorganized attention? 0 1 2 3

SECTION: G (K50)

- Does your child seem depressed? 0 1 2 3

- Does your child have mood changes with overcast weather? 0 1 2 3

- Does your child have symptoms of inner rage? 0 1 2 3

- Does your child seem uninterested in games or hobbies? 0 1 2 3

- Does your child have difficulty falling into deep restful sleep? 0 1 2 3

- Does your child seem uninterested in friendships? 0 1 2 3

- Does your child have symptoms of unprovoked anger? 0 1 2 3

- Does your child seem uninterested in eating? 0 1 2 3

SECTION: H (K49)

- Does your child have difficulty handling stress? 0 1 2 3

- Does your child have anger and aggression while being challenged? 0 1 2 3

- Does your child feel tired even after long sleeps? 0 1 2 3

- Does your child tend to isolate from others? 0 1 2 3

- Does your child get distracted easily? 0 1 2 3

- Does your child have constant need and desire for candy and sugar? 0 1 2 3

- Does your child have disorganized attention? 0 1 2 3

SECTION: I (K48)

- Does your child have difficulty with visual memory? 0 1 2 3

- Does your child have difficulty remembering locations? 0 1 2 3

- Does your child have fatigue or low endurance for learning activities? 0 1 2 3

- Does your child have difficulty with attention or low attention span or endurance? 0 1 2 3

- Does your child have slow or difficult speech? 0 1 2 3

- Does your child have uncoordinated or slow movement? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only

Metabolic Assessment Form™

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

PART I

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

1. _____ 4. _____
 2. _____ 5. _____
 3. _____

PART II

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

<p>Category I</p> <p>Feeling that bowels do not empty completely 0 1 2 3</p> <p>Lower abdominal pain relieved by passing stool or gas 0 1 2 3</p> <p>Alternating constipation and diarrhea 0 1 2 3</p> <p>Diarrhea 0 1 2 3</p> <p>Constipation 0 1 2 3</p> <p>Hard, dry, or small stool 0 1 2 3</p> <p>Coated tongue or “fuzzy” debris on tongue 0 1 2 3</p> <p>Pass large amount of foul-smelling gas 0 1 2 3</p> <p>More than 3 bowel movements daily 0 1 2 3</p> <p>Use laxatives frequently 0 1 2 3</p> <p>Category II</p> <p>Increasing frequency of food reactions 0 1 2 3</p> <p>Unpredictable food reactions 0 1 2 3</p> <p>Aches, pains, and swelling throughout the body 0 1 2 3</p> <p>Unpredictable abdominal swelling 0 1 2 3</p> <p>Frequent bloating and distention after eating 0 1 2 3</p> <p>Category III</p> <p>Intolerance to smells 0 1 2 3</p> <p>Intolerance to jewelry 0 1 2 3</p> <p>Intolerance to shampoo, lotion, detergents, etc 0 1 2 3</p> <p>Multiple smell and chemical sensitivities 0 1 2 3</p> <p>Constant skin outbreaks 0 1 2 3</p> <p>Category IV</p> <p>Excessive belching, burping, or bloating 0 1 2 3</p> <p>Gas immediately following a meal 0 1 2 3</p> <p>Offensive breath 0 1 2 3</p> <p>Difficult bowel movements 0 1 2 3</p> <p>Sense of fullness during and after meals 0 1 2 3</p> <p>Difficulty digesting proteins and meats; undigested food found in stools 0 1 2 3</p> <p>Category V</p> <p>Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3</p> <p>Use of antacids 0 1 2 3</p> <p>Feel hungry an hour or two after eating 0 1 2 3</p> <p>Heartburn when lying down or bending forward 0 1 2 3</p> <p>Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3</p> <p>Digestive problems subside with rest and relaxation 0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3</p> <p>Category VI</p> <p>Difficulty digesting roughage and fiber 0 1 2 3</p> <p>Indigestion and fullness last 2-4 hours after eating 0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage 0 1 2 3</p> <p>Excessive passage of gas 0 1 2 3</p> <p>Nausea and/or vomiting 0 1 2 3</p> <p>Stool undigested, foul smelling, mucus like, greasy, or poorly formed 0 1 2 3</p> <p>Frequent loss of appetite 0 1 2 3</p>	<p>Category VII</p> <p>Abdominal distention after consumption of fiber, starches, and sugar 0 1 2 3</p> <p>Abdominal distention after certain probiotic or natural supplements 0 1 2 3</p> <p>Decreased gastrointestinal motility, constipation 0 1 2 3</p> <p>Increased gastrointestinal motility, diarrhea 0 1 2 3</p> <p>Alternating constipation and diarrhea 0 1 2 3</p> <p>Suspicion of nutritional malabsorption 0 1 2 3</p> <p>Frequent use of antacid medication 0 1 2 3</p> <p>Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/Diverticulitis, or Leaky Gut Syndrome? Yes No</p> <p>Category VIII</p> <p>Greasy or high-fat foods cause distress 0 1 2 3</p> <p>Lower bowel gas and/or bloating several hours after eating 0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning 0 1 2 3</p> <p>Burpy, fishy taste after consuming fish oils 0 1 2 3</p> <p>Unexplained itchy skin 0 1 2 3</p> <p>Yellowish cast to eyes 0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown 0 1 2 3</p> <p>Reddened skin, especially palms 0 1 2 3</p> <p>Dry or flaky skin and/or hair 0 1 2 3</p> <p>History of gallbladder attacks or stones 0 1 2 3</p> <p>Have you had your gallbladder removed? Yes No</p> <p>Category IX</p> <p>Acne and unhealthy skin 0 1 2 3</p> <p>Excessive hair loss 0 1 2 3</p> <p>Overall sense of bloating 0 1 2 3</p> <p>Bodily swelling for no reason 0 1 2 3</p> <p>Hormone imbalances 0 1 2 3</p> <p>Weight gain 0 1 2 3</p> <p>Poor bowel function 0 1 2 3</p> <p>Excessively foul-smelling sweat 0 1 2 3</p> <p>Category X</p> <p>Crave sweets during the day 0 1 2 3</p> <p>Irritable if meals are missed 0 1 2 3</p> <p>Depend on coffee to keep going/get started 0 1 2 3</p> <p>Get light-headed if meals are missed 0 1 2 3</p> <p>Eating relieves fatigue 0 1 2 3</p> <p>Feel shaky, jittery, or have tremors 0 1 2 3</p> <p>Agitated, easily upset, nervous 0 1 2 3</p> <p>Poor memory, forgetful between meals 0 1 2 3</p> <p>Blurred vision 0 1 2 3</p> <p>Category XI</p> <p>Fatigue after meals 0 1 2 3</p> <p>Crave sweets during the day 0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar 0 1 2 3</p> <p>Must have sweets after meals 0 1 2 3</p> <p>Waist girth is equal or larger than hip girth 0 1 2 3</p> <p>Frequent urination 0 1 2 3</p> <p>Increased thirst and appetite 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p>
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Category XII				
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 XIII				
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 XIV				
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 XV				
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 XVI				
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

Category XVI (Cont.)				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Category XVII (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 XVIII (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 XIX (Menstruating Females Only)				
Perimenopausal		Yes	No	
Alternating menstrual cycle lengths		Yes	No	
Extended menstrual cycle (greater than 32 days)		Yes	No	
Shortened menstrual cycle (less than 24 days)		Yes	No	
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 XX (Menopausal Females Only)				
How many years have you been menopausal?		_____ years		
Since menopause, do you ever have uterine bleeding?		Yes	No	
Hot flashes	0	1	2	3
Mental foginess	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 caffeinated beverages do you consume per day? _____

How many times do you eat fish per week? _____

How many times do you eat out per week? _____

How many times do you work 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:

Valeo Payment Policy

Returned Check Policy - Valeo accepts checks as a form of payment; however should a check be returned due to insufficient funds, we will require immediate payment of another form plus a \$35.00 returned check fee and any bank charges. If there is no response from you, we must send this to collections.

Signature _____ Date _____

Insurance Payment Agreement - *For Personal Injury, Work Comp or Medicare Only:*

I understand that insurance will be billed for Valeo services and I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Signature _____ Date _____

Service Agreement - I clearly understand and agree that all services and products rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. Valeo will work with you regarding payment plans if necessary. There will be an 18% APR charged on balances over 30 days past due. Anything older than 120 days will be sent to collections. Please contact us if you have any questions regarding this policy.

Signature _____ Date _____

Policies & Procedures

1. The practitioners design specific health plans in order for you to get better in the shortest amount of time. It is to your benefit to maintain your visit schedule and care plan as explained to you in the Report of Findings. The practitioners take your health very seriously and we ask that you do the same.
2. If you need to cancel or reschedule an appointment, please provide the office with at least a 24 hour notice. Our goal is to stay on time; however, occasionally emergencies or unforeseen circumstances arise where the practitioner will spend more time with a client. We will do our best to inform you if the practitioner is running behind schedule.