BOONE HEART & WELLNESS

Name: Date:

Address

Phone: Email

DOB Referred By

Occupation

| My goal for the visit: | Prior Work up/ Evaluation | Relief |
|---|---|---|
| Ex: Allergies | I had skin testing<br>Food allergy testing | Stopped eating eggs and I feel great! |
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |

BOONE HEART & WELLNESS

| Medical Conditions I Have | Hospitalizations | Date |
|---|---|---|
| 1 | 1 | |
| 2 | 2 | |
| 3 | 3 | |
| 4 | 4 | |
| 5 | 5 | |
| 6 | 6 | |
| 7 | 7 | |

| Current Medication | Supplements/Vitamins |
|---|---|
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |

**Allergies to Medications/Food/Environmental**

BOONE HEART & WELLNESS

## 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/silver filings: { Yes / No } If so, how many? _____

I was a { term / premature } baby I was a { vaginal / cesarian } delivery

I was breast fed { Yes / No } If yes, for how long? _____

**2. Early Childhood ages 1-4:** Circle all that apply

As a child I was { healthy and had no problems / sickly all the time }

I had symptoms of _____

I took many antibiotics and "Pink Liquid" { Yes / No }

**3. Ages 5-10:** Circle all that apply

I had routine immunizations { Yes / No }

I was healthy { Yes / No }

I was sickly { Yes / No } Symptoms: _____

I ate a well-rounded diet with fresh vegetables and fruits { Yes / No }

I ate a standard American diet - high in sugar, carbs, grains, sodas, fried foods { Yes / No }

I began getting cavities at age ___ and had __# of silver amalgam fillings.

**4. Ages 10-20:** Circle all that apply

I was healthy { Yes / No }

I was sickly { Yes / No } Symptoms: _____

BOONE HEART & WELLNESS

I participated in sports (which ones and how long)

_____

I was active in extracurricular activities such as:

_____

I had good friends and felt loved { Yes / No }

I was exposed to toxins where I lived { Yes / No } - If so, what were they:

_____

I felt loved and supported { Yes / No }

I ate healthy foods with a diet rich in fresh vegetables and fruits { Yes / No }

I have / had cavities: total # ____ How many are silver fillings? _____

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

I went to college and thrived { Yes / No }

If no, after high school I _____

**5. Adult Life:** Circle all that apply

I love my job { Yes / No }

I hate my job { Yes / No } and with I was: _____

I have unresolved grief or resentment from: _____

I feel loved in my current relationship { Yes / No }

I have been traumatized and still suffer from this { Yes / No }

I have been traumatized but have worked through it and have moved on { Yes / No }

I have a network of friends and family who I can count on { Yes / No }

I'm more of a loner and don't need many friends { Yes / No }

I'm Lonely { Yes / No }

I work with toxins or have been exposed to toxins{ Yes / No } - if yes, give details:

_____

I have amalgams/silver fillings in my mouth { Yes / No } if so, how many? _____

I have had root canals { Yes / No } if so, how many? _____

BOONE HEART & WELLNESS

## Social Habits

I smoke cigarettes { Yes / No } if yes, how many per day? _____ for _____Years

I drink caffeine{ Yes / No } if yes, number of cups per day _____

I drink alcohol{ Yes / No } if yes, number of drinks per day _____ or week _____

I use marijuana regularly { Yes / No } if yes, I use it as { vape / food / smoke / oil }

if yes, number of times per day _____ or week _____

I use other recreational Drugs { Yes / No } if yes, what type(s) _____

## Nutrition, Diet and Meal Planning

I am an experienced cook and enjoy meal prep { Yes / No }

I hate meal prep and feel overwhelmed by it { Yes / No }

I eat out _____ times 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 generally:

My Lunch is generally:

My Dinner is generally:

BOONE HEART & WELLNESS

| I avoid the following foods: | Side Effects: |
| --- | --- |
| Ex: Dairy | Bloating and Diarrhea |
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |

## Exercise Habits

Exercises I like to do: _____

How many times per week do you exercise _____ How many hours per week total _____

## Sleep Habits

Average hours of sleep per night: _____ Bed Time: _____ Wake Time: _____

I wake up feeling refreshed and ready to start the day { Yes / No }

I fall asleep easily and stay asleep { Yes / No }

I can't fall asleep { Yes / No }

I have trouble falling asleep and maintaining my sleep { Yes / No }

I can't STAY asleep { Yes / No }

I snore, and it is bothersome to myself or my partner { Yes / No }

I'm tired all the time during the afternoon { Yes / No }

## Family History

Mother

Father

Grandparents

Siblings

Children

BOONE HEART & WELLNESS

## My Preventive Care History

Last Pap: _____ Last PSA: _____

Last Mammogram: _____ Last Colonoscopy: _____

Last Bone Density: _____ Last Coronary Calcium Score of CIMT: _____

My Primary Doctor: _____

Please send my notes to the following doctors/offices:

_____

My Pharmacy: _____

## Obstetrics History (for Women)

Have you ever been pregnant? { Yes / No }

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) { Yes / No }

Have you had other problems with pregnancy? { Yes / No } _____

Age of first period _____ Have you ever used birth control ? { Yes / No }

Are you on the pill now? { Yes / No } Did/Does taking the pill agree with you? { Yes / No }

Do you currently use contraception? { Yes / No } if yes, what type? _____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability? { Yes / No }

Are you in menopause? { Yes / No } if yes, age at last period _____

Are you on hormone replacement therapy? { Yes / No } if yes, for how long _____

Do you take (circle all that apply) Estrogen Ogen Estrace Premarin

Progesterone Provera Other (Please Specify) _____

BOONE HEART & WELLNESS

## 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, redness or sticky eyelids | | |
| | _____ | Bags or dark circles under eyes | | |
| | _____ | Blurred or tunnel vision | Total | _____ |
| | | (does not include near or far-sighted) | | |
| **Ears** | _____ | Itchy ears | | |
| | _____ | Ear aches, 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 | _____ |
| **Heart** | _____ | Irregular or skipped heart beat | | |
| | _____ | Rapid or pounding heartbeat | | |
| | _____ | | Total | _____ |

BOONE HEART & WELLNESS

| | | | |
|---|---|---|---|
| **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 in 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 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 | |
| | _____ | Low libido | Total _____ |
| | | | **GRAND TOTAL** _____ |

BOONE HEART & WELLNESS

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

| | Yes | No |
|---|---|---|
| 1. Have you ever taken antibiotics for a month or longer? | ❒ | ❒ |
| 2. Have you taken a broad-spectrum antibiotic 3 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** | _____ |

## Score

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

BOONE HEART & WELLNESS

# OFFICE POLICIES

1. Be prepared for the time commitment:
    - Our initial visit will run 90 minutes plus additional time for check in and check out.
    - In the case of Health Screening Package, prepare for 90.

2. 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.

3. 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

4. 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.

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

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

7. 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. As with all of our testing, these tests will be cash-pay.

8. 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.

9. 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: _____

BOONE HEART & WELLNESS

Dear Client and New Patient!

Thank you for choosing Boone Heart and Wellness to be a part of your healthcare team! We are excited for you to begin a new journey to optimal health and wellness. At Boone Heart and Wellness, 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 being open to change are paramount to achieving health goals.

A Functional Medicine visit is the most comprehensive and thorough evaluation that we offer. We feel that this is the most effective way to evaluate your overall health.

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

Please refer to our website for more information on Functional Medicine at https:// www.booneheartwellness.com/

Looking forward to the journey with you!

Rachel Fischer M. D. and the team at Boone Heart and Wellness

BOONE HEART & WELLNESS

# New Patient Health Programs

**New Patient Functional Medicine Program -$1350- $1700**
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. This package includes:

**Initial Visit – 90-120 minute consultation**
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.

**Second Visit – 90- 120-minute Consultation**
We will review all of your testing results. Please schedule your testing and blood draws as early as possible. Follow up visits will be delayed until all testing results that were recommended at the initial consultation 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.

**New Patient Health Screen - $850**
This option includes the Cleveland Heart Blood Panel and a one hour consultation with your provider to review all of your testing results. A great first step to achieving your health goals.

**All Testing recommended during your Consultations is not included in the prices listed above. Please feel free to ask our team for details about individual test prices.**

BOONE HEART & WELLNESS

# Continuing Patient Health Programs

**Continuing Patient Yearly Functional Medical Program – $1800**
This is an annual update to the most comprehensive evaluation that we offer. 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.
This package includes the following tests:

- Carotid Ultrasound and IMT
- Cleveland Heart Blood Panel
- NutrEval
- In-House Blood Draw
- 120-minute Consultation

**Functional Medicine and Boone Heart Attack Prevention Program – $3200**
This robust testing package bundles our Functional Medicine Evaluation with advanced heart disease prevention testing provided through our new partnership with Boone Heart, overread by Boone Heart physicians.
This package includes:

- Carotid Ultrasound and IMT
- Cleveland Heart Blood Panel
- NutrEval
- In-House Blood Draw
- Echocardiogram
- ABI with Lower Extremity Doppler
- Abdominal Aortic Ultrasound
- Abdominal General Ultrasound
- EKG
- 120-minute Consultation**

**A La Carte Testing**
Hourly consultation with your Provider - $450 an hour

- Carotid Ultrasound and IMT – $150
- Labcorp Blood Panel – $400 (In-House Blood Draw included)
- NutrEval – $400 (In-House Blood Draw included)
- Echocardiogram - $700
- ABI with Lower Extremity Doppler - $300
- Abdominal Aortic Ultrasound - $100
- Abdominal General Ultrasound - $200
- EKG - $100
- Stool Panel - $350
- Breath Test for Small Intestine - $200
- Food sensitivity Testing and Leaky GUT Markers $250
- Hormone Replacement Pellets- $350 Women/ $650 Men