



Appointment Instructions

What will occur?

Be sure to arrive on time for your appointment.

In your first appointment you will be given a few preliminary exams that will help determine if you are in a state of inflammation.

Examples of these preliminary exams are:

Body composition, Meta Oxy Urine Analysis, Vision Contrast Sensitivity, and an orthostatic BP test. These are all non-invasive and done in-office. You will also receive a comprehensive review of the Neurotoxic Questionnaire.

This first appointment requires a 4 hour fast from food and water. Please come prepared for that, we will provide you water and a snack after your testing is completed.

What do I need to bring?

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

What is the policy on rescheduling this appointment?

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

Revolution Wellness Center

*8509 Jefferson Lane N
Maple Grove, MN 55445
revolution-chiropractic.com
revolutionwellnesscenter@gmail.com*

Name:		Date:	
Address:		Unit:	
City:		State:	Zip:
PHONE	Home:	Mobile:	Work:
Email Address:			

Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
----------------	---

Age:	Height:	Weight:
------	---------	---------

Status:

- Married Widowed
 Separated Single
 Divorced Partnership

Live with:

- Spouse Children
 Partner Friends
 Parents Alone

Education:

Occupation: Hours per week: Retired

Employer	Work Address
<input style="width: 98%; height: 20px;" type="text"/>	<input style="width: 98%; height: 20px;" type="text"/>

In case of emergency, whom should we contact?

Name	Relationship	Address	Phone
<input style="width: 98%; height: 20px;" type="text"/>	<input style="width: 98%; height: 20px;" type="text"/>	<input style="width: 98%; height: 20px;" type="text"/>	<input style="width: 98%; height: 20px;" type="text"/>

How did you hear about our Wellness and Nutrition Program?

What is your major complaint. Please List when each symptom began and be as descriptive as possible

What are your current medications?

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

What are your current vitamins and/or supplements?

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

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 past or present allergies, including allergies to medications.

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

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

Patient History

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

Mercury

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

Lead

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

General Toxicity

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have your house sprayed with pesticides for pest control?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you spray herbicide (weed killers) in or around your home?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you use conventional insect repellants on your self or family?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you use conventional sunscreen?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you use conventional perfume or cologne every day?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you get your hair colored? If so, is it on the scalp?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you use aerosol hairspray?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you get your nails done? If so, how often? _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you use air freshener in your house, work or car?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you drink filtered water? If so, what type of filter do you have? _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you drink bottle water if so what kind?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have a water filtration system for your entire house or shower filtration? If so, what type? _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your spouse or other family members work around chemicals?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Can you think of any other toxic exposures you may have had?

Mold

How old is the house you are living in? _____ How long have you lived there? _____

Have you noticed any new symptoms since moving in? _____ If so, what? _____

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you see mold growing at home, work or school?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever had water damage at home, work or school?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your home, workplace or school have a damp or mildew smell?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does spending time in your basement cause or worsen your symptoms?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your basement ever get wet?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have a crawl space?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your basement or crawl space have a sump pump?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your car have a mildew smell?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does anyone in your home have asthma like symptoms?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does anyone in your family have chronic sinus infections or irritations?

Lyme Disease

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

Health History

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

Microbiome Health

- Yes No Do you get foul or sulfur smelling gas (distention, bloating, belching, feeling full and a noisy gut) after eating carbohydrates (ie. grains and vegetables) or fermented foods and/or probiotics?

- 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?

How many times a day are you having a bowel movement? _____

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 have it, mild effect	3 = Frequently have it, mild effect	

Column #1

	Anxiety
	Mood swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5°)
	Insomnia (can't get to sleep or return to sleep)
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound

Column #2

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

	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)

	Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	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 move 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 Columns 1 & 2

Name _____

Date Range _____

	DAY ONE	DAY TWO	DAY THREE
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			

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

Please list how many days per week you are eating out (1-7) beside each meal time, give me some examples of your most frequented spots.

Breakfast: _____ Days per week.

Where: _____

Lunch: _____ Days per week.

Where: _____

Dinner: _____ Days per week.

Where: _____

What time do you wake up in the morning? _____

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

What is your favorite food? _____

What is your favorite restaurant? _____

Do you wake up hungry? _____

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is defined to mean:

“Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

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

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

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

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

I have read and understand the above information:

Signature

Date



Patient Policy Form

Dear New Patient,

Welcome to Revolution Wellness Center. We are excited to provide you with your healthcare needs and feel blessed to work with you to achieve your optimal health goals.

Please review the information below. Enter your initials next to each line item below, and please sign and date the bottom of this form as acknowledgement of the patient policy contents listed below.

_____ Payment for all services and products is due at the time of the visit.

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

_____ Cancellation Policy: Any appointment time changes or cancellations must be received 48 hours prior to appointment time. Missed consultation without a 48 hour cancellation notification will result in a \$75 fee being charged to the client. Cancellations must be received via phone at 763.425.4577.

As the patient, you are responsible for the total charges incurred for each visit. We accept Visa, Mastercard, American Express and Discover credit cards, debit cards, checks, and cash for payment. There will be a charge of \$20.00 for every returned check(s).

We may recommend natural and alternative supplements, which may be purchased at Revolution Wellness Center. Most insurance companies do not cover the supplemental items that we recommend and sell.

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

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

X _____ DATE _____