revolution
chiropractic wellness center

Appointment Instructions

Be sure to arrive on time for your appointment to maximize your time with Dr. Crystal.

Completed paperwork should be sent in advance, again to maximize 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. **Please arrive fasting for 4 hours from all food and water.**

What do I need to bring?

We highly encourage you to bring your spouse to this appointment. In addition, bring this packet of paperwork completed- if not already sent in. 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
10800 Old County Road 15
Plymouth, MN 55441

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

Date of Birth:		Gender:	* Male * Female

Age:		Height:		Weight:	

Status:

- ❑ Married
- ❑ Separated
- ❑ Divorced
- ❑ Widowed
- ❑ Single
- ❑ Partnership

Live with:

- ❑ Spouse
- ❑ Partner
- ❑ Parents
- ❑ Children
- ❑ Friends
- ❑ Alone

Education:

Occupation: Hours per week: Retired

Employer Work Address

In case of emergency, whom should we contact?

Name Relationship Address Phone

What are your goals for this visit:

What are your health goals for one month from today:

What are your health goals for three months from today:

What is your ultimate goal for your health:

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

What are your current medications?

What are your current vitamins and/or supplements?

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)

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:

Yes No Do you have amalgam (silver) fillings in your teeth? If yes, How many? _____

Yes No Have you ever had an amalgam removed? If Yes, How many_____

Yes No If you had amalgams removed, was it done by a biological dentist using a safe protocol?

Yes No Did your mother have amalgam when pregnant with you?

Yes No Have you ever worked in a dental office? If so, how long? _____

Yes No Have you had any dental crowns? If yes, how many_____

Yes No Have you had any bridges?

Yes No Have you had any root canals?

Yes No Have you had any tooth extractions?

Yes No Do you have any dental implants, retainers or other metal in your mouth?
Explain:_____

Yes No Did you wear contact lenses during the 1980's or early 1990's?

Yes No Did you take oral contraceptives during the 1980's or early 1990's?

Yes No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?

Yes No Have you noticed any adverse reactions to these shots?

Yes No Do you have any tattoos with red ink?

Yes No Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead:

Yes No Does your occupation involve soldering or metal salvage?

Yes No Have you done any old home repair or sandblasting? If so, When_____

Yes No Do you do a lot of painting?

Yes No Was your home built before 1978?

Yes No Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment)

Yes No Are you around a lot of fake leather, or vinyl?

Yes No Do you get stomach aches in the morning?

General Toxicity:

Yes No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.

Yes No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)

Yes No Do you have your house sprayed with pesticides for pest control?

Yes No Do you spray herbicide (weed killers) in or around your home?

Yes No Do you use conventional insect repellants on your self or family?

Yes No Do you use conventional sunscreen?

Yes No Do you use conventional perfume or cologne every day?

Yes No Do you get your hair colored? If so, is it on the scalp?

Yes No Do you use aerosol hairspray?

Yes No Do you get your nails done? If so, how often? _____

Yes No Do you use air freshener in your house, work or car?

Yes No Do you drink filtered water? If so, what type of filter do you have?_____

Yes No Do you drink bottle water if so what kind?

Yes No Do you have a water filtration system for your entire house or shower filtration? If so, what type?_____

Yes No Does your spouse or other family members work around chemicals?

Yes No Can you think of any other toxic exposures you may have had?

Mold:

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

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

Yes No Do you see mold growing at home, work or school?

Yes No Have you ever had water damage at home, work or school?

Yes No Does your home, workplace or school have a damp or mildew smell?

Yes No Does spending time in your basement cause or worsen your symptoms?

Yes No Does your basement ever get wet?

Yes No Do you have a crawl space?
Yes No Does your basement or crawl space have a sump pump?
Yes No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
Yes No Does your car have a mildew smell?
Yes No Does anyone in your home have asthma like symptoms?
Yes 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 breastfed? 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? _____

How did you hear about our Wellness and Nutrition Program?

_____

_____

_____

Food Journal
Please track your food for 3 days prior to your appointment.

Name _____
Date Range _____

	Day One	Day Two	Day Three
Breakfast			
SNACK			
LUNCH			
SNACK			
DINNER			

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? _____

True Cellular Detox™ Neurotoxic Questionnaire

First Name: _____

Last Name: _____

Address: _____

City: _____

State/Zip: _____

Email: _____

Phone: _____

Date: _____

Current Age: _____

Gender: _____

Height: _____

Weight: _____

Name of Practitioner: _____

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 symptom, 1 = Occasionally have it, mild effect, 2 = Occasionally have it, severe effect,
3 = Frequently have it, mild effect, 4 = Frequently have it, severe effect

Section 1	NOT SEVERE				VERY SEVERE
Anxiety	0	1	2	3	4
Mood swings	0	1	2	3	4
Enraged behavior or anger	0	1	2	3	4
Excessive shyness, timidity, social phobia (not typical to your personality)	0	1	2	3	4
Irritability (not typical to your personality)	0	1	2	3	4
Low body temperature (below 97.3 F)	0	1	2	3	4
Insomnia (can't get to sleep or return to sleep)	0	1	2	3	4
Dizziness	0	1	2	3	4
Sound in ears (ringing or hearing your heart beat)	0	1	2	3	4
Psychological symptoms, even thoughts of suicide	0	1	2	3	4
Sensitivity to sound	0	1	2	3	4

Section 1 total: _____

Section 2	NOT SEVERE				VERY SEVERE
Indecisiveness	0	1	2	3	4
Feeling of being overwhelmed or fearful	0	1	2	3	4
Metallic taste in your mouth	0	1	2	3	4
Bad breath	0	1	2	3	4
Bleeding gums	0	1	2	3	4
Sensitive teeth	0	1	2	3	4
Canker sores or other sores in the mouth	0	1	2	3	4
Floaters, shadows or swimmers when you read or look into the sky	0	1	2	3	4
Dyslexia or loss of place while reading, even as a child	0	1	2	3	4
Swelling eyelids	0	1	2	3	4
Peeling on the top layer of skin (hands, feet)	0	1	2	3	4
Dry skin	0	1	2	3	4
Heart pain (angina) and you are under 45 years old	0	1	2	3	4
Depression	0	1	2	3	4
Gout (arthritic pain, especially in big toes)	0	1	2	3	4
Pain in shoulders or upper back	0	1	2	3	4
Twitching eyelids	0	1	2	3	4
Anemia	0	1	2	3	4
Wrist/ankle drop or weak extensor muscles	0	1	2	3	4
Hair falls out (not normal male pattern baldness)	0	1	2	3	4

Section 2 total: _____

Section 3:	NOT SEVERE				VERY SEVERE
Sensitivity to light	0	1	2	3	4
Fatigue after exercising (feeling worse)	0	1	2	3	4
Bad night vision or seeing halos around lights	0	1	2	3	4
Shortness of breath, with very little effort	0	1	2	3	4
Excessive thirst and/or frequent urination	0	1	2	3	4
Red eyes or tearing	0	1	2	3	4
Blurred vision at times	0	1	2	3	4
Morning stiffness	0	1	2	3	4
Sensitivity to smells (chemicals such as petrochemicals, perfumes, air fresheners)	0	1	2	3	4
Chronic fatigue or weakness	0	1	2	3	4
Non-restful sleep	0	1	2	3	4

Section 3 total: _____

Section 4	NOT SEVERE				VERY SEVERE
Receive static shock more often & with more dramatic effect than normal	0	1	2	3	4
Trouble processing new information	0	1	2	3	4
Word reversal or trouble finding words	0	1	2	3	4
Sensitivity to touch	0	1	2	3	4
Short-term memory loss	0	1	2	3	4
Chronic sinus congestion	0	1	2	3	4
Dry non-productive cough	0	1	2	3	4
Muscle twitching	0	1	2	3	4
Excessive sweating, especially at night	0	1	2	3	4

Section 4 cont...	NOT SEVERE				VERY SEVERE
Joint pain - not necessarily true arthritis - can move from joint to joint	0	1	2	3	4
Difficulty losing weight regardless of diet or exercise	0	1	2	3	4
Persistent fungal or viral infection, including athlete's foot, warts, jock itch,	0	1	2	3	4
candida	0	1	2	3	4
Frequent illness, prolonged illness or sick days	0	1	2	3	4
Numbness or weakness in arms and legs	0	1	2	3	4
Headaches	0	1	2	3	4
Trouble adding or dividing numbers in your head	0	1	2	3	4
Fluctuating constipation and diarrhea	0	1	2	3	4
Stomach pain for no apparent reason	0	1	2	3	4
Appetite swings	0	1	2	3	4
Frequent muscle aches, cramps, unusual sharp sudden pains	0	1	2	3	4
Rashes or rosacea	0	1	2	3	4
Cold extremities (hands and feet)	0	1	2	3	4

Section 4 total: _____

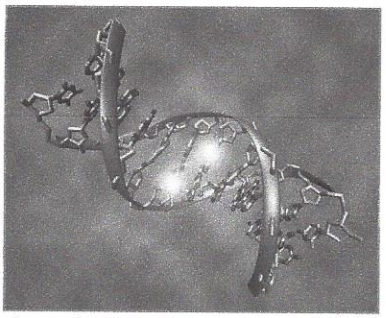
POINT SCALE TOTAL: _____

Scoring over 100: Severely neurotoxic; this patient is positive for neurotoxicity and undoubtedly needs TCD and will need to complete many brain phases to detox.

Scoring: 50-100: Moderate neurotoxicity; this patient is positive for neurotoxicity and needs TCD to decrease symptoms and improve overall health.

Less than 50: less toxic; this patient should still do TCD to increase vitality due to the ubiquitous neurotoxins in our modern world.

Remember, the most important part is to observe whether the patient is improving or not, returning to the initial health goals at each appointment, along with retaking the other tests (meta-oxy, VCS) every 30 days as well. Don't get too caught up in the specific symptomology but look at the trends and observe their overall detox progress results.



Under-Methylation Questionnaire

Methylation is an intracellular, metabolic process that supports thousands of body functions via chemical reactions including turning stress on and off, neutralizing genes that express diseases, and detoxification. Methyl donors (vitamins and compounds such as SAMe, homocysteine, methylcobalamine, and folate) help regulate methylation processes that control neurotransmitters, immunological responses, nerve function, and detoxification. A lack of methyl molecules (CH_3) in the body is an underlying cause of hundreds of symptoms and directly relates to the aging processes.

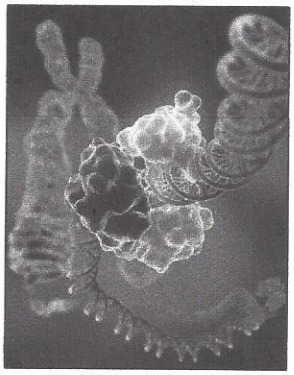
Check all that apply:

1. _____ Type A personality, perfectionistic, driven, obsessive, compulsive?
2. _____ Impulsive? Do you have impulses to do things that you know you shouldn't?
3. _____ If more than three brothers/sisters, are most of your siblings males?
4. _____ Large ears?
5. _____ Second toe as long or longer than your big toe?
6. _____ Do you need large doses of supplements or medications to get an impact?
7. _____ Do you struggle with excessive sugar, alcohol or drug use?
8. _____ Does your mind race? Hyperactive?
9. _____ Inwardly tense? Oppositional Defiance?
10. _____ Respiratory allergies? Asthma? Histamine reactions? Hives? Histadelia? Inhalant allergies?
11. _____ High sex drive, excessive libido? Easy to reach orgasm?
12. _____ Depression? Thoughts of suicide?
13. _____ Insomnia? Not need much sleep? Light sleeper?
14. _____ Headaches, chronic?
15. _____ Easily become aggressive?
16. _____ Need to eat frequently?
17. _____ Dry, cracked fingers, fingertips, heels?
18. _____ Chicken skin, areas of fatty bumps, lipomas?
19. _____ Dandruff?
20. _____ Neurological, brain, or nerve concerns?
21. _____ High libido (lhigh sex drive?)
22. _____ High salivary flow? High tear flow.
23. _____ Anxiety? Depression? Panic disorder? Phobias? Gambling/shopping disorder?
24. _____ Smoke tobacco?

_____ Total number of statements checked.

Scoring: More than 4—supplementation indicated.

WellnessWiz Nutrition Tip. Some 30% of the U.S. population has genetic defects in their methylation pathways: MTHFR (Methylenetetrahydrofolate reductase). Supplements with the ingredients: 5-hydroxymethyl folate, methycobalamine, and Vitamin B_6 can circumvent the genetic defect and allow the cells to conduct more efficient methylation processes such as stress relief, detoxification, and intracellular metabolic functions. Labs offer both genetic methylation tests and methylation profiles.



Over-Methylation Questionnaire

Methylation is an intracellular, metabolic process that supports thousands of body functions including turning stress on and off, turning genes one and off that express diseases, and other health regulatory functions. An overactive methylation processes is an imbalance that results in symptoms and can be improved with nutrition and supplements.

Check all that apply:

1. _____ Elevated neurotransmitters Serotonin, Dopamine? Norepinephrine?
2. _____ Highly artistic, highly musical? Can have grandiose thoughts?
3. _____ Multiple chemical sensitivities?
4. _____ Often obsessive, but not compulsive? Somewhat paranoid?
5. _____ Many food sensitivities?
6. _____ Depression? Despair?
7. _____ Fidgety? Restless legs?
8. _____ Anxiety? Wound up? Anxiousness observable by other people? Panic Attacks? Nervous?
9. _____ Difficult to break a sweat? Low perspiration?
10. _____ Poor reactions to taking SAM-e, inositol, methionine, tri-methyl-glycine supplements?
11. _____ Low libido, low sex drive?
12. _____ Depression? Thoughts of suicide?
13. _____ Insomnia? Not need much sleep? Light sleeper?
14. _____ Highly religious?
15. _____ Dry eyes and mouth? Low tears. Impeded lacrimation? Dry mouth? Low salivation?
16. _____ Underachiever as a child?
17. _____ Hyperactive? Learning disabilities?
18. _____ Apathy? Low Motivation?
19. _____ Hairy body? Hirsuite
20. _____ Hear things that did not occur? Auditory hallucinations?
21. _____ Spacey? Often distracted and unaware of ambient surroundings?
22. _____ High tolerance to pain?
23. _____ Can injure self? Self mutilation?

_____ Total number of statements checked.

Scoring: More than 5—supplementation indicated.

WellnessWiz Nutrition Tip. While fewer people are over-methylators compared to under-methylators; over-methylation is a growing concern. Labs offer methylation profiles that can reveal over-methylation. Nutrients can help balance over-methylation such as niacin and a diet rich in protein. Such nutritional work often alleviates mysterious aches and pains such as upper body and head pains. Your natural health practitioner can help!

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 LONG TERM 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_____

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