Grace Alessi, M.D.
Balanced Well-Being Healthcare

Name:____

Address:____

____

Phone number:____

Email :____

DOB :____

Today's date:____

Referred by :____

Occupation:____

My goals for this visit:	**Prior Work up/ Evaluation**	**Relief:**
Ex: Allergies	I had skin testing Food allergy testing Food sensitivity testing	Great! Stopped eating nuts and eggs and i feel great
1.________________________	________________________	____________________
2.________________________	________________________	____________________
3.________________________	________________________	____________________
4. ________________________	________________________	____________________
5.________________________	________________________	____________________
6.________________________	________________________	____________________

MEDICAL CONDITIONS I HAVE:

1.____________________________

2. ___________________________

3.____________________________

4.____________________________

5.____________________________

6.____________________________

7.____________________________

MEDICATIONS I TAKE:

____

____

____

____

____

____

____

ALLERGIES TO MEDICATIONS/FOODS/ENVIRONMENTAL:

____

SUPPLEMENTS/VITAMINS (currently taking):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

HOSPITALIZATIONS/SURGERIES: **DATE:**

Example : pregnancy April, 2015

1.____

2.____

3. ____

4. ____

5.____

A. **My HEALTH TIMELINE:**

1.**Prenatal/Natal**: (circle all that apply)

My mom was healthy / not healthy during her pregnancy with me. Tell us what made her un-healthy:

My mom had many amalgam fillings; if so, how many? _____   My mom had no amalgam fill-ings

I was a term/ premature baby

I was a vaginal delivery
I was breast fed for ___ months. I was bottle fed

2. **Early childhood ages 1-5** (circle all that apply)

As a child I was:

Healthy and had no problems

I was sickly all the time with:

I had symptoms of _________

I took many antibiotics and "pink liquid"

2. **Ages 5-10** (circle all that apply)

I had routine immunizations

I was healthy

I was sickly with ____

I ate a well-rounded diet with fresh vegetables and fruits.

I ate a standard American diet — high in sugar, carbs, grains, sodas, fried foods

I began getting cavities at age____ and had ___# of silver/ amalgam fillings

4. **Ages 10-20** (circle all that apply)

I was healthy

I was sickly with:
____

I participated in sports (which ones and how long):
____

I was active in extracurricular activities such as:
____

I had good friends and felt loved

I was exposed to toxins where I lived. If so, what were they?
____

I felt loved and supported

I ate healthy foods with a diet rich in fresh vegetables and fruits.

I have / had cavities: total # ________. How many are silver fillings? __________

I had acne and was treated with oral antibiotics, Accutane, topical therapies or birth control pills (circle all that apply)

I went to college and thrived

I never went to college; after high school I ____

5. **Adult Life: (circle all that apply)**

I love my job

I hate my job and wish I was:____

I have unresolved grief or resentment from:____

I feel loved in my current relationship

I have been traumatized and still suffer from this

I have been traumatized but have worked through it and have moved on

I have a network of friends and family who I can count on

I'm more of a loner and don't need many friends

I'm lonely

I work with toxins or have been exposed to toxins (give details):
____

I have amalgams (silver fillings) in my mouth. How many? _________

I have had root canals. How many?
____

B. Social habits:

I smoke cigarettes. # per day__________ # of years smoked _______________________

I drink caffeine. # of cups per day ____

I drink alcohol. Number of drinks a day_____ or per week ________

I use marijuana regularly. I use it as: a vape, food, smoke, oil

I use marijuana ____ # of times a day, _____ # of times a week.

I use other recreational drugs ____

C. My Nutrition/ Diet and Meal planning (circle all that apply)

I am an experienced cook and enjoy meal prep

I hate meal prep and feel overwhelmed by it

I eat out # of meals per week_______

Tell us about your typical meals:
(Ex: I never eat breakfast or I have a bowl of cereal and milk or bacon and eggs)

My breakfast is:

My lunch is:

My dinner is:

I avoid the following foods:	**Side effects:**
Ex. Dairy	Bloating and diarrhea
1.	
2.	
3.	
4.	

D. **My exercise habits :**

I like to do (type of exercise): ____

I do it # of times per week/hours per week
____

E. **Sleep habits:** On average, I get ____# of hours per night. Bed time: _______ Wake time: _______

I wake up feeling refreshed and ready to start the day

I fall asleep easily and stay asleep

I can't fall asleep

I have trouble falling asleep and maintaining my sleep

I can't stay asleep

I snore, and it is bothersome to myself or my partner

I'm tired all the time during the afternoon

F. **Family history:**

Mother-

Father-

Grandparents-

Siblings-

Children-

F. **My preventive care:**

Last pap: ____

Mammogram: ____

Bone Density: ____

PSA:____

Colonoscopy: ____

Coronary calcium score or CIMT:______________________________________

My primary doctor:____

Please send my notes to the following doctors/offices:

____

My pharmacy:____

G. **Obstetric History (for women):**

Have you ever been pregnant? ______

Number of miscarriages ____ Number of abortions _____ Number of premature births_____

Number of term births ______ Birth weight of largest baby _______ Smallest baby _______

Did you develop toxemia (high blood pressure) ________

Have you had other problems with pregnancy? __________

Age at first period ______ Have you ever used birth control? ________

Are you taking the pill now? _______

Did taking the pill agree with you? __________________ Not applicable ________

Do you currently use contraception? _______ If so, what type? ________________________

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability? ____________

Are you in menopause? _____________ If yes, age at last period __________

Do you take (circle all that apply): Estrogen Ogen Estrace Premarin Progesterone Provera Other (please specify) _____________

How long have you been on hormone replacement therapy (if applicable)? _____________

Health Profile Questionnaire

Name ______________________________ Date ______________

Rate each of the following symptoms based on how you've been feeling for the: ☐ Past 48 hours ☐ Past Week ☐ Past 30 days

Point Scale

0 — Never or almost never have the symptoms
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 farsightedness) **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 or 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** ____

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/ Muscles
_____ 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 ______

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Altered GI Ecology (or Imbalanced Gut or GI Flora) Questionnaire

	Question	YES	NO
1.	Have you ever taken antibiotics for a month or longer?	☐	☐
2.	Have you taken a broad-spectrum antibiotic three or more times a year?	☐	☐
3.	Have you had at least one annual round of a broad-spectrum antibiotic for a couple of years?	☐	☐
4.	Do you ever feel like an airhead after eating sugar, bread, or pasta?	☐	☐
5.	Have you ever had oral thrush?	☐	☐
6.	Have you ever had yeast vaginitis?	☐	☐
7.	Have you taken prednisone or cortisone for longer than two weeks?	☐	☐
8.	Have you taken birth control pills longer than two years?	☐	☐
9.	Have you ever had fungal skin problems (athlete's foot, ringworm, jock itch, or nail fungus)?	☐	☐
10.	Do you crave sugar?	☐	☐
11.	Do you crave breads or pasta?	☐	☐
12.	Do you crave alcohol or cheese?	☐	☐
13.	Are you intolerant to perfumes, fragrances, or chemical odors?	☐	☐
14.	Do you have regular bouts of abdominal bloating and gas?	☐	☐
15.	Do you have vaginal itching or discharge?	☐	☐
16.	Do you have regular abdominal pain, constipation, or diarrhea?	☐	☐
17.	Do you have food sensitivities or food intolerances?	☐	☐
18.	Do you have rectal itching?	☐	☐
19.	Are your symptoms of abdominal bloating and gas worse when you eat aged cheese, drink alcohol, or have soy sauce?	☐	☐
20.	Have you taken chemotherapy medications for cancer?	☐	☐

Points for each "yes" answer:

- Questions 1–2: 10 points each — Subtotal________
- Questions 3–8: 5 points each — Subtotal________
- Questions 9–20: 2 points each — Subtotal________

Total________

SCORE:

- 0–9: Unlikely you have altered GI ecology or imbalanced gut flora
- 10–19: Mild symptoms of imbalanced gut flora
- 20–29: Moderate symptoms of imbalanced gut flora
- 30+: Severe symptoms of imbalanced gut flora

Thank you for choosing Balanced Well-Being Healthcare to be a part of your healthcare team!

We are excited for you to begin a new journey to optimal health and wellness.

At Balanced Well-Being Healthcare our goal is to establish a healthy foundational relationship with each and every one of our patients. In order to ensure this, we ask that you first review our office policies handout that is attached. We may operate in a manner that is different from your prior experiences.

We also ask you to seriously consider your readiness and willingness to embark on a journey that will require a major commitment to making lifestyle changes. We use changes in diet, food, exercise, sleep, nutritional supplements and other natural therapies to promote your personal health goals. If this does not sound appealing to you or you are not ready for the commitment, please do not choose us to be a part of your healthcare team. Our treatment plans can be difficult for some people to adhere to and we want to make sure you are ready.

Being prepared to examine your personal behaviors and being open to change is paramount to achieving health goals.

A Functional Medicine visit is the most comprehensive and thorough evaluation that we offer and feel that it's the most appropriate way to evaluate your overall health.

We will be examining biological systems thru in-depth testing including analysis of blood, urine, stool and sometimes breath.

We use a team approach to facilitate different levels of the treatment plan. This includes visits with our lifestyle educator, nutritionist and then practitioner. Your results will be evaluated by the entire team so that each of us is an integral part of your treatment plan.

Because our testing program is so rigorous and complete we will complete the evaluation thru various levels. You will be asked to begin with an evaluation of GUT health. This requires a stool sample that can be tedious to collect but is critical in the analysis of your health. Do not skip it! A healthy GUT is the most important foundational piece to beginning any journey to health or recovery from illness.

Please refer to our website for more information on Functional Medicine at www.balancedwellbeinghealthcare.com.

Looking forward to the journey with you!

Grace Alessi, M.D. and the team at Balanced Well-Being Healthcare

About Your Functional Medicine Visit:

Total cost of the package **$975 (Megan Anderson, N.P.) $1500 (Dr. Grace Alessi, M.D.)**, inclusive of the following:
****NOTE – this package DOES NOT include the cost of laboratory testing.**

This type of visit is the most comprehensive evaluation that we offer and we are thrilled you have chosen it. Functional medicine seeks to find the root cause imbalanced in our seven biological systems. It is thru rebalancing and repairing these systems that we can make our way back to optimal health.

1. Your First visit will be 90 - 120 minutes.

Be prepared for a physical exam during this initial visit. A comprehensive nutritional physical is performed to better assess your needs.

Ladies, this may include a pap smear if and when appropriate. Men, a prostate exam may be indicated as well.

We will assess the need for testing and outline a test panel at this time. Most, but not all, of our clients will be offered a comprehensive cardiometabolic panel, a breath test for small intestinal infections, a stool sample to assess large intestinal disease, a thorough hormonal assessment, food sensitivity testing when indicated, and an exhaustive nutritional panel.

We will end this visit with dietary guidelines which will be built upon by our nutritionist. We will also begin basic supplementation per individual needs at this time.

2. Your Second visit, with our master nutritionist, will review and assess guidelines for eating and living based upon initial metabolic screening and gut health. Depending on testing results the GUT healing process may be initiated.

3. Your Third visit. The goal here is to clearly outline your gut health and begin the gut healing process. If the testing has not been completed as we have recommended, your visits will be delayed. Please get your stool and breath test completed immediately.

4. Your Fourth visit is designed to tie it all together and outline for you the areas of imbalance that need addressing and treatment. You will leave with a long-range treatment plan that is specifically designed for you!!

SAMPLE TESTING PRICES

Nutritional Analysis: $179 - $379 (with accepted insurance), $380 (cash price)
Stool Panel, large intestine: $221 - $505 (with accepted insurance), $484 (cash price)
Breath Test, small intestine: $109 - $244 (with accepted insurance), $179 (cash price)
Food Sensitivity IgG: $90 - $350 (with accepted insurance), $149 (cash price)
True Health Diagnostics: (Bills Insurance)

OFFICE POLICY:
1. Be prepared for the time commitment: Our initial visit will run 120 minutes plus additional time for check in and check out. Plan for a minimum of 2.5 hours. In the case of Health Screening Package, prepare for 90-120 minutes.

If you have records with recent rest results, labs, procedures, or office visit notes and think they are relative to your visit, please bring them.

2. Cancellation policy: We allow for large amounts of time for each visit. When you no show we lose valuable time and income that could have been directed to other patients in need. A cancellation fee will be charged in the event that you “Cancel” or “no show” an appointment without prior 24-hour notice. Fee for new patient visits: $100. Return visits: $50. Nutrition: $25

3. We DO NOT BILL INSURANCE: We will in most case provide you with a super-bill with medical diagnosis codes, in which case you may elect to submit to your insurance. We do not guarantee that insurance will cover any of your visit or laboratory testing costs.

MEDICARE and MEDICAID: WE ARE NOT PROVIDERS. In this case we cannot provide a super-bill as we are not contracted under their agreements.

We are a cash-based practice, NOT contracted with any insurance providers.

4. Diagnostic Tests: We use specialized functional lab testing. The hospital, LabCorp and Quest DO NOT provide most of these services. This is state of the art nutritional and gastrointestinal evaluation. Some of this testing ay be billed to your insurance as you see appropriate. You will be provided with a choice to bill or not bill your insurance. When you elect to bill insurance, the company performing the tests submits your billing to your insurance directly. We ARE NOT a mediator in this process. For those of you with high deductible insurance plans, you may elect to use the easy pay system. When you use the easy pay system you are in a sense paying your part of the testing that insurance may not cover in advance. You may also elect to pay cash pricing. If you elect to bill insurance, the payment of testing is directly between you and the company that provided the test, and your insurance. We do not serve as an intermediary.

5. We ARE NOT a Primary Care Provider: We are not a PCP or a substitute for your primary care office. We see our role as an adjunct to your primary care provider. Our functional medical approach to your healthcare is in addition to your routine health screen. We ask each of our patients to continue or establish a relationship with a primary provider. You may request that results and office notes be sent to your provider.

6. We DO NOT PRACTICE PHONE MEDICINE: Results of your testing will be reviewed at scheduled visits. In the event that there is a critical result, you will be notified by our office staff. On occasion you may be notified that we would like to begin a therapeutic intervention prior to your follow-up visit. Most test results will require an in-office visit to be reviewed, unless stated otherwise. Phone Calls will be charged for 15 minute conversations or longer at $25 per 15 minutes for Nutritionist and $50 per 15 minutes for either practitioner.

Signature ______________________________________ Date ________________