



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:

Example : pregnancy

DATE:

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 unhealthy:

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

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:

Ex. Dairy

1.

2.

3.

4.

Side effects:

Bloating and diarrhea

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)? _____



Balanced Well-Being HEALTHCARE

Medical Symptom Questionnaire

Name _____

Date _____

The Medical Symptom Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps to track your progress over time.

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

____ past 48 hours

____ past 14 days

____ past 30 days

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-sighted)

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, lips, gums

____ Canker sores

Total _____

Skin

____ Acne

____ Hives, rashes, dry skin

____ Hair loss

____ Flushing, hot flashes

____ Excessive sweating

Total _____

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

- _____ Chest congestion
- _____ Asthma, bronchitis
- _____ Shortness of breath
- _____ Difficulty breathing

- _____ Nausea, vomiting
- _____ Diarrhea
- _____ Constipation
- _____ Bloating
- _____ Belching, passing gas
- _____ Heartburn
- _____ Intestinal, stomach pain

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation in movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

- _____ Binge eating/drinking
- _____ Craving certain foods
- _____ Excessive weight
- _____ Compulsive eating
- _____ Water retention
- _____ Underweight

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

- _____ Poor memory
- _____ Confusion, poor comprehension
- _____ Poor physical coordination
- _____ Difficulty in making decisions
- _____ Stuttering or stammering
- _____ Slurred speech
- _____ Learning disabilities

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ Low libido

GRAND TOTAL

ALTERED GI ECOLOGY (OR IMBALANCED GUT OR GI FLORA) QUESTIONNAIRE

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

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

Dear Client and new Patient!

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 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 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 is 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.

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. Don't 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 Medical Visit:

cost of package \$1500, 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 root cause imbalances 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 120 minutes. First payment due \$750

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 first visit with dietary guidelines which will be built upon as testing is completed. We will also begin basic supplementation per individual needs at this time.

2. Second visit will be 120 minutes. Second payment due \$750

We will review all of your testing results. Please do your test kits as early as possible. Follow up visits will be delayed until all testing is back.

We will develop specific and personal treatment plans at this visit and outline areas of imbalance indicated by test results. We will also apply these results to your specific symptoms, medical history and outline for you triggers and mediators of disease. You will leave with an understanding of how identified imbalances can lead to specific symptoms and cause disease.

Follow up visits will be scheduled on an individual basis depending on your test results and personal desires. These follow up visits will be billed per hour at \$275/ hour.

Sample of testing prices, if billed to insurance or cash:

Nutritional analysis \$379 cash, \$170 copay if billed to insurance
Stool panel, \$300 cash, \$125 copay if billed to insurance

Breath test for small intestine \$179 cash only

Food sensitivity testing and leaky GUT markers \$199 cash only

We are proud to be able to serve you and look forward to this journey with you!!

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 test 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

3. We DO NOT BILL INSURANCE: We will in most case provide you with a superbill 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 superbill 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 may 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.

Signature: _____ Date: _____