TOTAL NUTRITION AND THERAPEUTICS

METABOLIC EVALUATION *"GET TO KNOW YOU"* PACKET

This patient packet must be completed and returned at least one week prior to your first appointment.
If you need assistance, please call before your appointment: 352-259-5190

Please take your time and fill out completely. Should you have any records, labs, etc. you would like to provide to us, please include with your paperwork.

Please print clearly:

Date_____

Participant Name: _____ D.OB._____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ _____ Work/Cell Phone:_____

Email Address:_____

Would you like to receive our monthly newsletter by email? Yes☐ No☐

Work Type:_____ Occupation: _____

DOB: _____ Age: _____ Height: _____ Sex: _____

Marital Status: ☐Single ☐Partner ☐Married ☐Separated ☐Divorced ☐Widow(er)

Primary Care Physician: _____ Date last seen:_____

Do you currently have a My Fitness Pal account for logging food and/or another program for logging food? Yes☐ No☐
If Yes, what program are you using? _____

TOTAL NUTRITION
AND THERAPEUTICS

What is a Metabolic Evaluation?

The Whole Body Approach:

*Your **Metabolic Evaluation** consists of TWO scheduled appointments.*

Visit One: (Getting to know you)

This appointment with a TNT Provider is designed for us to obtain a thorough and complete history and to get a clear understanding of your goals. After reviewing your history, previous labs, medical records, and body composition test, recommendations are made for additional diagnostic tests to "fill in the gaps" needed to give you the proper advice to reach your wellness goals.

Visit Two: (Review of Findings)

This appointment with a TNT provider is designed to review your labs and help you gain better understanding of your current state of health. Then, time is spent collaboratively developing your individual wellness plan.

Subsequent Visits:

There are different avenues for you to take with TNT on your road to wellness. Individual sessions or packages are available to meet your individual needs. You choose what meets your needs.

HEALTH HISTORY

Current Health Problems being treated for: _____

Pacemakers or other implanted medical device: Yes or No (circle).
Describe:
_____

Medication Allergies with Reaction:_____

Other Allergies: _____

Primary Health concern/objective:
_____
_____

Laboratory procedures performed (stool analysis, blood and urine chemistries, hair analysis)
_____
_____

Outcome to Previous Diagnostic studies for these problems:
X-ray_____ Ultrasound _____
Colonoscopy_____ Upper endoscopy_____
Other_____ Thermogram_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ◉ 9 ○ 10 ○

Identify the major causes of stress (changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ○ **underweight** ◉ **overweight** ○ **just right**
Your weight today is_____
Unintentional weight loss or gain of 10 or more pounds in the last three months? Yes or No ◉ ○

Is your job associated with potentially harmful chemicals (pesticides, radioactivity, solvents) and/or life threatening activities (fireman, etc.)?
_____

Signature:_____ Date:_____

MEDICATIONS/SUPPLEMENTS/OVER-THE-COUNTER PRODUCTS USED:

Please list all medications and dosages you are currently taking.
(Prescription and/or OTC – including all Supplements)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please place a '*'by any medications which are new or have been changed in the last 30 days.

Signature:_____ Date:_____

TOTAL NUTRITION

- ☐Arthritis
- ☐Allergies/hay fever
- ☐Asthma
- ☐Alcoholism
- ☐Alzheimer's disease
- ☐Anemia
- ☐Autoimmune disease
- ☐ Blood Clotting Disorder
- ☐Blood pressure problems
- ☐Bowel irregularity
- ☐Brokenbones/fixes
- ☐Bronchitis
- ☐Coumadin Use
- ☐Cancer:_____
  Date Diagnosed:_____
- ☐Chronic fatigue syndrome
- ☐Chronic fever
- ☐Carpal tunnel syndrome
- ☐Chest pain
- ☐Cholesterol, elevated
- ☐Circulatory problems
- ☐Colitis
- ☐Dental problems
- ☐Depression
- ☐Diabetes
- ☐Diphtheria
- ☐Diverticular disease
- ☐Dizziness/Fainting
- ☐Drug Addiction
- ☐Eating disorder:
  Type:_____
- ☐Epilepsy
- ☐Emphysema
- ☐Eyes, ears, nose, throat problems:_____
- ☐Environmental sensitivities
- ☐Fibromyalgia
- ☐Food intolerance
- ☐Frequent infections
- ☐Gastroesophageal refux disease
- ☐Gallbladder disease
- ☐Genetic disorder
- ☐GI Disorder
- ☐Glaucoma
- ☐Gout
- ☐Hashimotos Thyroiditis
- ☐Heart disease
- ☐Heart palpitations
- ☐Heart Murmur
- ☐Headache
- ☐Hepatitis
- ☐ High Blood Pressure
  Last BP Reading:_____
  Date:_____
- ☐Incontinence
- ☐Infection, chronic
- ☐Inflammatory bowel disease
- ☐Irritable bowel syndrome
- ☐Joint Pain
- ☐Kidney or bladder disease
- ☐Lactose intolerance
- ☐Learning diabilities
- ☐Liver or gallbladder disease
- ☐Loss of conciousness/passing out
- ☐Lupus
- ☐Measles
- ☐Mental illness
  Treated Where:
  _____
- ☐Mental retardation
- ☐Migraine headaches
- ☐Mumps
- ☐Muscle aches
- ☐Nervouseness
- ☐Neurological problems
- ☐Pneumonia
- ☐Polio
- ☐Problems with circulation
- ☐Prostate disease
- ☐Obesity
- ☐Osteoporosis
  Last bone density scan Date:___
  Meds:past/present
  _____
  Side Effects:
  _____
- ☐Rheumatic fever ☐Rubella
- ☐Sexually transmitted disease
  Type:_____
  Date Diagnosed:_____
- ☐Seasonal affective disorder
- ☐Scarlet fever
- ☐Shingles
- ☐Shortness of breath
- ☐Sinus problems
- ☐Siogrens disease
- ☐Skin problems
- ☐Stroke
- ☐Tetanus
- ☐Thyroid trouble
- ☐Tuberculosis
- ☐Ulcer
- ☐Urinary tract infection
- ☐Varicose veins
- ☐Venereal disease
  Other_____
  _____

Surgical History Date:

- ☐Adenoids :_____
- ☐Appendix:_____
- ☐Back surgery:_____
- ☐Biopsy:_____
  Biopsy Location:_____
- ☐Breast augmentation:_____
- ☐Breast reduction:_____
- ☐Cancer:_____
  Location:_____
- ☐Cataracts:_____
- ☐Colonoscopy:_____
- ☐Cyst removal_____
- ☐Dilatation:_____
- ☐Gallbladder:_____
- ☐Gastric Bypass:_____
- ☐Hysterectomy:_____
  Total or Partial?
- ☐Joint replacement:_____
- ☐Laparoscopy:_____
- ☐Oral surgery:_____
- ☐Rhinoplasty:_____
- ☐Tonsils:_____
- ☐Vision correction:_____
  Others _____

Signature: _____

Medical (WOMEN)

☐Ablation
☐Birth control
Describe _____
☐Breast cancer
☐Changes in normal menstrual flow (heavier, large clots, scanty)
-Date last GYN exam_____
Pap ☐ + ☐ -
Mammogram ☐ + ☐ -
Date of last study:_____
☐Currently pregnant?
pregnancies _____
#live childbirths_____
☐Children Breast Fed
☐Decreased sex drive
☐Endometriosis
☐Fibrocysitic breasts
☐Fibroids/ovarian cysts
☐Frequent vaginal infection
☐Hormones
Name _____
_____
☐Natural hormones
☐Synthetic hormones
Decribe experience
_____
☐History Of Infertility
☐Losing urine w/coughing or sneezing
☐ Menstrual irregularities
-Date-last menstrual cycle_____
-Length of cycle_____ days
-Interval of time between cycles_____days
☐Menopause
☐Moodiness/Depression with menstrual cycle
☐Pelvic inflammatory disease
☐Premenstrual syndrome (PMS)

Medical (WOMEN) Cont.

☐Sexually transmitted disease
☐Surgical menopause
☐Tubal Ligation
☐Vaginal dryness
☐Vaginal infections
☐History of Rape, violence or sexual assault.
☐Currently sexually active/ Desire to be.
☐Other_____
_____

Medical (MEN)

☐Benign prostatic hyplasia
☐Decreased sex drive
☐Infertility
☐Prostate problems
☐Prostate cancer
☐Sexually transmitted disease
☐Trouble w/premature ejaculation
☐Trouble w/erectile dysfunction
☐Trouble urinating
☐Decrease in size of urinating stream
time urinate night _____

Immunizations

☐Td (date) _____
☐Pneumonia (date) _____
☐Flu (date) _____
☐Shingles (date) _____
☐Childhood immunizations
☐Hepatitis
☐Others
_____

Health Habits

☐Tobacco: Past / Present
Cigarettes: #/day_____
Cigars: #/day_____
How long? _____
☐Interested in stopping?
☐Alcohol:
Wine: #glasses/d or wk____
Liquor: #ounces/d or wk___
Beer: #glasses/d or wk_____
Current Elicit Drug use:_____
Marijuana Use:_____
History Of Drug Or Alcohol Dependance:_____
Recovered:_____

Sleep

Number of hours you sleep per night: _____
Bedtime:_____
Awake time:_____
Diagnosed Sleep Apnea: _____
C-Pap/ Bi-Pap use:_____
Last Sleep Study:_____
Do you snore or have you been told you snore? Yes or No
Do you Dream? Yes or No
Awake rested? Yes or No
Sleep in a chair or a bed?_____
Any medications, or supplements for sleep:_____

Signature:_____ Date:_____

TOTAL NUTRITION

Fluid Intake:

☐Caffeine:
Coffee: #8oz cups/d_____
Tea: #8oz cups/d_____
Soda w/caffeine: #cans/d___
Diet soda #cans/d _____
Other sources_____
☐Water: #glasses/d_____

Eating Habits

☐Skip meals- which ones_____
☐One meal/day
☐Two meals/day
☐Three meals/day
☐Graze(sm. Frequent meals)
☐Generally eat on the run
☐Eat constantly whether hungry or not

Nutrition & Diet

☐Mixed food diet (animal and vegetable sources)
☐Vegetarian
☐Vegan
☐Salt restriction
☐Fat restriction
☐Starch/carbohydrate restriction
☐The Zone Diet
☐Total calorie restriction
Specific food restrictions:
☐Dairy ☐Wheat ☐Eggs
☐Soy ☐Corn ☐All gluten
☐Gluten free
☐Dairy free
☐Grain free
☐Sugar cravings
Yes,describe:_____
☐Carbohydrate cravings
Yes, describe:_____

Trigger Foods: (foods that once eaten have difficulty stopping)_____
_____
Who shops for the household?_____
Who Cooks?_____
How many people live in the household?_____
Any family members on restricted diets?_____
What kitchen appliances do you own to cook with: (George forman grill, outdoor grill (gas, Electric, Charcoal), other: Please Name:_____
_____
Do you Own a blender?_____
Do you drink meal replacement drinks?_____
Would you rather eat food or drink it?_____
Your Biggest Pitfall to "dieting"?_____
_____
_____
Percentage you eat out per week:_____
What meals are eaten out most: Breakfast/ Lunch/ Dinner
Reason for eating out? (Enjoyment/ Convenience, Other)_____
Foods you absolutely will not eat despite how good they might be for you:_____
_____
Foods you crave: _____
_____
_____

What do you snack on:_____
_____
_____
Typical Breakfast you eat? Or Don't eat:_____
_____
Eating Style you grew up with:_____
_____
_____
How do you view Food:_____
_____

Food Frequency

of servings per day:
Fruits (citrus, melon, etc.)_____
Dark green or deep yellow/orange vegetables_____
Grains (unprocessed)_____
Beans, peas, legumes_____
Dairy, eggs_____
Meat, poultry, fish_____

Exercise

☐ Do you Enjoy exercise? Yes or No
☐5-7 days per week
☐3-4 days per week
☐1-2 days per week
☐45 minutes or more duration per workout
☐30-45 minutes duration per workout
☐Less than 30 minutes
☐Walk-#days/wk_____
☐Run, jog, other aerobic-#days/wk_____
☐Weight lift-#days/wk____
☐Stretch-#days/wk_____
☐Personal trainer
☐Other_____

Signature:_____ Date:_____

Social History

Hobbies: What do you like to do:_____
_____
_____

What do you like to do that you can't do now? What limits you?
_____
_____
_____

Last Year Of School completed: Name of Degree::_____
_____

What were your occupations:_____
_____

Did you serve in the millitary? What Branch? How Long? Did you serve in active combat?_____
_____
_____

Any History of PTSD?_____
_____
_____
_____

Birth History:

Full Term or Premature:_____
Vaginal or C- section?_____
Problems During your mothers pregnancy?_____

Childhood Illnesses

☐Measles
☐Mumps
☐Rubella
☐Chicken pox
☐Polio

Childhood History

Any Trauma (Car Accidents, concussions):
Yes or No
_____
_____

Prolonged Hospitilizations:_____
Frequent Antibiotic Use:
Yes or No
How often were you sick?_____
Any Contact Sports? Yes or No
Any Injuries as a result of sports? Yes or No:_____
_____

Current Supplements

☐Multivitamin
☐Vitamin C
☐Vitamin E
☐EPA/DHA
☐Evening Primrose/GLA
☐Calcium, source
☐Magnesium
☐Zinc
☐Minerals, describe_____
☐Friendly flora (acidophilus)
☐Digestive enzymes
☐Amino acids
☐CoQ10
☐Antioxidants(lutein, resveratrol, etc.)
☐Herbs
☐Homeopathy
☐Protein shakes
☐Superfoods (bee pollen, phytonutrient blends)
☐Liquid meals(Ensure)
Others_____

Where do you currently purchase supplements?
☐ GNC
☐ Vitamin Shoppe
☐ Drs. Office
☐ Health Food Store

Any adverse effects of supplements in the past?
☐ Yes ☐ No
If Yes, please explain:
_____
_____
_____

Signature:_____ Date:_____

Bowel Habits

Frequency per day: (circle)
Once Twice Three or more

Consistency: (check all apply)
- ☐ Hard
- ☐ Soft & Formed
- ☐ Soft & Unformed
- ☐ Large
- ☐ Small
- ☐ Watery
- ☐ Mucous
- ☐ Blood

Color: (check all apply)
- ☐ Yellow
- ☐ Brown
- ☐ Red
- ☐ Other

☐ Odor

Other Symptoms (Check all apply)
- ☐ Gas
- ☐ Bloating
- ☐ Distension
- ☐ Hlopolyps
- ☐ Rectal Pain
- ☐ Rectal Bleeding
- ☐ Recent change in bowel habits
- ☐ Any foods Known to cause you Gas or Bloating:_____
_____
- ☐ Over the Counter Medication for constipation or diarrhea
_____
_____
- ☐ Any history of chronic laxative use? ☐ Yes ☐ No
Type? _____

Family Health History

(Parents and Siblings)

	Relationship	Age/ Deceased
☐ Arthritis:	_____	_____
☐ Asthma:	_____	_____
☐ Alcoholism	_____	_____
☐ Alzheimer's disease:	_____	_____
☐ Cancer:	_____	_____
Type:_____	_____	_____
☐ Depression:	_____	_____
☐ Diabetes:	_____	_____
☐ Drug addiction:	_____	_____
☐ Eating disorder:	_____	_____
☐ Epilepsy:	_____	_____
☐ Genetic disorder:	_____	_____
☐ Glaucoma:	_____	_____
☐ Heart disease:	_____	_____
☐ Infertility:	_____	_____
☐ Kidney disease:	_____	_____
☐ Learning disabilities:	_____	_____
☐ Mental illness:	_____	_____
☐ Migraine headaches:	_____	_____
☐ Neurological disorders:	_____	_____
☐ Obesity:	_____	_____
☐ Osteoporosis:	_____	_____
☐ Stroke:	_____	_____
☐ Suicide:	_____	_____
☐ Thyroid disease:	_____	_____
☐ Early Death's in the family:	_____	_____
Other_____	_____	_____

How many siblings do you have:_____
Number of biological children you have? _____
Genetic disease states in children or chronic illness?
☐ Yes ☐ No
Please explain: _____
_____

Signature:_____ Date:_____

809 Hwy 466 Unit 202-C Lady Lake, FL 32159 352-259-5190
TNT4ME.COM

LOW THYROID SYMPTOM CHECKLIST

NAME:_____ DATE:_____CURRENT DOSE: _____

These symptoms arise from Low Intracellular Thyroid Hormone, not what is in the blood!

Rate the following symptoms based on Severity in last 72 hours – 0 (None) 5 (Severe)

Fatigue		Anxiety	
Depression		Lack of sweating	
Weight gain/difficulty losing weight		Weakness	
Cold extremities		Pale skin	
Dry or coarse skin		Shortness of breath	
Constipation		PMS	
Cold intolerance		Heavy menstrual flow	
Hair loss or dry hair		Muscle or joint aches	
Poor memory		Poor motivation	
Poor concentration		Water retention	
Migraines			

Total Score: _____

Recommendations Resulting: ☐ Continue Same Dose

☐ Increase Dose to_____daily/other

☐ Decrease Dose to_____daily/other

Signature:_____ Date:_____

MALE BHRT QUESTIONNAIRE

Patient Info

Name_____

Last Middle First

Phone_____ DOB_____

Mild → Moderate Severe

(PLEASE denote to the left which number)

Sleep disruption	N/A	1	2	3	4	5	6	7	8	9	10
Irritability	N/A	1	2	3	4	5	6	7	8	9	10
Depression	N/A	1	2	3	4	5	6	7	8	9	10
Breast development	N/A	1	2	3	4	5	6	7	8	9	10
Decreased morning erections	N/A	1	2	3	4	5	6	7	8	9	10
Decreased sex drive	N/A	1	2	3	4	5	6	7	8	9	10
Harder to reach climax	N/A	1	2	3	4	5	6	7	8	9	10
Reduced testicular size	N/A	1	2	3	4	5	6	7	8	9	10
Decreased motivation	N/A	1	2	3	4	5	6	7	8	9	10
Decreased self confidence	N/A	1	2	3	4	5	6	7	8	9	10
Abdominal fat	N/A	1	2	3	4	5	6	7	8	9	10
Muscle atrophy	N/A	1	2	3	4	5	6	7	8	9	10
Fatigue	N/A	1	2	3	4	5	6	7	8	9	10
Loss of recent memory	N/A	1	2	3	4	5	6	7	8	9	10
Dry skin	N/A	1	2	3	4	5	6	7	8	9	10
Arthritis	N/A	1	2	3	4	5	6	7	8	9	10
Hair loss	N/A	1	2	3	4	5	6	7	8	9	10
Weight gain	N/A	1	2	3	4	5	6	7	8	9	10

Signature:_____ Date:_____

809 Hwy 466 Unit 202-C Lady Lake, FL 32159 352-259-5190
TNT4ME.COM

FEMALE HORMONE SYMPTOM ASSESSMENT

Patient Name: _____ Date: _____

Which of the following symptoms apply to you at this time? Please make the appropriate box for each symptom. For symptoms that do not apply, please mark 'None'.

Score:	None 0	Mild 1	Moderate 2	Severe 3	Very Severe 4
1. Hot flashes, sweating (episodes of sweating)	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness	☐	☐	☐	☐	☐
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. Bladder problems (difficulty urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse.	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in joints, rheumatoid complaints.	☐	☐	☐	☐	☐

Last Pap: Date: _____ Normal/Abnormal: _____

Last Mammogram Date: _____ Normal/Abnormal: _____

Family History of Breast Cancer? Yes/No Last Menstrual Period: Date: _____

1st Degree Relative Yes/No Cycle every 28 days or Irregular

Osteoporosis/Osteopenia Yes/No Flow: Heavy ☐ Medium ☐ Light ☐

Have you been on Hormones in the past? Yes/No Type: _____ Length of Treatment: _____

Any history of Cancer? Type: _____ Treatments: _____

Any complications: _____

Signature: _____ Date: _____

TOTAL NUTRITION
AND THERAPEUTICS

MEDICAL SYMPTOMS QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for: Past 48 Hrs

Point Scale *0 –**Never** or **almost never** have the symptom*
*1 – **Occasionally** have it, effect is **not severe***
*2 – **Occasionally** have it, effect is **severe***
*3 – **Frequently** have it, effect is **not severe***
*4 – **Frequently** have it, effect is **severe***

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	Total _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	
		(does not include near or far-sightedness)	Total _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	Total _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total _____
MOUTH/THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	Total _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total _____
HEART	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	Total _____

Signature: _____ Date:_____

Information provided by The Institute for Functional Medicine. www.functionalmedicine.org

MEDICAL SYMPTOMS QUESTIONNAIRE

LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	Total _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total _____
JOINTS/MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	Total _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	Total _____
ENERGY/ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	Total _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	
			Total _____

GRAND TOTAL *TOTAL* _____

Signature:_____ Date:_____

PRIVACY RIGHTS

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.
If you have any questions about this notice , please contact the Privacy Official for Total Nutrition and Therapeutics P.A. 352-259-5190

Introduction
This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).
At Total Nutrition and Therapeutics P.A., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice
You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information
Each time you visit Total Nutrition and Therapeutics P.A., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Total Nutrition and Therapeutics P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Total Nutrition and Therapeutics P.A. is required to:
1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Total Nutrition and Therapeutics P.A., reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization. Examples of How Total Nutrition and Therapeutics P.A., May Use or Disclose Your Health Information

For Treatment: Total Nutrition and Therapeutics P.A., may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: Total Nutrition and Therapeutics P.A., may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointments: Total Nutrition and Therapeutics P.A., may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we ' ve asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification, or Communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons ' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties. Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health- related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: Total Nutrition and Therapeutics P.A., may use and disclose information about you as required by law. For example, Total Nutrition and Therapeutics P.A., may disclose information for the following purposes:

for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice ' s Privacy Official.

Total Nutrition and Therapeutics P.A.
510 CR 466 Suite 104-B Lady Lake, Florida 32159 Phone: 352-259-5190

If you believe your privacy rights have been violated, you can file a complaint with the practice ' s Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights –
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Acknowledgment of Receipt of this Notice

Total Nutrition and Therapeutics P.A. is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:
Total Nutrition and Therapeutics P.A.

Name of Patient (PRINT)_____

_____ _____
Signature of Patient or Authorized Representative Date

I acknowledge and agree that Total Nutrition and Therapeutics P.A. may: (CHECK ALL THAT APPLY)

- ☐ Leave a message regarding upcoming appointments
- ☐ Leave a message regarding lab results/medication refills on my home answering machine
- ☐ Leave a message regarding billing questions on my home answering machine
- ☐ Email receipts, appointment reminders, etc.
- ☐ Receive text message apppointment reminders, etc.

I acknowledge and agree that Total Nutrition and Therapeutics P.A. may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

_____
Print name, relationship, and phone number

_____
Print name, relationship, and phone number

_____
Print name, relationship, and phone number

I have read and understand the information in this consent. I may receive a copy of this consent if I so choose, and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

Date: _____

_____ Please Print Name: _____
Signature of Patient or Authorized Representative

PHOTO RELEASE FORM
(Strictly For Electronic Medical Software)

PHOTO RELEASE FOR ADULTS:

I, being of legal age, consent that the photograph taken of myself can be used for TNT's electronic medical software for my safety and protection. This photograph release form does not give permission for my photograph to be used for any marketing purposes. It is strictly for TNT office use in preparing my medical chart.

Name of Client (Print) _____Date: _____

Signature of Client: _____

Address: _____ City: _____ ST: _____ Zip: _____

PHOTO RELEASE FOR MINORS:

I, being a Parent/Legal Guardian of _____, hereby give consent that the photograph taken of him/her can be used for TNT's electronic medical software for their safety and protection. This photograph release form does not give permission for his/her photograph to be used for any marketing purposes. It is strictly for TNT office use in preparing his/her medical chart.

Name of Client (Print) _____Date: _____

Signature of Parent/Guardian: _____

Address: _____ City: _____ ST: _____ Zip: _____

TOTAL NUTRITION
AND THERAPEUTICS

AUTHORIZATION FOR MEDICAL CONSULTATION/TREATMENT

I the undersigned patient ot this office, hereby authorize the staff of Total Nutrition and Therapeutics to administer such treatments as are responsible and necessary. I also authorize such additional treatments, diagnostics and procedures, which may arise during the course of my treatment, based on the finding of the said treatment.

This authorization applies to any location in which services are rendered, whether they are administered in a clinical setting or other venue. I recognize the limitations of certain venues and hereby agree to follow through with the doctor's recommendation regardless of the location, unless I waive the rights to such procedures or treatment.

I certify that no guarantees or assurance have been made as to the results that may be obtained from any and all treatments and I have been fully informed of the risks associated with the treatment performed by the licensed medical provider. I also acknowledge that I will notify the licensed medical provider promptly (within a period of one week from the time of any incident) if there are any questions, concerns, complication or problems relating to my care.

I also hereby certify that I have read and fully understand the authorization for medical treatment, the reason why the treatment is being performed, its advantages and disadvantages, possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by the staff at Total Nutrition and Therapeutics.

_____ _____

Signature of Participant Date

_____

Print Name of Patient or Legal Guardian

TOTAL NUTRITION
AND THERAPEUTICS

OFFICE FINANCIAL POLICY

I. We will collect your payment and fees at the time of service. Payment methods are: cash, check, Mastercard, Discover and Visa or American Express. Metabolic Evaluations and classes are collected prior to scheduling and are non-refundable.

II. There is a $25 charge on all returned checks

III. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside of this office.

Patient No-Show / Cancellation Policy

In order for Total Nutrition and Therapeutics to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.
IMPORTANT: There is a $150.00 NO SHOW fee for ALL initial office visits if cancellation is not made at least 24 hours prior to your appointment. There is a no show fee of $90.00 for subsequent office visits if cancellation is not made at least 24 business hours prior to your appointment regardless of the provider you are scheduled with or the program you are enrolled in.
Due to the demand of TNT's programs, all appointment times are often filled several weeks in advance with no openings for those desiring earlier appointments. Cancellation made at least 24 business hours in advance allows us to accommodate others. We do realize that on rare occasion emergencies may arise and we will address these situations with you at that time. We thank you in advance for your cooperation and for working with us to ensure services are provided to you in the best possible way.

Signature of Patient or Legal Guardian: _____

Patient' s Name:_____ Date: _____

_____
Print Name of Patient or Legal Guardian

TOTAL NUTRITION
AND THERAPEUTICS

FINANCIAL RESPONSIBILITY AGREEMENT

I, _____, hereby acknowledge by this statement that I have been fully informed that payment for any and all of the medical services provided by Total Nutrition and Therapeutics is solely my responsibility. I understand that the services provided by this company will not be billed to any medical insurance company, whether or not they may be covered services that are medically necessary and covered by my insurance. I understand that most, if not all, of the services provided by Total Nutrition and Therapeutics are "non covered" services. I realize that I am the sole party responsible for payment to Total Nutrition and Therapeutics for all services rendered.

Signature of Patient or Legal Guardian: _____

Patient ' s Name:_____ Date: _____

_____
Print Name of Patient or Legal Guardian

METABOLIC EVALUATION FINANCIAL AGREEMENT

Please be advised that *all FEES* for obtaining Metabolic Evaluation Paperwork are NON-REFUNDABLE.

By signing this waiver you agree to the fees for the above mentioned and fully understand that they are non-refundable. If you have any concerns or questions please do not hestitate to ask before signing.

Print name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

Patient ' s Name:_____ Date: _____

It is important for us to hear how you found us, please take a minute and let us know how you found out about us.

Phone Book:
- ☐ Villages Phone Book
- ☐ Embarq Yellow Pages
- ☐ Embarq Business Pages
- ☐ Lake, Sumter, or Marion Yellow Pages

Newspaper:
- ☐ Which one:_____

Television:
- ☐ HomeTown Health ☐ Public Television

Family Doctor:
- ☐ Doctor's name:_____

Magazine:
- ☐ Lake Sumter Style
- ☐ Focus Style
- ☐ Style Magazine
- ☐ Other: _____

Seminar:
- ☐ Which:_____

Family or Friend:
- ☐ Name:_____

May we thank them for referring you? ☐ Yes ☐ No

Other:_____

TOTAL NUTRITION
AND THERAPEUTICS

Supplementation Policy

Excerpt from: FDA NEWS RELEASE November 2015
*'The U.S. Food and Drug Administration, in partnership with other government agencies, today announced the results of a yearlong sweep of dietary supplements to identify potentially unsafe or tainted supplements. The sweep resulted in civil injunctions and criminal actions against **117 various manufacturers** and/or distributors of dietary supplements and tainted products falsely marketed as dietary supplements.'*

Dear Client,
Total Nutrition and Therapeutics takes pride in the knowledge that our Clinic has spent countless hours researching the supplements we carry and suggest to our clients.
Our supplementation protocol is designed to 'fill in the gaps'. If we find that a client is deficient in certain areas we make recommendations on specific supplements that can help with these deficiencies.
However, before we decide to carry any supplement, extensive research is conducted. Three major issues we look at are as follows:

1. Is the supplement safe to take?—contamination and toxicity

2. How does the supplement get absorbed?—disintegration; dissolution; strength; purity; expiration date

3. Is the company/manufacturer science based?—what is the research and science behind their product

Therefore, for the reasons stated above, each time we make a recommendation on a particular supplement we are secure in the integrity of the supplement.
This same integrity can not be established on supplements that we do not carry and have not researched. Our clients are free to do their own research on other supplements but please note, TNT can not and will not guarantee the purity of that product. Furthermore, TNT does not have the time or resources to research other supplements brought in by clients. In addition, we can not guarantee that you will have the same health outcomes with another supplement as you will with ours.

☐ ***I have read and understand the Supplementation Policy established by Total Nutrition and Therapeutics.***

Printed Name of Client Date Signature of Client Date