PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Occupation: _____

Street Address (not PO Box): _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ E-Mail Address: _____

Must have email address to be seen by Dr. Thomas

Daytime Phone: _____ Evening Phone: _____

Primary Care Physician's Name & Phone Number: _____

Must have primary care physician to be seen by Dr. Thomas

Emergency Contact Name & Phone Number: _____

Preferred Lab: ☐ LabCorp ☐ Quest ☐ Self-Pay ☐ Other: _____

Preferred Pharmacy's Name & Phone Number: _____

How did you hear about us? _____

Please review, initial, and sign below:

_____ I acknowledge receiving a copy of the Notice of Privacy Practices.

_____ By supplying my email address above, I understand that I am granting permission for the office of Dr. Daniel Thomas to communicate with me by email for such things as laboratory results, appointment reminders, health updates, and responding to medical questions.

_____ Dr. Thomas is "opted-out" of Medicare and is not a Medicare provider. Therefore, I understand that his office will not bill Medicare and I am not eligible for Medicare reimbursement or reimbursement from a Medicare supplement, nor a Medicare HMO plan for medical services rendered by Dr. Thomas.

_____ I understand that Dr. Thomas does not accept insurance, nor does he bill my insurance company. However, if you have health insurance coverage or an HSA (Health Savings Account), he will help you get reimbursed for some of your expenses by referring you to our outside medical billing service who can file a medical claim on your behalf after each office visit.

_____ I understand that Dr. Thomas is not a substitute for my primary-care physician and the care that he or she provides. The purpose of Dr. Thomas is to supplement, not replace, the relationship between you and your primary-care physician.

_____ I understand that a doctor-patient relationship is not established until I am seen in person by Dr. Thomas and that no medical recommendations can be given until such time.

_____ _____

Patient Signature Date

MEDICAL HISTORY FORM

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Gender: ☐ M ☐ F

SIGNS AND SYMPTOMS: Please check if you are experiencing any of the following:

Men and Women:
☐ Decreased Energy/Stamina
☐ Decreased Sex Drive
☐ Difficulty Concentrating
☐ Lack of Mental Clarity
☐ Decreased Short-Term Memory
☐ Difficulty Sleeping
☐ Irritability or Grumpiness
☐ Sadness or Depression

Men and Women:
☐ Anxiety
☐ Decreased Motivation
☐ Weight Gain or Excess Fat
☐ Loss of Muscle Mass or Strength
☐ Decreased Response to Exercise
☐ Joint Pain or Muscle Aches
☐ Migraine/Severe Headaches
☐ High Cholesterol

Men Only:
☐ Weak Erections

Women Only:
☐ Hot Flashes
☐ Night Sweats
☐ Vaginal Dryness
☐ Sagging Breasts
☐ Fibrocystic Breasts

MEDICAL HISTORY: Please check if you have OR have ever had any of the following:

Men & Women:
☐ Diabetes or Pre-Diabetes
☐ High Blood Pressure
☐ Heart Attack or Stroke
☐ Head trauma of any kind
☐ Parkinson's disease
☐ Bipolar Disorder
☐ Depression or Anxiety
☐ Attention Deficit Disorder
☐ Sleep Apnea

Men & Women:
☐ Alcoholism
☐ Family History of Dementia
☐ Family History of Cancer
☐ Kidney Disease
☐ Low Thyroid
☐ Hepatitis or Liver Disease
☐ HIV Positive
☐ Osteopenia or Osteoporosis
☐ Phlebitis or Blood Clots

Men Only:
☐ Prostate Enlargement
☐ Prostate Cancer
☐ Breast Cancer

Women Only:
☐ Uterine Fibroids
☐ Uterine Cancer
☐ Breast Cancer

Men Only: Date of Last Prostate Exam: _____ Results: _____

Women Only: Do you still have periods? ☐ Yes ☐ No First Day of Last Period: _____
Date of Last Mammogram: _____ Results: _____
Date of Last Pelvic Exam:_____ Results: _____

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE FOR ANY ILLNESSES OR CONDITIONS?

☐ Yes ☐ No *If yes, please explain*: _____

_____

_____

_____

_____

PREVIOUS HOSPITALIZATIONS OR SURGERIES: _____

_____

_____

_____

_____

Continued on Next Page

MEDICAL HISTORY FORM cont'd

CURRENT MEDICATIONS (prescription and over-the-counter) AND VITAMIN SUPPLEMENTS:

Name	Dosage	Frequency

MEDICATION ALLERGIES: _____

LIFESTYLE:

What is your overall stress level? ☐ Mild ☐ Moderate ☐ Severe
Do you engage in strength-training exercise at least 3 days per week? ☐ No ☐ Yes
How often do you have bowel movements*?* _____
How many hours do you sit each day? _____
Do you smoke, chew tobacco, or vape? ☐ No ☐ Yes
Do you drink alcoholic beverages? ☐ No ☐ Yes *Times per week?* _____
Hours of sleep per night: _____
Number of glasses of pure water per day: _____
Number of cups of coffee, tea, or caffeinated soda per day: _____
Number of servings of fruit and vegetables per day: _____
Who does your grocery shopping? _____ Who cooks your meals? _____
Hours per week spent with friends: _____ Hours per week spent outdoors: _____
Highest educational level achieved: ☐ Grade School ☐ High School ☐ College ☐ Graduate School
Do you engage in lifelong learning activities? ☐ No ☐ Yes
Women: Do you get your hair and/or nails done on a regular basis? ☐ No ☐ Yes

Continued on Next Page

MEDICAL HISTORY FORM cont'd

FAMILY HISTORY: Did your mother or father have a heart attack before age 60? ☐ No ☐ Yes

HEALTH RATING: With 1 being "poor" and 10 being "excellent," on a scale of 1-10, please circle below how you would rate your overall health right now:

1 2 3 4 5 6 7 8 9 10

WHEN WAS THE LAST TIME YOU FELT <u>REALLY</u> GOOD? _____

GOALS OF TREATMENT: Please check any of the following that you would like to achieve:

☐ Have more energy
☐ Sleep well
☐ Have better digestion
☐ Be able to eat a greater variety of foods
☐ Get rid of my allergies
☐ Have a stronger immune system (e.g., less colds and flus)
☐ No longer use laxatives or stool softeners
☐ Be able to exercise again
☐ Have better muscle tone
☐ Have less pain
☐ No longer use pain medication
☐ No longer use allergy medication
☐ No longer use sleep medication
☐ Feel less sleepy in the afternoon
☐ Lose weight
☐ Increase my sex drive
☐ Have less hot flashes and/or night sweats
☐ Increase my metabolism to burn more fat
☐ Increase my flexibility
☐ Reduce my stress
☐ Improve my memory
☐ Be more mentally focused
☐ Have more stable moods
☐ Have stronger erections
☐ Have fewer headaches

COMMITMENT: Preventing or reversing disease can require major changes in diet and lifestyle. It can also require you to be ready, willing, and able to pay for medical services not covered by insurance. On a scale of 1-10, our commitment to your health and well-being is a 10. So as not to waste our time or yours, on a scale of 1-10, how strong is your commitment to do what it takes to improve and/or maintain your health?

1 2 3 4 5 6 7 8 9 10

QUESTIONS AND CONCERNS: Please write down the items you would like to discuss with Dr. Thomas:

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

BIOLOGICAL AGE CALCULATOR

Name: _____ Age: _____ Today's Date:_____

How old are you really and which is more accurate: Chronological age or biological age? Biological age is the measure of your inner health, which is influenced by genetics and lifestyle choices. Biological age is an indicator of your TRUE age because it measures how well you are taking care of yourself. For example, a well-maintained car will run for a long time. Conversely, a poorly-maintained car will break down within a few years. Your body is no different. It requires proper maintenance to support a long and healthy life.

The Biological Age Calculator is divided into five sections with a total of 26 questions. Choose and write the number that best answers each question. To achieve an accurate measure of your biological age, it is crucial to answer the questions as accurately and honestly as possible.

SECTION A: Dietary Choices

1. How often do you eat fried, broiled, or barbequed foods?

   More than once a day (4)
   Once a day (3) Number: _____
   Few times per week (2)
   Once a week (1)
   Almost never (-2)

2. How often do you eat healthy fats, such as olive oil, flax seed oil, coconut oil, or avocados?

   Almost never (2)
   Once a week (1) Number: _____
   Once a day (0)
   2+ times per day (-1)

3. How many servings of fruits or vegetables do you eat? (1 serving = 1 cup)

   Almost never (3)
   Few times per week (2) Number: _____
   One per day (1)
   3 per day (-1)
   5+ per day (-2)

4. How often do you eat whole grains and/or take a natural fiber supplement?

   Almost never (3)
   Once a week (2) Number: _____
   Few times per week (1)
   Often (-2)

6. How many glasses of plain water do you drink?

   Almost never (3)
   One per day (2) Number: _____
   4 per day (1)
   6 per day (0)
   8+ per day (-2)

7. Do you consume sugar, soda, white flour, or other refined/processed foods?

   3+ times per week (3)
   Once a day (2) Number: _____
   Few times per week (1)
   Almost never (-1)

8. How many alcoholic drinks do you consume per week?

   12+ per week (3)
   8 per week (2) Number: _____
   4 per week (1)
   1-2 per week (0)
   None (-1)

9. How often do you add salt to your food?

   All food (3)
   Daily (2) Number: _____
   Few times per week (1)
   Once a month (0)
   Almost Never (-1)

TOTAL SCORE FOR SECTION A: _____

SECTION B: Dietary Supplementation

10. Do you take a multivitamin?

    Almost never (2) Number: _____
    Once a week (1)
    Few times per week (0)
    Daily (-1)

11. Do you take a separate antioxidant supplement, such as vitamin C or E?

    Almost never (3) Number: _____
    Once a week (2)
    Few times per week (1)
    Daily (-2)

TOTAL SCORE FOR SECTION B: _____

SECTION C: Daily Activities

12. How often do you exercise (30 or more minutes of continuous activity)?

    Almost never (3)
    Once a week (2) Number: _____
    3 times per week (-2)
    5+ times per week (-3)

13. When you exercise, do you do so for more than 2 hours straight?
    (If you do not exercise, please put “0” as your answer.)

    Most times (4)
    50% of the time (2) Number: _____
    Almost Never (0)

14. Do you sleep well and awaken feeling fully rested?

    Almost never (3)
    Sometimes (2) Number: _____
    Usually (0)
    Always (-1)

15. How often do you have normal bowel movements?

    Once a week (4)
    Every 4 days (3) Number: _____
    Every second day (2)
    Daily (0)
    2+ times per day (-2)

TOTAL SCORE FOR SECTION C: _____

SECTION D: MEDICAL HISTORY

16. Do you have a family history of any of the following conditions: Cancer, diabetes, heart disease, depression, obesity, liver disease, high cholesterol, or high blood pressure?

    2 or more (1)
    One (0) Number: _____
    None (-1)

17. Have you personally had any of the following conditions: Cancer, diabetes, heart disease, depression, obesity, liver disease, high cholesterol, or high blood pressure?

    2 or more (4)
    One (3) Number: _____
    None (-2)

18. How often do you experience any of the following: Headaches, fever, sore throats, muscle aches (not exercise induced), colds or flu, rash, or swelling?

    Once a day (3)
    Once a week (2) Number: _____
    Once a month (0)
    Almost never (-1)

19. How often are you exposed to heavy metals or toxic substances?
    (Examples: Mechanics, hair dressers, nail salons, etc.)

    Daily (4)
    Weekly (3) Number: _____
    Monthly (2)
    Almost never (0)

20. How many mercury dental fillings do you have?

    3+ fillings (4)
    2 fillings (3) Number: _____
    1 filling (2)
    None (0)

TOTAL SCORE FOR SECTION D: _____

SECTION E: STRESS

21. How many full meals do you eat per day? (A snack is not a full meal.)

    Never (3)
    4+ per day (2) Number: _____
    3 per day (0)
    2 per day (1)
    One per day (2)

22. At work or at home, how often are you in front of electronic equipment? (Examples: Computers, television, live cameras, electrical wires.)

    8+ hours per day (3)
    6+ hours per day (2) Number: _____
    Few hours per day (1)
    Almost never (0)

23. How often are you exposed to cigarette or other smoke (direct or second-hand)?

    All day (4)
    Few times a day (3) Number: _____
    Few times per week (1)
    Almost never (-1)

24. Do you use recreational or street drugs?

    2+ times per day (4)
    Once a day (3) Number: _____
    Once a week (2)
    Once a month (1)
    Never (0)

25. Do you drive in heavy traffic?

    For a living (3)
    Daily (3+ hours) (2) Number: _____
    Daily (1-2 hours) (1)
    Almost never (-1)

26. At work and/or home, how much stress do you experience?

    Very high (4)
    High (3) Number: _____
    Moderate (2)
    Slight (1)
    Almost none (-2)

TOTAL SCORE FOR SECTION E: _____

TO CALCULATE YOUR BIOLOGICAL AGE, ADD YOUR AGE AND SCORES FROM SECTIONS A-E:

AGE: _____
SECTION A: _____
SECTION B**:** _____
SECTION C**:** _____
SECTION D**:** _____
SECTION E**:** _____
BIOLOGICAL AGE: **TOTAL:** _____

INFORMED CONSENT

Patient Name:_____ Date of Birth: _____ _

Florida's freedom of medicine law allows physicians to choose therapies they feel will most benefit their patients and allows patients to choose the kind of medical care they feel is best for them. Under the law, you are permitted to make informed choices for any type of medical care you deem to be an effective option for treating disease, pain, injury, deformity, or other physical or mental condition. You are permitted to choose from all healthcare options, including the prevailing or conventional treatment methods, as well as other treatments designed to complement or substitute for the prevailing or conventional treatment methods. As such. healthcare practitioners are permitted to offer complementary or alternative health care treatments with the same requirements, provisions, and liabilities as those associated with the prevailing or conventional treatment methods.

Dr. Daniel Thomas, DO, MS provides complementary and alternative treatment. Under Florida law, this is defined as: "Any treatment that is designed to provide patients with an effective option to the prevailing or conventional treatment methods associated with the services provided by a health care practitioner. Such a treatment may be provided in addition to or in place of other treatment options."

Dr. Thomas may, in his discretion and without restriction, recommend any mode of treatment that is, in his judgment, in your best interest, including complementary or alternative health care treatments, including but not limited to dietary therapy; lifestyle changes; oral and/or intravenous nutrient, herbal, and oxidative compounds; hormonal therapy; and repurposed conventional medications. Due to the complexity of the human body and the various responses to treatment, no claims or guarantees of "cure" are being made regarding any medical condition. Dr. Thomas does not provide hospital or emergency care and is not a substitute for your primary-care physician and the care that he or she provides.

Dr. Thomas has been in practice since 1987. He has a Bachelor of Science degree in biochemistry from Andrews University and a medical doctorate from Des Moines University. Dr. Thomas served his hospital internship at Northwest General Hospital in Milwaukee, Wisconsin. He also has a Master of Science degree in Metabolic and Nutritional Medicine from the University of South Florida College of Medicine, as well as a Graduate Certificate in Metabolic Endocrinology and a Graduate Certificate in Brain Fitness & Memory Management, also from the University of South Florida College of Medicine. Dr. Thomas has Certificate in Plant-Based Nutrition from Cornell University, and he completed a Fellowship in Integrative Cancer Therapies with The Metabolic Medical Institute.

If Dr. Thomas offers to provide a you with complementary or alternative health care treatment, he will inform you of the nature of the treatment and will explain the benefits and risks associated with the treatment to the extent necessary for you to make an informed and prudent decision regarding such treatment options.

By signing this form, you acknowledge that you understand the above information, and that you are consenting to a medical consultation and/or treatment with Dr. Thomas. Furthermore, you declare that you are seeing Dr. Thomas for your own purposes and not on behalf of a third-party.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS:

"Protected Health Information" ("PHI") is individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for the health care. We are required to extend certain protections to you PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice information practices upon request, inspect, and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communications of your health information, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITY:

We are required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices in regards to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice in our waiting room. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR ADDITIONAL INFORMATION OR TO REPORT A PROBLEM:

If you believe there is a mistake or missing information in our records of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is (i) correct and complete; (ii) not created by us and/or not part of our records, or; (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request denial, along with any statement in response that you provide, amended to you PHI. If we approve the request for amendment, we ill change the PHI and so inform you, and tell others what they need to know about the change in the PHI.

If you have questions and would like additional information, you may contact Dr. Sylvia Torres-Thomas, PhD, RN who is the Privacy Officer at 352-729-0923. If you believe your rights have been violated, you may file a complaint with the Dr. Torres-Thomas. There will be no retaliation for filing a complaint.

DISCLOSURES FOR TREATMENT AND PAYMENT:

We will use your information for treatment. Information obtained by any healthcare team member will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure and medications provided.

Business Associates: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose you health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with Family: Health professional, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to you care.

Research: We may disclose information to researchers when and institutional review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.

Marketing: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by federal, state or local law or in response to a valid subpoena.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any purposes other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization* in writing at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

CANCER MEDICAL HISTORY

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Today's Date:_____

Who is your oncologist? _____

What type of cancer do you have? _____

_____

When were you first diagnosed? _____

What stage is your cancer?_____

What organs/tissues has it metastasized (spread) to?_____

_____

_____

What are the dates and results of your most recent scan (CT, MRI, PET) and/or tumor markers?

_____

_____

_____

_____

What treatments and/or surgeries have you had for cancer thus far and what were the results?

_____

_____

_____

_____

_____

_____

_____

_____

_____

What side effects are you experiencing from your current treatment?

_____

_____

_____

_____

_____

What do you expect from treatment: Cure (achieving remission) or palliation (only improving quality of life)? _____

CANCER QUESTIONNAIRE

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Today's Date:_____

SECTION 1: GENETICS AND EPIGENETICS			
1. Have you tested positive for BRCA1 and/or BRCA2?	☐ Yes	☐ No	☐ I don't know
2. Have you tested positive for any other type of gene mutation, including EPCAM, MLH1, MSH2, MSH6, PMS2, or TP53?	☐ Yes	☐ No	☐ I don't know
3. Are you heterozygous or homozygous for a MTHFR gene mutation?	☐ Yes	☐ No	☐ I don't know
4. Are you heterozygous or homozygous for a VDR, COMT, and/or CYP1B1 gene mutation?	☐ Yes	☐ No	☐ I don't know
5. Do you have a family history of cancer?	☐ Yes	☐ No	☐ I don't know
6. Were your grandparents affected by the Great Depression or any other type of famine, natural disaster, or major stressful period?	☐ Yes	☐ No	☐ I don't know
7. Were your parents exposed to large amount of stress and/or environmental toxins?	☐ Yes	☐ No	☐ I don't know
8. Did your mother smoke or take any types of drugs or medications while she was pregnant with you?	☐ Yes	☐ No	☐ I don't know
9. Did you experience any type of trauma in your childhood?	☐ Yes	☐ No	☐ I don't know
10. Do you take any pharmaceutical drugs, including over-the-counter medications?	☐ Yes	☐ No	☐ I don't know
SECTION 2: BLOOD SUGAR BALANCE			
1. Do you have a sweet tooth?	☐ Yes	☐ No	☐ I don't know
2. Do you find it difficult to fall asleep without an evening or late-night snack, and/or awaken hungry during the night?	☐ Yes	☐ No	☐ I don't know
3. Do you get "hangry" (irritable because of hunger) if meals are skipped or delayed?	☐ Yes	☐ No	☐ I don't know
4. Do you regularly skip breakfast?	☐ Yes	☐ No	☐ I don't know
5. Are sugar-based foods (e.g., candy, cookies. cake, soda, bread, waffles) what you crave the most, and/or consider your "comfort foods?"	☐ Yes	☐ No	☐ I don't know

6. Do you consume more than 25 grams of added sugar a day (more than one soda, candy bar, or flavored yogurt)?	☐ Yes	☐ No	☐ I don't know
7. Is your body-fat content over 25%?	☐ Yes	☐ No	☐ I don't know
8. Do you feel tired or crave sugar after a meal?	☐ Yes	☐ No	☐ I don't know
9. Do you or any family member have a history or diagnosis of metabolic syndrome, hypoglycemia, prediabetes, insulin resistance, polycystic ovarian syndrome (PCOS), pancreatitis, pancreatic cancer, or type 1 or 2 diabetes?	☐ Yes	☐ No	☐ I don't know
10. Do you consume alcoholic beverages more than 3 times per week?	☐ Yes	☐ No	☐ I don't know
SECTON 3: TOXIC BURDEN			
1. Do you currently live (or were you raised) near a toxic waste or factory site, military base, industrial complex, agricultural area, or airport?	☐ Yes	☐ No	☐ I don't know
2. Do you have any known environmental sensitivities, such as to odors like perfume or diesel fuel?	☐ Yes	☐ No	☐ I don't know
3. In total, do you use a microwave, cell phone, or laptop computer more than 3 hours a day?	☐ Yes	☐ No	☐ I don't know
4. Do you use pesticides or herbicides in or around your home or garden or on your pets?	☐ Yes	☐ No	☐ I don't know
5. Do you use any non-organic body care or household cleaning products (e.g., shampoo or laundry detergent) and/or have your hair professionally dyed?	☐ Yes	☐ No	☐ I don't know
6. Do you have your clothes dry-cleaned, use nonstick cookware, drink unfiltered water, or either drink from or store food in plastic containers?	☐ Yes	☐ No	☐ I don't know
7. Have you been exposed to first-hand, second-hand, or third-hand cigarette smoke?	☐ Yes	☐ No	☐ I don't know
8. Do you have any mercury fillings, work in a dental office, eat fish more than 3 times a week, and/or have you ever been exposed to heavy metals, including lead?	☐ Yes	☐ No	☐ I don't know
9. Do you have an occupational history with known exposure to toxic chemicals, such as asbestos or heavy metals?	☐ Yes	☐ No	☐ I don't know
10. Do you find it difficult to sweat?	☐ Yes	☐ No	☐ I don't know
SECTION 4: GUT MICROBIOME AND DIGESTIVE FUNCTION			
1. Were you born via cesarean delivery?	☐ Yes	☐ No	☐ I don't know

2. Were you fed infant formula before the age of one-year?	☐ Yes	☐ No	☐ I don't know
3. Have you ever, or do you now. use hand sanitizer and/or antimicrobial soap?	☐ Yes	☐ No	☐ I don't know
4. Have you been diagnosed with small intestine bacterial overgrowth (SIBO), ulcerative colitis, Crohn's disease, or colon cancer? Or do you have digestive symptoms such as gas, bloating, diarrhea, or constipation?	☐ Yes	☐ No	☐ I don't know
5. In your lifetime have you ever taken more than one course of antibiotics, or have you ever completed the recommended prep for a colonoscopy?	☐ Yes	☐ No	☐ I don't know
6. Do you eat non-organic meat and/or dairy products?	☐ Yes	☐ No	☐ I don't know
7. Have you had chemotherapy?	☐ Yes	☐ No	☐ I don't know
8. Do you take nonsteroidal anti-inflammatory drugs (NSAIDs), such as acetaminophen (Tylenol), aspirin, or ibuprofen (Motrin or Advil), or acid-blocking medications, such as Nexium, Prilosec, or Zantac more than a couple of times a year?	☐ Yes	☐ No	☐ I don't know
9. Do you typically eat fewer than 6 servings of different vegetables per day?	☐ Yes	☐ No	☐ I don't know
10. Do you eat processed non-organic grains such as pasta, bread, or cookies more than once a month?	☐ Yes	☐ No	☐ I don't know
SECTION 5: IMMUNE FUNCTION			
1. Have you been told that your vitamin D level is below 50 ng/mL?	☐ Yes	☐ No	☐ I don't know
2. Do you have a personal or family history of any autoimmune disease such as rheumatoid arthritis?	☐ Yes	☐ No	☐ I don't know
3. Do you use over-the-counter medications to suppress a fever?	☐ Yes	☐ No	☐ I don't know
4. Do you have a history of any of the following: Epstein-Barr virus (can cause infectious mononucleosis); human papillomavirus (HPV); cytomegalovirus (CMV); a sexually-transmitted disease (STD); herpes zoster (shingles); Lyme disease; yeast infection; or infection with a parasite?	☐ Yes	☐ No	☐ I don't know
5. Is either of the following true: You are never sick or you catch every cold and flu that comes your way?	☐ Yes	☐ No	☐ I don't know
6. Do you have allergies (i.e., seasonal allergies, asthma, hives, and/or allergies to certain foods)?	☐ Yes	☐ No	☐ I don't know

7. Have you been diagnosed with Celiac disease or gluten intolerance?	☐ Yes	☐ No	☐ I don't know
8. Have you ever received any vaccinations, including against seasonal influenza or herpes zoster, and vaccines needed for travel); or have you been prescribed any type of immunotherapies?	☐ Yes	☐ No	☐ I don't know
9. Have you ever taken steroids, such as cortisone or prednisone?	☐ Yes	☐ No	☐ I don't know
10. Do any children younger than 5 years live in your house and/or do you work in a school, hospital, or medical setting?	☐ Yes	☐ No	☐ I don't know
SECTION 6: INFLAMMATION			
1. Do you have a history of eczema, psoriasis, acne, flushing, or rashes?	☐ Yes	☐ No	☐ I don't know
2. Have you ever been diagnosed with arthritis. or do you suspect that you have it?	☐ Yes	☐ No	☐ I don't know
3. Do you have any physical pain patterns, including back or hip pain, that is either constant or intermittent?	☐ Yes	☐ No	☐ I don't know
4. Do you have Crohn's disease or ulcerative colitis?	☐ Yes	☐ No	☐ I don't know
5. Do you ever eat fried or fast foods?	☐ Yes	☐ No	☐ I don't know
6. Do you have any known food allergies or do you experience acid reflux?	☐ Yes	☐ No	☐ I don't know
7. Do you rely on NSAIDs for pain management?	☐ Yes	☐ No	☐ I don't know
8. Have you ever or do you now experience high amounts of stress?	☐ Yes	☐ No	☐ I don't know
9. Do you engage in vigorous exercise more than 5 days a week?	☐ Yes	☐ No	☐ I don't know
10. Are you overweight, do you consume alcohol, and/or do you eat fewer than 6 different vegetables a day?	☐ Yes	☐ No	☐ I don't know
SECTION 7: BLOOD CIRCULATION AND ANGIOGENESIS			
1. Do you bruise easily?	☐ Yes	☐ No	☐ I don't know
2. Have you ever been diagnosed with a clotting disorder?	☐ Yes	☐ No	☐ I don't know
3. Have you ever been diagnosed with hemochromatosis or elevated ferritin (iron) level?	☐ Yes	☐ No	☐ I don't know
4. Do you have a history of deep vein thrombosis (DVT)?	☐ Yes	☐ No	☐ I don't know
5. Do you have a history of pulmonary embolism (PE)?	☐ Yes	☐ No	☐ I don't know

6. Do you have high or low blood pressure?	☐ Yes	☐ No	☐ I don't know
7. Do you drink less than 2 quarts of water a day?	☐ Yes	☐ No	☐ I don't know
8. Do you take any pharmaceutical anticoagulants, such as warfarin (Coumadin) or enoxaparin (Lovenox)?	☐ Yes	☐ No	☐ I don't know
9. Are you on medication to control your blood pressure and/or do you take a daily aspirin?	☐ Yes	☐ No	☐ I don't know
10. Do you exercise less than 30 minutes 3 times a week?	☐ Yes	☐ No	☐ I don't know
SECTION 8: HORMONE BALANCE			
1. Do you have a history of birth control pills, bioidentical or standard hormone replacement therapy. steroid use, fertility treatments, and/or hormone-blockade therapies?	☐ Yes	☐ No	☐ I don't know
2. Women: Do you have a history of premenstrual syndrome (PMS), irregular cycles, fibrous breasts, and/or menopausal symptoms?	☐ Yes	☐ No	☐ I don't know
3. Women: Do you have a history of fertility problems, including miscarriage?	☐ Yes	☐ No	☐ I don't know
4. Men: Do you have difficulty getting or maintaining an erection?	☐ Yes	☐ No	☐ I don't know
5. Do you have a low libido (sex drive)?	☐ Yes	☐ No	☐ I don't know
6. Have you ever been diagnosed with a thyroid disorder?	☐ Yes	☐ No	☐ I don't know
7. Have you ever been diagnosed with adrenal fatigue and/or low cortisol levels?	☐ Yes	☐ No	☐ I don't know
8. Do you experience weight fluctuations of more than 10 pounds on a regular basis?	☐ Yes	☐ No	☐ I don't know
9. Do you handle store receipts, drink out of plastic bottles, have exposure to paraben-containing products, or eat non-organic animal protein more than once a month?	☐ Yes	☐ No	☐ I don't know
10. Do you now or have you ever followed a low-fat diet?	☐ Yes	☐ No	☐ I don't know
SECTION 9: STRESS AND BIORHYTHMS			
1. Did any of your symptoms or lab results worsen after a stressful period? And/or, if you have a cancer diagnosis. was the diagnosis made following a stressful period?	☐ Yes	☐ No	☐ I don't know
2. Are you a night owl and/or have you ever had a job working at night or caring for a small child who kept you up late?	☐ Yes	☐ No	☐ I don't know
3. Do you often travel back and forth across many time zones?	☐ Yes	☐ No	☐ I don't know

4. Are there lights on while you sleep during the night (e.g., streetlights or a TV)?	☐ Yes	☐ No	☐ I don't know
5. Do you feel you are you easily fatigued?	☐ Yes	☐ No	☐ I don't know
6. Do you often crave salt?	☐ Yes	☐ No	☐ I don't know
7. Do you sleep fewer than 8 hours a night and/or go to bed after 11:00 pm?	☐ Yes	☐ No	☐ I don't know
8. Do you have screen time (i.e., watch TV or use an electronic device) after 5:00 pm?	☐ Yes	☐ No	☐ I don't know
9. Do you spend less than 15 minutes outdoors every day?	☐ Yes	☐ No	☐ I don't know
10. Do you feel that you experience high levels of stress every day?	☐ Yes	☐ No	☐ I don't know
SECTION 10: MENTAL AND EMOTIONAL HEALTH			
1. Do you experience irritability, mood swings, and/or unstable emotions?	☐ Yes	☐ No	☐ I don't know
2. Have you been diagnosed with a mental disorder (e.g., bipolar disorder, depression, anxiety)?	☐ Yes	☐ No	☐ I don't know
3. Are you easily offended?	☐ Yes	☐ No	☐ I don't know
4. Are you sensitive to other people's energy and reactions?	☐ Yes	☐ No	☐ I don't know
5. Do you ever experience racing, repetitive thoughts?	☐ Yes	☐ No	☐ I don't know
6. Do you find it difficult to speak the truth in certain situations?	☐ Yes	☐ No	☐ I don't know
7. Have you ever used drugs or alcohol, sex, shopping, TV, gambling, gaming, or time on the internet to self-medicate?	☐ Yes	☐ No	☐ I don't know
8. Do you feel that you lack a good support system, such as a supportive spouse, friends, and/or spiritual community?	☐ Yes	☐ No	☐ I don't know
9. Do you feel like your life lacks purpose or direction?	☐ Yes	☐ No	☐ I don't know
10. Do you find it difficult to feel gratitude and joy?	☐ Yes	☐ No	☐ I don't know