Anita Sadaty, MD
Redefining Health

Thrive!

Thrive Medical Wellness Program

What is Thrive Wellness?

This program is designed to treat ***YOU***. YOUR body. YOUR symptoms. YOUR imbalances.

It is designed to uncover the CAUSE of your dis-EASE by using advanced lab testing and understanding the lifestyle stressors that are not supporting optimal health. By listening to your story and understanding the reasons behind your health issues, we will create a highly personalized plan of healing.

What is it NOT?

This is not a one-size-fits-all, cookie-cutter approach to your health. This is not merely hiding or masking your symptoms without eliminating the cause of symptoms. This is not a "quick-fix" approach that leads to only temporary benefits that won't last.
This is not standard lab work that says "You are normal" when you know that you are not.

Is this for me? *Please answer the following questions:*

» I want to know how my diet and lifestyle choices are impacting my health
» I am willing to make changes to how I live my life in order to get better
» I am willing to invest time and energy in my health at this time.
» I am ready for a new approach to health and wellness.
» If you answered "YES" to these questions, this IS for you.

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Thrive Medical Wellness Program 2

What is involved? 3 Phases:

PHASE I: The INITIAL INTERVIEW – 15-30 minutes

You can schedule a short introductory 15 minute visit to see if this program is appropriate for you. You can discuss your health concerns and symptoms and Dr. Sadaty will describe the process in more detail as it pertains to your issues.

If you wish to proceed with the program, you may dispense with the short introductory visit and complete the intake forms in our WELLNESS PACKET prior to the INITIAL INTERVIEW. We will email you the packet which is also available on our website drsadaty.com under Patient Forms.

During this meeting, we will review your history, target your health problems and goals, determine which lab testing is required and create an initial lifestyle and nutrition action plan. At this visit you will:

- Initiate a personalized nutrition plan
- Receive a customized lifestyle adjustment plan
- Receive ADVANCED LAB TESTING prescriptions specific to your health situation
- Receive a complimentary one-on-one 15-minute health coaching session (included with any 60 minute visit which can be scheduled separately at your convenience)

PHASE 2: The CASE REVIEW – 30 to 60 minute blocks

We will discuss the results of the ADVANCED TESTING, the reasons behind your health concerns and review your comprehensive, individualized program. At this point, we continue to use lifestyle medicine, with the addition of targeted supplements, vitamins, botanicals or possibly medications.

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Thrive Medical Wellness Program 3

What is involved? 3 Phases:

PHASE 3: Follow up Interview – 15 to 60 minute blocks

Here we check in to see if you have resolved your problems and achieved your goals. We discuss next steps. Some of you will be done here. Others may need more time and testing to achieve your wellness objectives. Dr. Sadaty will work with you on a once-per-month basis to help you achieve your goals if needed.

What treatment methods are used?

1. Targeted Nutrition to correct the nutritional imbalances and lifestyle modification (exercise, sleep, stress reduction) to address the cause of most chronic conditions and symptoms.
2. Professional grade supplements to correct nutrient and hormone imbalances and to support the body's internal healing process to create health and vitality.
3. Prescription medications, if required, depending on the specific condition that needs to be addressed

What lab tests are ordered?

Each patient will require a different set of lab assessments depending on the issues that are identified during the INITIAL INTERVIEW. We have tests designed to evaluate the following:

Adrenal Stress Hormone Evaluation – in depth evaluation of cortisol pathways and cortisol rhythm in the body that can impact female hormone imbalance, weight gain, fatigue, inability to handle stress, poor thyroid function, fertility and miscarriage concerns, mood imbalance.

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What lab tests are ordered? (continued)

Female Hormone Balance and Detoxification – evaluation of female hormone pathways for fertility, hormone imbalance, menopause and evaluation of Hormone Replacement efficacy and safety.

Comprehensive Stool Analysis – designed to uncover possible Bacterial, Yeast or Parasitic infections as well as digestive enzyme deficiency, malabsorption and poor beneficial bacterial balance.

Hydrogen Breath Testing – designed to evaluate the small intestine for abnormal bacterial colonization.

Comprehensive Blood Chemistries – a comprehensive blood analysis of thyroid function, nutritional deficiencies, inflammatory markers, anemia panel, liver and kidney function, heart disease risk, autoimmune disorders.

Genetic Map for Weight and Metabolism – Mapping your genes to determine what nutrition profile, what exercise choices and training schedule would work optimally with your genetic make up.

Integrated Genetics Solution – A comprehensive hormone, vitamin and mineral panel that includes the identification of certain genes responsible for metabolism, detoxification and hormonal balance. This panel will identify your optimal zone for vitamins, minerals and hormones needed to achieve balance in metabolism, athletic performance, brain chemistry and anti-aging goals. From this panel, Dr. Sadaty will develop a very personalized recommendation for minerals, vitamins and possibly hormone therapy that is right for you. This is a separate program – please ask Dr. Sadaty if you are interested in this assessment.

Depending on your health insurance you may be covered for these Functional Medicine laboratory assessments. Most blood work should be completely covered by your insurance subject to your individual insurance policies and applicable deductible. ***It is your responsibility to find out if you will be financially responsible for all testing that is ordered.***

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Thrive Medical Wellness Program 5

Are Thrive Medical Programs covered by insurance?

This program is a highly individualized medical coaching program that focuses on optimizing wellness and identifying imbalances that undermine your health. **Unfortunately, this type of preventive care and health optimization approach is not a covered service under private insurance plans and cannot be submitted for reimbursement.**

How much does it cost? *Please refer to Invoice Estimation Of Cost on the next page...*

CANCELLATION POLICY:

Your appointment time has been specifically reserved for you. If you are late for your appointment, you will only have the time left that was originally scheduled for you. If you have to reschedule your appointment, please give at least 48 hours notice, so we can free up your appointment for someone else. If you fail to show up to your appointment or cancel WITHIN the 48 hour window, you will be charged the full amount for the visit. We appreciate your understanding and compliance with this policy.

» ***Schedule an Appointment today by calling: 516.801.1313 or emailing contact@drsadaty.com.***

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Invoice Estimation of Cost

How much does the program cost? 3 Sections:

1. Cost of Lab Testing (see Laboratory Assessment fees) Only labs specifically selected for you
2. Case Review includes:
   a. Review and interpretation of all lab work
   b. Review of all medical history, questionnaires and intake forms
   c. Construction of personalized wellness program
   d. Consultation appointment with the physician
3. Follow up visits – as dictated by your progress and complexity of case (generally follow ups occur every 6 weeks as needed)

Case Review and Follow up visits: you are charged only for the time with Dr. Sadaty
60 minutes $500 45 minutes $450 30 minutes $300 15 minutes $150
Phone and Skype Consultations available upon request billed at the above listed rates.
These remote visits are available only ***AFTER*** the initial face to face meeting

Laboratory Assessment fees: These may or may not be covered by insurance, copays apply

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Invoice Estimation of Cost (continued)

Dr. Sadaty will likely recommend doing a comprehensive blood panel and possibly one or two specialized tests listed below. The tests recommended will vary depending on your particular situation.

1. Comprehensive blood panel (should be covered by your insurance, deductibles apply – please contact your insurance carrier regarding your responsibility for any blood work you have drawn)
2. Adrenal DUTCH Testing (without hormone testing $250, with hormone testing $325) – not covered by insurance. This is the most comprehensive assessment available from Precision Analytics to evaluate stress hormone and female hormone imbalance.
3. Genova Salivary Adrenal Testing A basic salivary adrenal test that is generally covered by insurance (cost ranges between $149-$349)
4. Gut Health Evaluation (cost for a comprehensive stool test analysis may range from $189 to $379) Insurance coverage varies
5. Small Intestinal Bacterial Overgrowth Breath Testing (may range from $149-$189) Insurance coverage varies
6. Female Hormone Test ($325 if done with the adrenal test, $250 if done separately) – NOT covered by insurance
7. Organics Acid Testing – checks markers for metabolism, energy production, liver detox capacity, methylation, B vitamin status, neurotransmitter status, bacterial markers (cost from $149 to $389) Insurance coverage varies
8. Integrated Genetics Solution Testing: checks for certain genetic mutations, female hormone panel, vitamin and mineral levels that all impact hormone health, metabolism, and mood. Requires separate payment for use of the software program to determine YOUR specific personalized requirements. Gives specific information for vitamin, mineral and hormone amounts to optimize your health. (Blood work is generally covered by your insurance HOWEVER, the software program and visit to review results costs $300)
9. Other functional testing is available if your case requires, however this varies with each individual patient

INSURANCE COVERAGE VARIES BASED ON YOUR SPECIFIC INSURANCE CARRIER. YOU WILL NEED TO CONTACT THE TESTING COMPANY TO DETERMINE PRICING AND INSURANCE COVERAGE.

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Health Information Form 1

How The Process Works

1. You will be asked to submit paperwork regarding your health history – please have these completed and submitted to the office so that we can schedule your appointment
2. Once you have completed and submitted the above paperwork, we will schedule the consultation appointment. Here Dr. Sadaty will provide an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice. She will determine which ADVANCED lab testing is required.
3. Once we receive the test results, you will schedule a follow up appointment to discuss your personalized wellness and treatment program.
4. Follow up consultations are scheduled as needed to monitor your clinical progress.

We invite you to contact us at 516.801.1313 or contact@drsadaty.com, if you have any questions. We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

Policies & Procedures

Payment is due at time of consultation

Methods of payment are: Check, Cash, Visa, MasterCard or American Express.

All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments

Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time.

We encourage you to book your appointments in advance.

Lab Tests

The results of your lab test(s) will be sent to Dr. Sadaty 2 to 4 weeks after mailing your specimens to the lab.

Please be sure to contact the company directly prior to mailing your samples to be clear on what your financial responsibility will be and avoid any problems AFTER they have processed your lab tests. Some testing is covered by insurance and some is not depending on the company and your insurance coverage policy.

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Health Information Form 2

Policies & Procedures (continued)

Cancellations

If you are unable to keep your scheduled appointment, you must notify our office a minimum of 48 hours before your scheduled time or you will be charged for the appointment.

Important Notes

» Thrive Medical Wellness Program is not an insurance based program. It is considered a high level, health and wellness optimization program using the Functional Medicine paradigm and cannot be submitted for insurance reimbursement.

» Laboratory fees may or may not be covered by your insurance carrier. This will be discussed with you at the time that you receive your lab kits.

» Blood work ordered by our office is generally a covered medical expense but is dependent on your personal insurance carrier's specific benefits and coverage.

» Please contact the office if you are unclear about any of the policies and procedures outlined in this document

I_____(please print your name) have read and understood the above referenced Policies and Procedures.

Patient's Signature:_____ **Date:**_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ **Date:**_____

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Health Information Form 3

Patient Health Information

Name:			Date:
Address:			
City:	State:	Zip/Postal Code:	Country:
Cell Phone:	Home Phone:	Work Phone:	Fax:
Email:			
Please mark your preference for occasional follow up communication from our office: ◯ Email ◯ Phone			
Age:	Birth date:	Sex: M F	Status: M S W D	Number of Children:

What are your top 3 health concerns you wish to address?

1.

2.

3.

How long has it been since you really felt good?

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Health Information Form 4

Patient Health Information

Please answer all questions frankly, completely and to the best of your ability:

WEIGHT:_____ HEIGHT:_____

1. ARE YOU PRESENTLY TAKING ANY MEDICATIONS, VITAMINS OR SUPPLEMENTS? PLEASE LIST:

_____

_____

2. IN THE PAST HAVE YOU USED, BIRTH CONTROL PILLS OR HORMONE REPLACEMENT?_____

   FOR HOW LONG DID YOU USE THESE? _____

3. IN THE PAST HAVE YOU USED ANTIBIOTICS?_____

   IF SO FOR WHAT CONDITIONS AND HOW LONG?_____

   _____

4. WERE YOU BORN BY: C-SECTION VAGINAL DELIVERY DON'T KNOW
5. WERE YOU BREAST-FED? YES NO DON'T KNOW
6. DID YOU HAVE FREQUENT INFECTIONS AS A CHILD? (CIRCLE ALL THAT APPLY)

   Ear infection Sinus infection Strep Throat Eczema Food Allergies Asthma Tonsillitis
7. DO YOU HAVE MERCURY FILLINGS? YES NO
8. DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? (CIRCLE ALL THAT APPLY)

   • Anemia • Frequent Headaches • Skin condition • Arthritis • Heartburn • Thyroid condition

   • High blood pressure • Unexplained weight change • Chest pains • High cholesterol • PMS

   • Asthma • Endometriosis • Fibroids • Chronic cold/flu symptoms • Hypoglycemia (low sugar)

   • Infertility • Recurrent Miscarriages • Chronic fatigue • Kidney problems • Breast disease

   • Breast Cancer • Fibroadenomas • Breast biopsies • Depression • Liver problems

   • Painful periods • Heavy Periods • Diabetes • Osteoporosis • Menopause • Vaginal dryness

   • Painful intercourse • Low Libido

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Health Information Form 5

Patient Health Information

9. HOW MANY HOURS DO YOU SLEEP A NIGHT ON AVERAGE? _____

   A. WHAT IS YOUR USUAL BEDTIME? _____

   B. HOW WOULD YOU DESCRIBE YOUR SLEEP? GREAT DISRUPTED OKAY

10. DO YOU HAVE ANY FOOD ALLERGIES OR SENSITIVIES? IF SO, WHICH ONES? _____

    _____

11. TOBACCO / ALCOHOL / RECREATIONAL DRUGS

    A. DO YOU SMOKE? Yes No IF YES, HOW MUCH DO YOU SMOKE? _____

    B. DO DRINK ALCOHOL? Yes No IF YES, HOW MUCH AND HOW OFTEN? _____

    C. DO YOU USE RECREATIONAL DRUGS? Yes No IF YES, WHICH DRUGS AND HOW OFTEN?

    _____

12. PLEASE LIST FOODS YOU TEND TO OVEREAT OR CRAVE:

    SWEETS BREADS FATTY FOODS MEAT DAIRY SUGAR CHOCOLATE

13. FAMILY HISTORY OF ANY OF THE FOLLOWING:

    ☐ DIABETES ☐ HEART DISEASE ☐ AUTOIMMUNE DISEASE ☐ OBESITY ☐ CANCER

14. WRITE BRIEFLY ABOUT YOUR WEIGHT GAIN/LOSS HISTORY: _____

    _____

    _____

    A. WHAT DO YOU FEEL TRIGGERED YOUR WEIGHT ISSUE?: (Circle All That Apply)

    HEREDITY STRESS EATING HABITS BOREDOM OTHER: _____

    B. WAS YOUR WEIGHT GAIN/LOSS?: (Circle All That Apply)

    SUDDEN GRADUAL A PROBLEM SINCE CHILDHOOD OTHER: _____

    C. WHAT METHODS HAVE YOU TRIED TO LOSE/GAIN WEIGHT: _____

    _____

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Health Information Form 6

Patient Health Information

15. HOW IS YOUR ENERGY LEVEL ON A SCALE OF 1 TO 10 (1 Low Energy – 10 High Energy) _____

    A. Are there times in the day that you feel best?_____ Worst?_____

    B. Are you happy in your life right now? Why or Why not?_____

    _____

16. WHAT ARE YOUR MAIN SOURCES OF STRESS?_____

    _____

17. HOW DO YOU DEAL WITH YOUR STRESS?_____

    _____

18. PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO:

    A. If I'm feeling down, a snack makes me feel better. YES NO

    B. I sometimes have a hard time going to sleep without a bedtime snack. YES NO

    C. I get tired and/or hungry in the mid-afternoon. YES NO

    D. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. YES NO

    E. Now and then I think I am a secret eater. YES NO

    F. At a restaurant, I almost always eat too much bread before the meal is served. YES NO

    G. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. YES NO

    H. I experience cravings for sugar, breads, pasta and baked goods. YES NO

    I. I feel shaky if I don't eat on time or if I don't snack. YES NO

    J. I often find myself irritable or angry. YES NO

    CHECK OFF ANY OF THE FOLLOWING THAT HAVE APPLIED TO YOU WITHIN THE LAST 30 DAYS:

    ☐ Do you feel nauseous? ☐ Do you have abdominal/intestinal pain? ☐ Do you have bloating?

    ☐ Do you get bloated after meals? ☐ Do you get heartburn? ☐ Do you have diarrhea?

    ☐ Do you have constipation? ☐ Do you travel outside of the U.S.? ☐ Do you belch following meals?

    ☐ Do your bowel movements alternate between constipation and diarrhea? ☐ Do you have gas?

    ☐ Are your stools compact/hard to pass? ☐ Do you have gurgles in your stomach?

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Health Information Form 7

Patient Health Information

19. SURGERIES STARTING WITH MOST RECENT List Year and Type of Surgery and ***WHY***:_____

_____

_____

_____

_____

_____

_____

20. HOSPITALIZATIONS? If so, please explain when and why:_____

_____

_____

_____

_____

_____

21. PLEASE LIST ANY COUNTRIES OUTSIDE OF THE UNITED STATES IN WHICH YOU HAVE TRAVELED OR LIVED:

Child/Teenager:_____

Young Adult:_____

Currently:_____

_____

_____

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Thrive Initial Intake Form 1

Patient Name:_____ **Date:**_____

What are you top 3 most significant complaints/concerns?

Rate each on a scale of 0 to 10 with 0 = No symptoms and 10 = Severe symptoms

1._____ **Rating:**_____
2._____ **Rating:**_____
3._____ **Rating:**_____

When did the complaints begin?

_____

_____

_____

What was going on in your life around that time? PLEASE BE SPECIFIC

Emotionally stressful events?_____
Parents:_____
Family:_____
Work:_____
Financial:_____
Trauma/Surgery/Injury:_____
Personal Stress:_____

Dietary Stresses (circle all that apply)

CAFFEINE CARBS SUGARS ALCOHOL ERRATIC EATING UNHEALTHY FOODS

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Thrive Initial Intake Form 2

What are your complaints/concerns? (continued)

Pain and/or Inflammation (circle all that apply)

IBS MIGRAINES REFLUX GASTRITIS FIBROMYALGIA RASHES ALLERGIES
CHRONIC NECK BACK PAIN JOINT ACHES MUSCLE ACHES OTHER:_____

List all medications and supplements

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

What is the current status of your lifestyle and diet?

Exercise: time/week:_____ Type of exercise:_____
Bedtime:_____ Hours of sleep/night:_____
Gluten free? ☐ Yes ☐ No ☐ Somewhat
Dairy free? ☐ Yes ☐ No ☐ Somewhat
Soy free? ☐ Yes ☐ No ☐ Somewhat
☐ Skipping meals? ☐ Carb cravings? ☐ Binging? ☐ Weight loss?
☐ Weight gain? ☐ Alcohol (how many times a week?) _____

Stress Management: ***What are you doing to relieve stress?***

_____
_____
_____
_____
_____
_____
_____

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Medical Symptoms Questionnaire 1

Patient Name:_____ **Date:**_____

Rate Each Of The Following Symptoms Based Upon Your Typical Health Profile For The Past 14 Days:

Point Scale:

0 - Never or almost never have a symptom
1 - Occasionally have a symptom, effect is not severe
2 - Occasionally have a symptom, effect is severe
3 - Frequently have a symptom, effect is not severe
4 - Frequently have a symptom, 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 / Hearling Loss

Total:_____

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Medical Symptoms Questionnaire 2

Point Scale:

0 - Never or almost never have a symptom
1 - Occasionally have a symptom, effect is not severe
2 - Occasionally have a symptom, effect is severe
3 - Frequently have a symptom, effect is not severe
4 - Frequently have a symptom, effect is severe

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: _____

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Medical Symptoms Questionnaire 3

Point Scale:

0 - Never or almost never have a symptom
1 - Occasionally have a symptom, effect is not severe
2 - Occasionally have a symptom, effect is severe
3 - Frequently have a symptom, effect is not severe
4 - Frequently have a symptom, effect is severe

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: _____

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Medical Symptoms Questionnaire 4

Point Scale:

0 - Never or almost never have a symptom
1 - Occasionally have a symptom, effect is not severe
2 - Occasionally have a symptom, effect is severe
3 - Frequently have a symptom, effect is not severe
4 - Frequently have a symptom, effect is severe

ENERGY / ACTIVITY

_____ Fatigue, Sluggishness
_____ Apathy, Lethargy
_____ Hyperactivity
_____ Restlessness

Total: _____

MIND

_____ Poor Memory
_____ Poor Concentration
_____ Learning Disabilities
_____ Slurred Speach
_____ Confusion, Poor Comprehension
_____ Difficulty In Making Decisions
_____ Poor Physical Coordination
_____ Stuttering Or Stammering

Total: _____

EMOTIONS

_____ Mood Swings
_____ Anxiety, Fear, Nervousness
_____ Anger, Irritability, Aggressiveness
_____ Depression

Total: _____

OTHER

_____ Frequent Illness
_____ Frequent Or Urgent Urination
_____ Genital Itch Or Discharge

Total: _____

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Adrenal Stress Profile Initial Form 1

Take the following questionnaire to identify your personal stress level

Patient Name: _____ **Date:** _____

Next to each question assign a number:
0 = Not True | 3 = Somewhat True | 5 = Very True

_____ 1. I experience problems falling asleep
_____ 2. I experience problems staying asleep
_____ 3. I frequently experience a second wind (high energy) late at night
_____ 4. I have energy highs and lows throughout the day
_____ 5. I feel tired all the time
_____ 6. I need caffeine (coffee, tea, cola, etc.) to get going in the morning
_____ 7. I usually go to bed after 10 pm
_____ 8. Things I used to enjoy seem like a chore lately
_____ 9. My sex drive is lower than it used to be
_____ 10. I frequently get fewer than 8 hours of sleep per night. I am easily fatigued
_____ 11. I suffer from depression, or have recently been experiencing feelings of depression, such as sadness or loss of motivation
_____ 12. If I skip meals I feel low energy or foggy and disoriented
_____ 13. My ability to handle stress has decreased
_____ 14. I find that I am easily irritated or upset
_____ 15. I have had one or more stressful major life events (i.e.: divorce, death of a loved one, job loss, new baby, new job)
_____ 16. I tend to overwork with little time for play or relaxation for extended periods of time
_____ 17. I crave sweets
_____ 18. I frequently skip meals or eat sporadically
_____ 19. I am experiencing increased physical complaints such as muscle aches, headaches or more frequent illnesses

_____ **Add up your score and write in the total**

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Adrenal Stress Profile Initial Form 2

What does your score mean?

If you scored between:

0 to 29 – You are in good health

30 to 39 – You are under some stress

40 to 49 – You are a candidate for adrenal burnout and may at some point experience fatigue, weight gain, insomnia, irritability and mood swings

50 to 59 – You are in adrenal burnout 60 + You are in severe adrenal burnout and it is important that you take immediate steps to correct this condition to prevent further adverse effects

Whatever the form of the stress, the adrenal glands are the first to react! If there is a period of prolonged stress, eventually the adrenal glands burn out and are no longer able to produce the amount of cortisol that is required by the body. At this point you may begin to experience symptoms such as fatigue, insomnia, weight gain, irritability and an inability to cope with stress.

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Thrive Consent Form 1

Consent For Thrive Wellness Program

Thrive Medical Wellness Program is not an insurance-based program. It is considered a health and wellness program that falls outside of insurance coverage and cannot be submitted for insurance reimbursement. If you choose to participate in this wellness program you will be responsible for payment at the time of visit.

Premise – A person's lifestyle including diet, exercise pattern, sleep habits, stresses and interpersonal relationships are believed to be directly related to the development and maintenance of illness. This program evaluates these factors and seeks to help you establish more positive lifestyle patterns regardless of age or type of medical problem.

Testing – I understand that this program may use diagnostic and treatment methods that are variously known as complementary, integrative, holistic or nutritionally oriented.

Lab work – Because we look for imbalances in the body and for trends that may result in illness if not addressed, we at times order tests that may be considered by mainstream medicine to be "unnecessary or of no value." This may include tests for nutritional status, hormone levels, gut infections, heavy metal levels and vitamin or mineral levels. These may or may not be covered by your insurance carrier. This will be discussed with you at the time that you receive your lab kits. Blood work ordered by our office is generally a covered medical expense but is dependent on your personal insurance carrier's specific benefits and coverage. Deductibles may apply. You are responsible for determining your financial responsibility from your insurance carrier for all testing that is recommended.

Supplementation – Although prescription and over the counter medications are used when necessary, an attempt is first made, when appropriate, to use nutritional supplements such as vitamins, minerals, amino acids, enzymes and botanical formulas. These products may be purchased online from FullScript – an online dispensary that offers access to a wide range of professional grade supplements and botanical formulas that have been used successfully in our wellness programs, however YOU ARE IN NO WAY OBLIGATED TO PURCHASE THESE PRODUCTS through this dispensary and are free to purchase them from any source that you may choose.

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Thrive Consent Form 2

Consent For Thrive Wellness Program (continued)

Your Participation – We believe in your involvement in improving your own health and encourage questions and participation in decisions surrounding any aspect of your wellness program. We encourage discussion with your other health care practitioners about any health care concerns or questions. Please continue on your prescribed medications and advise your pharmacist of any supplements you are taking along with any medications to ensure no harmful interactions exist.

Goals --We will do our best to achieve your healthcare and wellness goals. However, we are making no claims or guarantees that your medical problems or conditions will be resolved by following the program recommendations.

Please contact the office if you are unclear about any of the information outlined in this document.

I have read the above consent form for enrollment in the wellness program and understand its provisions. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I_____(please print your name) have read and understood the above referenced Policies and Procedures.

Patient Signature:_____ **Date:** _____

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Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name:_____ Date:_____

Food Plan Type:_____

Day 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins; F: Fats; C: Carbohydrates; R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black; W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good Relaxation ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

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Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name:_____ Date:_____

Food Plan Type:_____

Day 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins; F: Fats; C: Carbohydrates; R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black; W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good Relaxation ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

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Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name:_____ Date:_____

Food Plan Type:_____

Day 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack Time		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins; F: Fats; C: Carbohydrates; R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black; W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good Relaxation ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

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Case Review Questionnaire 1

Patient Name:_____ **Date:**_____

The single most important criteria for effective case management is a comprehensive and detailed health history. Please answer the following questions with as much detail as possible. It is important for me to know everything about you and your case. Even when you feel the questions may not be directly relevant to your situation, please do your best to answer them. Please type answers to the following questions with as much detail as possible. Please answer each question independently.

Health History Questions

1. Please List The Following:

Education: _____

_____

Profession: _____

_____

Interests (Sports, Hobbies, etc.): _____

_____

2. List Your Top Chief Complaints In Order Of Importance To You:

» **1.** _____

_____

» **2.** _____

_____

» **3.** _____

_____

» **4.** _____

_____

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Case Review Questionnaire 2

Health History Questions (continued...)

3. **List all diagnoses given to you in a timeline sequence and your personal opinions about them:**_____

4. **What is your opinion of what has happened to your health?**_____

5. **List any treatments, medications, or supplements that have improved your health:**

6. **List any treatments, medications, or supplements that have caused reactions or decreased your health:**_____

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Case Review Questionnaire 3

Health History Questions (continued...)

7. List in a timeline sequence any medical procedures or surgeries you have had:

_____

_____

_____

_____

Personal Opinion Questions

Please do not answer *"I don't know"* to any of the questions.

1. Why do you think healthcare practitioners have failed with your case?

_____

_____

_____

_____

_____

2. What are you looking for in a healthcare practitioner?_____

_____

_____

_____

_____

_____

_____

_____

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Case Review Questionnaire 4

Personal Opinion Questions (continued...)

3. What do you consider a realistic window of time to see changes in your health under our care?_____

4. Are you prepared to pay for the laboratory testing, consulting fees, and nutritional supplements that may be required to successfully manage your condition?

   ☐ *Yes!* ☐ No

5. On a scale of 1 to 10, how committed are you to recovering your health?

   1 2 3 4 5 6 7 8 9 10

6. What obstacles or beliefs, if any, stand in the way of you recovering your health?

7. Are there emotional or psychological issues that may be contributing to your health problems? If so, please explain them briefly._____

8. Do you enjoy your work? Do you believe your work contributes to your health problems?_____

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