JACE Wellness Center

Dear Patient and Friend,

Congratulations on your interest in nutrition and your desire to make your health the best that it can be. With some teamwork, we'll work together to bring this about. The first thing we need to do is to understand your metabolism and gland function. To do this, we'll be using a process called Metabolic Typing. Using this system of Metabolic Typing, which is based on over 20 years of research, as well as using ancient dietary laws, we'll learn how best to support your body chemistry. This letter explains how it all works.

Metabolic Typing is a systematic method of determining your individual nutritional requirements. Since there is no one diet that is right for everyone, and because your metabolism is as unique as your fingerprints, before we can make medical and nutritional recommendations, we first need to understand your metabolism-what biochemically and metabolically makes you the unique individual that you are. The first step in this process is the Metabolic Type Evaluation. Here are the elements of the evaluation:

- Survey (included in this packet)
- Symptom record (Day #1 and Day #2)
- Lab Testing (performed at an outside central computer center)
- Analysis (performed at an outside central computer center)
- Metabolic Type Report, Metabolic Program Recommendations
- Consultation (this is where we discuss your results)
- Rechecking or Retesting (Rechecking basic labs usually should be done in 5 weeks after starting the program)

So, those are the elements. Here's how they all work together. Use the following as a checklist:

- Appointment. As a reminder, we've scheduled an appointment with you to come in for your testing on _____
- Survey. Between now and your appointment, carefully complete the enclosed survey. Follow the instructions on the first page of the survey. ***Bring the survey with you when you come in for your appointment***
- 2- day diet record. This is very important. Two days prior to your appointment: **please record your food intake 2-days prior to test date, enter everything you eat each day and your symptoms both before and after eating.**
  Make sure to drink six 8-ounce glasses of water each day of diet.

✓ **Preparation Guidelines.** Prior to your appointment, in order to obtain the most accurate results from your evaluation. Please strictly adhere to the following guidelines:

Avoid all non-essential medications for 1-2 days prior to performing the test.
Avoid all non=essential nutritional supplements for 1-2 days before test.

Avoid all necessary, essential medications for 24 hours prior to testing, when possible
If you're on prescription medication(s), try to take them after the test, rather than before
If possible. Do the best you can with this issue. Just try to take the medication as far away from the testing time as possible. Consult your prescribing doctor about this
Avoid coffee, tea (all), colas and chocolate for 24 hours prior to performing the test.
Avoid candy, cough drops, breath fresheners, mouthwash, toothpaste, etc., for 12 hours prior to testing.

- ✓ **6 hour fast.** Unless otherwise instructed by Doctor Jace, please don't eat for 6-8 hours before coming in for testing. You can eat immediately after your appointment.

  If you have an early morning appointment for testing, don't eat before coming in. Instead, you can eat something before retiring the night before. If you have an appointment later in the day, just don't eat within 6 hours before coming in.
  In the 6-8 hours before your appointment, you can drink one 8 ounce glass of water up to 1 hour before your appointment - no other water or liquid should be consumed until after your appointment.
- ✓ **Testing appointment.** A series of Physiological and Biochemical tests will be run.
- ✓ Bring your completed Survey and your 2-day Diet Record sheets in with you to your appointment

  The tests are simple and will include: blood pressure, respiration rate, pulse rate, breath hold time, blood draw, urine pH and specific gravity, and saliva pH, EKG and other electrical tests.
- ✓ **Consultation.** Following the testing, the results will be checked in-house as well as being sent to an outside lab for analysis. Dr. Jace will put all the information together and type a report summarizing your results, as well as recommendations for treatment and food plan.
- ✓ **Retesting.** After you've been following your new program for 5 weeks, it'll be time to recheck your basic labs in a followup appointment.
- ✓ This type of testing represents the very latest advancements in nutritional science. You're on the cutting edge, and we're appreciative and happy to be able to serve you!
- ✓ **Reminder – Bloodwork sent to an outside lab to check hormones and other conventional parameters are not included in the initial price.**

2 DAY TEST DIET AND SYMPTOM RECORD

FOOD INTAKE List all food & drink consumed	**REACTIONS** Record any reactions you may have to your food and beverage intake		
DAY ONE		**BEFORE**	**AFTER** .
Breakfast Time: ___:___	***Appetite***		
	Cravings		
	Energy		
	Mind		
	Emotions		
Snack Time: ___:___	***Appetite***		
	Cravings		
	Energy		
	Mind		
	Emotions		
Lunch Time: ___:___	***Appetite***		
	Cravings		
	Energy		
	Mind		
	Emotions		
Snack Time: ___:___	***Appetite***		
	Cravings		
	Energy		
	Mind		
	Emotions		
Dinner Time: ___:___	***Appetite***		
	Cravings		
	Energy		
	Mind		
	Emotions		
Snack Time: ___:___	***Appetite***		
	Cravings		
	Energy		
	Mind		

	Emotions		

2 DAY TEST DIET AND SYMPTOM RECORD

FOOD INTAKE List all food & drink consumed	**REACTIONS** Record any reactions you may have to your food and beverage intake		
DAY TWO		**BEFORE**	**AFTER .**
Breakfast Time: ___:___	*Appetite*		
	Cravings		
	Energy		
	Mind		
	Emotions		
Snack Time: ___:___	*Appetite*		
	Cravings		
	Energy		
	Mind		
	Emotions		
Lunch Time: ___:___	*Appetite*		
	Cravings		
	Energy		
	Mind		
	Emotions		
Snack Time: ___:___	*Appetite*		
	Cravings		
	Energy		
	Mind		
	Emotions		
Dinner Time: ___:___	*Appetite*		
	Cravings		
	Energy		
	Mind		
	Emotions		
Snack Time: ___:___	*Appetite*		
	Cravings		
	Energy		

	Mind		
	Emotions		

QUESTIONNAIRE

- Circle the **TRUE** or **FALSE** answer that best describes you.
- Neither choice may fit you exactly, but try to chose the one that comes closest to describing your tendencies
- If neither choice applies, do not circle either
- When responding to a statement phrased in the negative (e.g. "Fruits generally do not agree with me"). A TRUE answer would mean that you agree with the statement (e.g. "Yes it is true that fruits do not agree with me"); a FALSE answer would mean that you disagree with the statement ("Fruits do agree with me")

Last Name	First Name	MI	Sex	Age	Height	Weight

Street Address	City	State	Zip	Phone Number
				( ) -

PART ONE

1. Appetite at breakfast is strong	TRUE	FALSE
2. Appetite at lunch is strong	TRUE	FALSE
3. Appetite at dinner is strong	TRUE	FALSE
4. Eating before bedtime improves my sleep	TRUE	FALSE
5. I live to eat not to subsist	TRUE	FALSE
6. Often I get hungry between meals	TRUE	FALSE
7. Fruits generally do not agree with me	TRUE	FALSE
8. Fasting makes me feel awful	TRUE	FALSE
9. I crave salt	TRUE	FALSE
10. Orange juice in the morning does not agree with me	TRUE	FALSE
11. A meal heavy with fat agrees with me	TRUE	FALSE
12. Going without food for 4 hours is uncomfortable	TRUE	FALSE
13. I do not care for sweet desserts	TRUE	FALSE
14. Vegetarian meals are not satisfactory to me	TRUE	FALSE
15. Meat or fish for breakfast makes me more energetic	TRUE	FALSE
16. Meat or fish for lunch makes me more energetic	TRUE	FALSE
17. Meat or fish for dinner makes me more energetic	TRUE	FALSE
18. Eating meats or fatty foods restores my energy	TRUE	FALSE

TOTAL _____ _____

PART TWO

1. I tend to cough occasionally or a lot	TRUE	FALSE
2. My ear color is red or pink	TRUE	FALSE
3. I seem to have good digestion	TRUE	FALSE
4. My eyes tend to be moist	TRUE	FALSE
5. My hands and feet tend to be warm	TRUE	FALSE
6. Cuts heal quickly	TRUE	FALSE
7. Strong bright light does not bother me	TRUE	FALSE
8. My nose tends towards being moist	TRUE	FALSE
9. I rarely get goose bumps	TRUE	FALSE
10. My skin tend toward oily and moist	TRUE	FALSE
11. I urinate large volumes daily	TRUE	FALSE
12. Often I need to urinate during the day	TRUE	FALSE
13. I cannot hold urine for long periods of time	TRUE	FALSE
14. Strong & lasting reactions to sting and insect bites	TRUE	FALSE

TOTAL _____ _____

PART THREE

1. I accommodate easily and tend to give in	TRUE	FALSE
2. I am passive about achievements	TRUE	FALSE
3. My activity level is sedentary, inactive or sluggish	TRUE	FALSE
4. I easily show affection	TRUE	FALSE
5. I am not very ambitious	TRUE	FALSE
6. I am slow to anger	TRUE	FALSE
7. I like to get to bed later and get up late	TRUE	FALSE
8. I am not a detail oriented person	TRUE	FALSE
9. I prefer not to take responsibility	TRUE	FALSE
10. I am careful, cautious and reserved	TRUE	FALSE
11. Challenges are not important to me	TRUE	FALSE
12. I prefer cooler and colder weather	TRUE	FALSE
13. I tend not to be competitive	TRUE	FALSE
14. I have poor concentration	TRUE	FALSE
15. I am bothered by confrontation	TRUE	FALSE
16. I react poorly to criticism	TRUE	FALSE
17. I do not like decision making	TRUE	FALSE
18. I am not punctual	TRUE	FALSE
19. I would rather give in than argue	TRUE	FALSE
20. I often get drowsy	TRUE	FALSE

TOTAL _____ _____

21. I have food endurance	TRUE	FALSE
22. I have even, steady energy patterns	TRUE	FALSE
23. I am not efficient in my daily tasks	TRUE	FALSE
24. I can easily express emotions	TRUE	FALSE
25. It is hard to put thought into words	TRUE	FALSE
26. I do not easily care to exercise	TRUE	FALSE
27. I am not goal oriented	TRUE	FALSE
28. I am easily hurt by harsh words	TRUE	FALSE
29. I make friends easily	TRUE	FALSE
30. I love eating and socializing	TRUE	FALSE
31. I rarely get impatient	TRUE	FALSE
32. I tend to have low level of outside interest	TRUE	FALSE
33. I do not tend to make lists of things to do	TRUE	FALSE
34. Leaving loose ends does not bother me	TRUE	FALSE
35. I tend to have low drive and motivation	TRUE	FALSE
36. I am rarely or never obsessive	TRUE	FALSE
37. I tend to be somewhat disorganized	TRUE	FALSE
38. I am a feeling intuitive person	TRUE	FALSE
39. My pace of living and working is slow	TRUE	FALSE
40. I tend not to be concerned with perfection	TRUE	FALSE
41. I am an easy to please sort of person	TRUE	FALSE
42. My personality is warm and sociable	TRUE	FALSE
43. I often procrastinate	TRUE	FALSE
44. I am slow at completing tasks	TRUE	FALSE
45. I respond slowly to emotional reactions	TRUE	FALSE
46. I do not like to have routines	TRUE	FALSE
47. I generally like a little more sleep than average	TRUE	FALSE
48. I am easy going and I am very sociable	TRUE	FALSE
49. I enjoy lots of friends and social interaction	TRUE	FALSE
50. Stress makes me depressed & to seek comfort	TRUE	FALSE
51. I have a cool, calm, collected temperament	TRUE	FALSE
52. My tendency is easy going and laid back	TRUE	FALSE
53. My thought reaction time is slow	TRUE	FALSE
54. I am trusting by nature	TRUE	FALSE
55. I am more family & friend oriented, not a workaholic	TRUE	FALSE
56. I am naturally prone to worrying about things	TRUE	FALSE
TOTAL	_____	_____

Circle the majority of answers

Part One totals	FALSE	TRUE
Part Two totals	FALSE	TRUE
Part Three totals	FALSE	TRUE

PATIENT INTAKE APPOINTMENT QUESTIONNAIRE

Date: _____ Date of Birth: _____

Name: _____

Home phone: _____ Work phone: _____

Address: _____

City_____State_____Zip_____

Occupation: _____Height: _____Weight: _____

Blood type_____ Email address_____

Chose three words to describe how you usually feel physically.

1. _____ 2. _____ 3. _____

Chose three words to describe how you usually feel emotionally.

1. _____ 2. _____ 3. _____

List the main symptoms/problems (in order of importance) for which you are seeking medical attention:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

When did these symptoms start and what was going on at that time?

_____

_____

HEAD, EYES, EARS, THROAT

Do you frequently have headaches? _____ How often? _____

When you have a headache, which part of your head hurts?

_____

What time of day do you get most of your headaches? _____

_____

Which pain reliever, if any, helps your headaches? _____

_____

What other symptoms accompany your headaches? _____

_____

Do you have any allergies to airborne materials (for example, hayfever) ? _____

_____

Which airborne things do you think cause you trouble? _____

_____

Do you frequently have a cough? _____

Describe the cough : _____

What time of day or under which conditions is your cough worse? Is your cough affected by weather changes? _____

_____

Have you had: _____ an increased loss of hair, _____ noticeable slow down in its growth,____ have you noticed a thinning of eyebrows, _____ eyelashes? Please describe:

_____

Have you had the sensation of clouded eyesight, as if looking through a fog, that no amount of blinking would clear? _____ What time of day or under what circumstances is this feeling worse?_____

_____

Have your eyes been changing lately? _____ For example, if you wear glasses, have you noticed that your prescription seems suddenly wrong, or that you don't see as well with your present glasses as you did before? _____ Describe. _____
_____

Do you have? : (circle)

sinus trouble	earaches
post nasal drip	itching inside ears
colds	metallic taste in mouth
sore throat	burning in mouth
strep throat	dark circles under eyes
sore gums	shortness of breath
bleeding gums	hyperventilation
dry mouth	burning eyes
dry throat	teary, watering eyes
runny nose	over sensitivity to tobacco smoke
coating on tongue	over sensitivity to bright lights
	over sensitivity to noise

DIGESTIVE SYSTEM

Do you often have diarrhea and/or constipation? (For example, always constipation, or alternating between the two conditions.) Describe. _____

_____

Circle any of these descriptions which seem to apply to your stool:
Dark color, light color, black, tarry, bulky, hard, soft, liquid, formed, unformed, sinking, floating, malodorous, mucousy. Other _____.

How often do you have bowel movements? _____

Do your bowel movements feel complete or incomplete? _____.

What time of the day do you most notice any abdominal bloating or intestinal gas?

_____

Do you often have the feeling that you have intestinal gas that is "stuck" or not

passing through? _____ How often? _____ Describe.

Do you take antacids _____ laxatives _____? How often? _____

Do you have allergies to particular foods, food additives or preservatives
(i.e. MSG)? _____ List which ones you think cause you trouble? _____

_____

Do you have environmental allergies? _____ To what? _____

_____

What kind of a diet do you follow (vegetarian, for example)? _____

_____

Do you have cravings for particular foods? _____ Which ones? _____

_____

Do you eat or drink anything with caffeine (i.e. coffee, tea, cola drinks, chocolate)?
What? How often? _____

_____

Do you drink any alcoholic beverages? Which ones? How often? _____

_____

Which foods do you think induce any indigestion, belching or heartburn? _____

_____

What time of the day do you usually experience the above symptoms? _____

_____

Have you ever been told you have high/low total cholesterol or triglycerides? _____

_____

Are you over or under weight? _____

Do you gain/lose weight very easily? _____

Have you tried to gain or lose weight in the past? _____
Gain? _____ Lose? _____

If so, what diets have you tried? _____

_____

Do you have? : (circle)

pain in upper abdomen
indigestion
belching
painful bowel movements
rectal itching
excessive thirst
lack of appetite
pain in lower abdomen
heartburn
abdominal bloating
painful intestinal gas
hemorrhoids
ravenous hunger

GENERAL SYSTEMIC SYMPTOMS

Do you have trouble going to sleep? _____ Waking up? _____Other sleep Problems? _____

_____

What do you find helps you if you have sleep disturbances? _____

_____

When you awaken in the morning or after a nap, do you feel refreshed? _____

Have you had flu like symptoms frequently (i.e. bone and muscle aches, fever, diarrhea, nausea)? _____ Which symptoms? _____

_____

Does there seem to be a pattern to the reoccurrences? _____ Describe. _____

_____

Do you have any arthritis like feeling that persists in any particular area of the body? _____ Which area or areas? _____

_____

Do you notice any change in bone and muscle pains during damp weather? _____
Describe.

_____

Do you notice any unusual or persistent change in your body odor, particularly an odor that resists washing away? _____ How would you describe the odor? _____

_____

Have you had: _____skin rashes, _____itchy bumps, _____pimples. Is skin particularly dry or oily? _____ Describe skin condition._____

_____

Do you sometimes get heart palpitations, the feeling of "excitement" of the heart, as if it "skipped-a-beat"? _____ Do you know if you have had any previous heart condition? _____ Explain. _____

_____

Do you ever have shortness of breath, heaviness or tightness in the chest, or trouble Breathing? _____ Explain. _____

_____

Have you been more fatigued than usual? _____ Describe any feelings of malaise or tiredness in your own words. _____

_____

How would you describe your energy level? _____

_____

Do you get regular exercise? What forms? _____

_____

Have you had any urinary difficulties, for example _____cystitis,_____Burning, _____ itching, _____urgency, _____frequency associated with urination?

Describe. _____

Are you sexually active? _____ Do you usually use condoms? _____

List any symptoms that you find are:

Worse in the morning: _____

Worse in the evening: _____

Better in the morning: _____

Better in the evening: _____

Do you have? : (circle)

water retention
swollen glands
muscle weakness
muscle twitches/spasms
lack of coordination
lack of balance
dizziness
drowsiness
cold hands/feet
joint swelling
chemical sensitivity
night sweats
puffy hands/feet
heavy feeling in chest
numbness of skin
tingling of skin
burning of skin
bruises
athlete's foot
ringworm
jock itch
finger/toe nail fungus
lack of sexual desire

MENTAL / EMOTIONAL

Have you noticed mood changes that seem unlike you….irritability when you might normally be more patient, depression disproportionate to the circumstances, crying, "flying-off –the-handle", etc.? _____ Describe the feelings: _____

_____

Do you often feel? : (circle)

loss of concentration
memory lapses
unmotivated
spacey/unreal
confusion
unable to cope
drained
anxious

FEMALE PROBLEMS

Have you had a hysterectomy? _____ If yes, when? _____

When was your last menstrual period? _____

When was your last PAP smear? _____ What was the result? _____

Have you had an abnormal PAP test? _____ When? _____

What was the outcome? _____

Do you think you have "PMS" or symptoms you feel are PMS? _____

Which symptoms and how often do you have them? _____
_____

Are your periods regular? _____ Describe your menstrual schedule and the duration of your flow. _____

_____

Describe any pain associated with periods. _____

_____

Describe the color of menses (or any recent change in color). _____

_____
Describe any recent changes in other symptoms during menstrual period.

_____
Is there any clotting? _____ Explain. _____

_____

Do you have: _____ frequent vaginal infections (bacterial or other), _____ itching,_____ burning, _____soreness, _____ discharge, _____dryness. Describe?

_____
Are your breasts often sore and swollen regardless of the time in your monthly cycle?

_____

When was your last mammogram? _____ What was the result? _____

_____

Do you regularly examine your breasts for lumps? _____

Do you have/have you ever had breast cysts? _____ Describe. _____

_____

Do you have endometriosis? _____ If yes, when diagnosed? _____

What treatment did you receive and what was the result? _____

_____

Have you ever been pregnant? _____ How many times? _____ How many children do you have? _____ Did any of your symptoms become worse during pregnancy? _____

Which ones? _____

Have you ever had an abortion? _____ When ? _____

MALE PROBLEMS

Do you have frequent sores or irritation on penis or foreskin? _____Describe. _____

_____

Do you often have burning or itching of groin, scrotum, or penis?_____ Describe.

_____

Do you often have urethral drainage or discharge? _____ Describe. _____

_____

Do you have prostatitis? _____ Have you ever had it? _____

_____

When was your last prostate exam? _____ What was the result? _____

_____

Have you had a PSA blood test? _____ When?_____ What was the result? _____

_____

Do you often experience a loss of sexual desire? _____ Does this follow any pattern? _____

Describe. _____

Do you have venereal warts? _____ Explain. _____

_____

_____

PATIENT HISTORY

Have you had lab test for or positive clinical diagnosis of:

Check Results	Positive lab test	Negative lab test	Positive clinical diagnosis
HIV			
Chronic Epstein Bar Virus			
Mononucleosis			
Cytomegalovirus			
Herpes Specify I or II			
Hepatitis Specify A or B or C			
Syphilis			
Gonorrhea			
Chlamydia			
Kaposi's Sarcoma			
Tuberculosis			
Pneumocystis carinii			
Thrush			
Candida albicans			
Intestinal parasites: _____			
Giardia			
Entamoeba histolytica			
Anemia			
Thyroid function Specify Low or High			
Hemophilia			
Diabetes			
Cholesterol (High Total)			
High LDL (bad)			
Low HDL (good)			

Other : _____			
Other: _____			
Other: _____			

Are copies of these test results accessible? _____

Do you have now or have you at any point had any of the following?

	Never had	**Have now**	**Had before**
High blood pressure			
Heart problems			
Angina			
Surgery			
Cancer			
Asthma			
Circulation problems			
Dialysis			
Blood transfusion			

If any of the above are positive, please explain: _____

_____

_____

Have you ever been hospitalized for any non-surgical illnesses? _____

Explain: _____

Which of the following have you taken or been exposed to:

How Long?

_____ Antibiotics _____
_____ Steroids _____
_____ Cortisone _____
_____ Birth Control Pills _____
_____ Sleeping pills _____
_____ Pain killers _____
_____ Stimulants / depressants _____

_____ Chemotherapy _____
_____ Anticoagulants _____

List the specific names of any medications you can remember taking for long periods of time.

_____ _____

_____ _____

_____ _____

Did you notice any symptoms that became worse during or after the taking of any of these medications or the exposure to any of these substances? Which symptoms, which medications?

_____

_____

List ALL medications, vitamins and supplements that you are currently taking orally, sub-lingually, rectally, topically, or as an inhalant. Include all herbals, homeopathics, EVERYTHING!

_____

_____

_____

_____

_____

_____

List ALL other medications, vitamins or supplements that you have taken within the past 3 months, but may not be taking now.

_____

_____

_____

_____

Have you ever used any recreational drugs? _____ Which ones? _____

How often? _____

Have you used any recreational drugs within the last 3 months? _____ Which ones

And how often? _____

_____

Do you smoke ? _____ Have you ever smoked? _____ For how long? _____

Have you ever chewed tobacco? _____ Explain: _____

_____

Do you have any drug allergies or sensitivities? _____ Please describe: _____

_____

FAMILY HISTORY

Is your father living? Yes _____ No _____

If yes, what is his current age and health status ? _____

_____

If no, age and cause of death? _____

Is you mother living? Yes _____ No _____

If yes, what is her current age and health status ? _____

_____

If no, age and cause of death? _____

List all siblings, age and health status:

_____

_____

_____

_____

Have your father, mother, siblings, grandparents, aunts or uncles had:

	Relationship		Relationship
High blood pressure	_____	Glaucoma	_____
Stroke	_____	Cancer	_____
Heart attack	_____	Tuberculosis	_____
Diabetes	_____	Osteoporosis	_____
Thyroid disease	_____	Asthma	_____

List the names and addresses of all doctors who are treating you now. Include acupuncturists, chiropractors, or other therapists.

Primary care physician: Name: _____
Address: _____
_____
Phone: _____

Name: _____
Address: _____
_____
Phone: _____

Name: _____
Address: _____
_____
Phone: _____

Name: _____
Address: _____
_____
Phone: _____

Name: _____
Address: _____
_____
Phone: _____

In treating you it may be helpful for us to contact the above doctors. Your signature below gives us permission to do so.

I authorize the release of information pertaining to my medical history and treatment given to me by the above named practitioners. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of my treatment, including a reasonable time thereafter. This authorization shall be binding upon me, my heirs, executors or administrator.

Name: _____

Signature: _____

Date: _____

DECLARATION, WAIVER AND RELEASE.

I _____ acknowledge and declare that I have chosen to seek other alternative avenues for my health care needs and am fully aware of the need to continue with any allopathic or conventional treatment that I am given by my medical doctor. I understand that these natural and homeopathic treatments are different from the standard of care, but I fully choose them. I confirm that there has been no suggestion made to me by Dr. Craig Jace or by anyone under his direction or control, that I refrain from seeking or following allopathic treatment. Therefore, I authorize my consent to treatment by Dr. Craig Jace.

It is Dr. Craig Jace's desire to provide premiere complementary medical care. He requests all patients to retain a primary care physician in case any emergency or hospital based care is required. After hour emergencies need to be directed to your primary care physician unless it is related to our treatments.

I understand that professional services are rendered and charged to patient, not the insurance company and that it is my responsibility to pay for these services at the time they are rendered, unless otherwise specified.

I also agree to pay account in full after each visit unless otherwise specified.

Date and signed this _____ day of _____ 20 _____

Signature: _____

CONSENT TO TREATMENT OF A MINOR CHILD

Please sign only if patient is age 18 or under.

I hereby authorize Dr. Craig Jace and his staff to administer treatment, as he deems necessary

to my child, _____

Date: _____ Signature : _____

NEW PATIENT INTRODUCTION:

Patient Name: _____ Date : _____

Date of Birth: _____ Marital Status: _____

Social Security No. _____ Driver's License No. _____

Home address: _____ Home Phone: _____

Referred by: _____ Referral source: _____

Patient employed by: _____Occupation: _____

Business address: _____ Phone: _____

Name of spouse: _____ Employed by: _____

Nearest relative not living with you: _____

Name of person legally responsible: _____

(if patient is a minor, name of parent, guardian, etc.)

INSURANCE:

Primary insurance: _____ Phone: _____

Address: _____ ID/Group #: _____

Secondary insurance: _____ Phone: _____

Address: _____ ID/Group #: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT

If this account is assigned for collection and/or suit, collection cost and/or interest, and/or attorneys fees, and./or court cost will be added to the total amount due.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including MediCare, private insurance and other health plans.

This assignment will remain in effect until revoked by the doctor in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____ Date: _____

Informed Consent for Integrated Allopathic/Alternative Medical Treatment at The Jace Wellness Center

I _____, have sought medical care from Craig Jace, CTN, LAc, DOM, PA-C, and/or staff at the Jace Wellness Center. I have chosen to do this of my own free will. I am aware that a t this center we practice allopathic and natural alternative medicine. Allopathic medicine refers to medicine as it is commonly practiced in the United States, a system which uses pharmaceuticals and surgery as the primary modes of therapy. Natural/Alternative Medicine refers to a system which uses naturally derived medications such as herbs, vitamins, mineral, enzymes, oxygen, ozone, chelation, colon hydrotherapy, etc., to promote and restore a healthy balance to the body. Because Dr. Jace is dually trained in both systems, he is qualified to determine whether the use of natural, allopathic, or a combination thereof would be in my best interest. At the Jace Wellness Center we emphasize the importance of nutrition, exercise, attitude, and non-toxic remedies as the therapeutic mainstays for restoring a patient to his or her optimal state of health.

I realize that the integrated approach by Dr. Jace or the staff at the Jace Wellness Center may not be as rapid as pharmaceutical or surgical therapy, that it may require more effort from me than the simple administration of a symptomatic medication for each complaint, and that some medical authorities consider it to be unproven, ineffective and even unsafe. I also understand that since every individual patient is inherently unique, Dr. Jace or staff cannot warrant or guarantee that the treatment programs will always result in an improvement of the condition being treated.

I also understand that many insurance plans have clauses which limit coverage to "Usual and customary fees for reasonable and necessary services". I realize that some of the natural / alternative medical services provided to me will not fall under this description and I do not hold Dr. Jace or the staff responsible for that possible decision by an insurance company that services provided to me are not covered under a specific insurance contract. I am consulting with Dr. Jace or the staff at the Jace Wellness Center concerning my own health. I am not consulting in order to provide any information to any enforcement, regulatory, or investigative agency of any kind.

By my signature below I certify that I have read and understand the above.

Signature : _____ Date: _____

HORMONE QUESTIONNAIRE

Please answer by writing next to the questions with a number 0 thru 4. Then write the total number after each section.

0= Never 1= Rarely 2= Sometimes 3= Often 4=Constantly

1. I have patches of hair loss _____
2. I have a very pale complexion _____
3. I sunburn easily _____
4. I have memory loss _____
5. I'm stressed out or facing many difficulties _____
6. My blood pressure has dropped _____
7. My friends tell me I look thinner _____

TOTAL_____ACTH

1. I urinate many times a day _____
2. I crave salty foods _____
3. My blood pressure is low _____
4. I feel dizzy when I stand up _____
5. I cannot stand for a long time _____

TOTAL _____AL

1. I have vertebral fractures (crushes) – compression fracture in my spine.
2. I have lost height ----------
3. I have chronic back pain _____
4. I am very sensitive to pain _____

TOTAL _____CA

1. My face looks thinner _____
2. My friends call me skinny _____
3. I have eczema, psoriasis, hives, skin allergies, or other rashes. _____
4. My heart beats quickly _____
5. My blood pressure is low _____
6. I crave salt or sugar (to the extent of bingeing) _____
7. I have digestive problems _____
8. I have allergies (hayfever, asthma, etc.) _____
9. I am stressed out _____
10. I am easily confused _____

TOTAL _____CT

1. My hair is dry _____
2. My skin and eyes are dry _____
3. My muscles are flabby _____
4. My belly is getting fat _____
5. I don't have much hair under my arm _____
6. I don't have much fatty tissue in the pubic area _____
7. My body doesn't have much of a scent during sexual arousal _____
8. I can't tolerate noise _____
9. My libido is low _____

TOTAL _____D

1. My hair is thinning _____
2. My cheeks sag _____
3. My gums are receding _____
4. My abdomen is flabby _____
5. My muscles are slack _____
6. My skin is thin and / or dry _____
7. It has hard to recover after physical exercise _____
8. I feel exhausted _____
9. I do not like the world. I tend to isolate myself _____
10. I feel anxious and worried _____

TOTAL_____GH

1. I look older than I am _____
2. I have trouble falling asleep at night _____
3. I wake up during the night _____
4. And I can't get back to sleep _____
5. My mind is busy with anxious thoughts while I'm trying to fall asleep _____
6. My feet are hot at night _____
7. When I get up, I don't feel rested _____
8. I feel like I am living out of sync with the world, going to bed late and waking up late.
9. I cannot tolerate jet lag _____
10. I use a beta-blocker or a sleep aid _____

TOTAL _____M

1. I have memory loss. _____
2. My joints hurt (finger, wrist, elbows, feet, ankles, knees) _____
3. I'm feeling a bit drained and I have a hard time handling stress _____
4. I don't see colors as brightly as before _____
5. I have lost interest in art, I don't appreciate art as much anymore _____
6. I don't have much hair under my arms or in the pubic area, _____
7. My muscles are flabby _____

8. I have abundant, light-colored urine during the day. _____
9. I have low blood pressure _____
10. I crave salty foods _____

TOTAL_____PREG

1. My face has gotten slack and more wrinkled _____
2. I've lost muscle tone _____
3. My belly tends to get fat _____
4. I feel like making love less often than I used to _____
5. I feel less self-confident and more hesitant _____
6. My sexual performance is poorer that it used to be _____
7. I have hot flashes and sweats _____
8. I tire easily with physical activity _____

TOTAL _____T

1. My hands and feet are cold _____
2. In the morning, my face is puffy and my eyelids are swollen _____
3. I put on weight easily _____
4. I have dry skin _____
5. I have trouble getting up in the morning _____
6. I feel more tired at rest that when I am active _____
7. I am constipated _____
8. My joints are stiff in the morning _____
9. I feel like I'm living in slow motion _____

TOTAL _____TH

1. I'm thirsty at night _____
2. I get up at night to urinate _____
3. I bleed a lot when I get hurt _____
4. I'm losing my memory _____
5. I have a hard time thinking straight

TOTAL_____VASO

<u>Women Only</u>

1. I am losing hair on the top of my head
2. I am getting thin, vertical lines around my lips
3. My breasts are droopy.
4. My face is too hairy.
5. My eyes are dry and easily irritated.
6. I have hot flashes.
7. I am depressed.
8. My menstrual flow is light, or my periods are too long. TOTAL _____E

Women Only

1. My breasts are large.
2. My close friends complain I'm nervous and agitated.
3. I feel anxious.
4. I sleep lightly and restlessly.
5. My breasts are swollen and tender or painful before my period.
6. My belly is swollen before my period.
7. I have heavy periods.
8. I have painful periods.

TOTAL_____P