Karisma for Life!

New Patient Instructions and Forms
For Dr. Kari Vernon

Thank you for your interest in becoming a patient. All new patients must complete the following forms and questionnaires. Dr. Vernon will review all of this information before meeting with you for the first time.

Copies of your medical records, including lab work and diagnostic testing are required **before scheduling an appointment** (a review of past medical records is included in the fees for your initial consultation).

The initial consultation lasts approximately 60 minutes. It is Dr. Vernon's goal during the visit to gather necessary details about you and your medical condition so she can order proper testing to determine root causes and necessary treatments.

Once Dr. Vernon has received all of your laboratory test results, she will review your intake forms, the information gathered from your initial consultation, and your test results. You will then be scheduled for a report of findings with Dr. Vernon. At this appointment she will present her specific recommendations pertaining to your health. Expect the report of findings to last 1 to 1½ hours, or longer, depending on the complication of your case. Dr. Vernon's hourly rate is $300 per hour billed in 15 minute increments.

New patients need to understand that successful management of any complicated case requires proper testing, diagnosis, financial commitments and realistic patient expectations.

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, because it is vital that Dr. Vernon know everything about you and your case.

Please schedule enough time (about 2-3 hours) to be thorough in completing the questions and intake forms; the more details you provide, the better Dr. Vernon can assess your health.

These forms can be filled out electronically and emailed back which is the preferred method. Forms can also be printed, filled out by hand, and faxed or mailed to our office. For your convenience, you will be provided a Word document to answer the open ended questions found on pages 7 & 8.

Thank you in advance for your time and effort in completing these forms. The information derived from these forms will provide Dr. Vernon invaluable data allowing for the appropriate course of treatment.

Please fax the completed forms to (208) 263-9077 or email them to DrKari@Karisma4Life.com

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New Patient Check List

DID YOU REMEMBER TO?

- ☐ Read **all** of our documents carefully and thoroughly.
- ☐ Obtain your medical records and/or test results from previously seen physicians using the Medical Records Release Authorization and have them sent to:

  Fax: (208) 263-9077

  Email: DrKari@Karisma4Life.com

  Mail: 8140 E. Cactus Road, Suite 730, Scottsdale, AZ., 85260

- ☐ Phone consultation patients, please email a photo of yourself to DrKari@Karisma4Life.com

FILL OUT AND/OR SIGN AND RETURN THE FOLLOWING FORMS:

- ☐ Patient Acceptance Policy
- ☐ Answered all Establishing Health Goals questions
- ☐ Answered all Health History Review Questions
- ☐ General Patient Information
- ☐ Functional Diagnostic Questionnaire
  - ☐ Dietary Evaluation
  - ☐ Past Medical History
  - ☐ Review of Systems
  - ☐ Family Medical History
  - ☐ Symptom Assessment Form
- ☐ Notice of Privacy Practices
- ☐ Credit Card Authorization

Thank you

Patient Acceptance Policy

In order to better serve you, the Patient Acceptance Policy should be carefully reviewed so you understand our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, please read the following steps and provide your signature.

1. **Completion of the following forms:**
   - ☐ **Patient Acceptance Policy**
   - ☐ **Health History Review Questions**
   - ☐ **Establishing Health Goals Questions**
   - ☐ **General Patient Information**
   - ☐ **Functional Diagnostic Questionnaire**
     - ☐ **Dietary Evaluation**
     - ☐ **Past Medical History**
     - ☐ **Review of Systems**
     - ☐ **Family Medical History**
     - ☐ **Symptom Assessment Form**
   - ☐ **Notice of Privacy Practices**
   - ☐ **Credit Card Authorization**

   It is **VERY** important for you to carefully and thoroughly complete all of these forms and questionnaires.

2. Medical Records from all physicians since you were first diagnosed with your health condition MUST be obtained prior to scheduling an appointment.

3. Once Dr. Vernon has your completed questionnaires, forms, and copies of all your medical records, a 1-hour appointment will be scheduled to review your case. Dr. Vernon will conduct a thorough history and case assessment at the time of your scheduled appointment. The cost for the 1-hour appointment as well as Dr. Vernon's time for reviewing your medical questionnaire, medical records and written medical history is $395. Any lab work provided to our office less than 3 days prior to your initial consultation is billed at an additional review fee of $300 per hour. A cancellation fee of $275 is charged if you cancel your initial consultation appointment with less than 24-hours notice.

4. Based on the review of all your medical information, it may be necessary to obtain a **comprehensive blood chemistry** at the conclusion of your initial consultation. The blood chemistry test includes:
   - **Comprehensive Executive Metabolic Panel:** this includes 24 important disease markers such as Glucose, Hemoglobin A1c (Blood Sugar), SGOT, SGPT, GGT, Bilirubin (Liver), BUN, Creatinine, Phosphorus, Uric Acid (Kidney), Alkaline Phosphatase (Bone), and others
   - **Cardiovascular Panel:** Cholesterol, Triglycerides, LDL, VLDL, HDL, Cholesterol/HDL Ratio, LDL/HDL Ratio, C-Reactive Protein (hs-CRP), Homocysteine, and Fibrinogen
   - **Thyroid Panel:** TSH, Total T4, Total T3, Free T4, Free T3, T3 uptake, and FTI
   - **CBC with differential:** White Blood Cells and Red Blood Cells, Platelets
   - **Vitamin D & Magnesium**

5. Additional medical laboratory tests may be ordered based on your condition and you will be presented with detailed information on why the **specific tests** are recommended. **The cost for your initial laboratory tests will be discussed at that time and is different for every patient.**

6. The results of your lab tests may take approximately 3 to 6 weeks. An appointment to review your lab results takes approximately 1 to 1½ hours, or longer, depending on the complication of your case. You will be presented with a written report detailing the results of your tests, the possible causes of your health problems, and the recommended treatment protocol. Your cooperation in taking "personal responsibility" for your health care will be vital for treatment success. **It is suggested that you have your spouse or a supportive family member attend this appointment to help you on your health journey.**

7. Your treatment may consist of dietary and lifestyle changes as well as prescribed Natural Nutriceuticals. Unopened product returns will be accepted if returned within 10 days of purchase if purchased from us. There are no returns on refrigerated supplements.

   It is strongly recommended that you have access to a computer and an Internet connection. A medical progress questionnaire will be posted to your e-mail one week before your next scheduled appointment. Completion of the questionnaire is required every 6-12 weeks to monitor your progress. If you do not have access to the Internet, a copy of the progress questionnaire will be mailed or faxed to you.

9. Correspondence by e-mail is strongly encouraged and is **Free**. Please keep emails short and to the point. Keep in mind that Dr. Vernon receives hundreds of emails per week and frequently lectures around the country. Due to this, her responses may be delayed by several days or more. Should you need an immediate response, please call the office at **(480) 905-1883**. To speak to Dr. Vernon personally for detailed assistance you may schedule an appointment.

10. Follow-up consultations are scheduled approximately every 3, 6 or 12 weeks so you can discuss your progress and any concerns with Dr. Vernon. At these times, Dr. Vernon will determine what direction to take to help you progress. Consultations can be conducted either by phone or in person at the office. The fee for follow-up consultations is $150 for 30 minutes.

11. Abnormal laboratory tests will need to be re-evaluated. Laboratory fees can vary depending on what needs to be re-tested. The success of your treatment will not only be measured by the reduction or elimination of your physical symptoms, but also on abnormal laboratory tests returning to a normal status.

    For example: Many physicians will prescribe Lipitor for individuals suffering with high cholesterol and will require periodic cholesterol blood tests to monitor the activity of the medication.

12. Payment is made at the time services are rendered and tests are ordered. Payments can be made via cash, check and/or credit card. We accept Visa and Master Card. A valid credit card must remain on file at all times.

I, _____ have read and fully understand the **Patient Acceptance Policy.**
Print Patient Name

_____ _____
Signature Date

Nutritional Informed Consent

According to the Federal Food, Drud, and Cosmetic Act, as amended, Section 201 (g)(1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand "Nutritional Informed Consent":

Signature:_____Date: _____

8140 E Cactus Rd, Suite 730, Scottsdale, AZ, 85260 • Tel: (480) 905-1883 • Fax: (208) 263-9077
www.KarismaForLife.com

Frequently Asked Questions

Can you help me with my health problem?

Our clinic uses an innovative approach to assessing and treating your health. Perhaps you have been examined by your doctor, had blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that all your tests are normal! Both you and your doctor know that your symptoms are anything but normal! Unfortunately this experience is all too common.

Most physicians are trained to look only in specific places for answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found this way. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies, and metabolic imbalances that our evaluation and testing uncover. Our practice also utilizes new gene testing to detect underlying genetic predispositions that can be modified through diet, lifestyle, supplements, or medications.

We use a variety of testing techniques and procedures to help our patients recover from many chronic and difficult to treat conditions. We use these same methods to help prevent illness. Our clinicians are skilled in evaluating, assessing and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behaviour disorders, memory problems and other chronic, complex conditions. We also focus on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

Will I need a blood test and where do I get that done?

During your consultation, we will determine which tests are needed to evaluate your health. Our office assistants can review the testing recommendations, instructions (e.g. fasting or non-fasting, etc.), and costs.

Most of the testing requires you to go to an outside facility to draw blood (an order form is provided to take to the facility). Some tests are only available through speciality laboratories, while others can be done at home to collect urine, saliva, or stool. In all cases, we assist you in coordinating initial and follow-up testing.

Do you take insurance?

Cash pricing has been negotiated on most of our diagnostic testing. The cash prices are up to an 80% discount off list pricing and often are less expensive than submitting a bill to insurance. The testing is cutting-edge and therefore not accepted by most insurance companies as it is not considered "mainstream".

Nutritional consultation services are typically not covered by insurance or Medicare. However, we can provide a receipt for services performed and you can submit that to your HSA. Payment in full by cash, check, credit card, or any combination is due when services and tests are provided.

What credit cards do you accept?

We accept the following credit cards: Visa and Master Card. An active credit card is kept on file at the office to bill follow-up consultations, laboratory testing, and other services.

Establishing Health Goals

Before we begin our journey together, I want to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with hundreds of patients and have seen many achieve significant improvement while others have become frustrated and failed in their attempts to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that the correct way to achieve health and stay healthy is to discuss of how you have lived your life up to this point and how you will live it in the future.

Have you ever wondered if you are on the right path to achieving optimal health? The definition of insanity is: "to keep doing the same thing over and over and expecting different results." If you keep following the course of treatment you have been following and it hasn't been successful, will your results ever change? No. You need a new and improved way to reach your destination.

Most people tell me they've made the decision to change. But how many people have truly decided to change? Very few! Why? Because there is a big difference between deciding something and having "reasons" to actually do it. When you make a decision to change and you know your reasons, you create an internal power that can propel you to achieving health and wellness.

Therefore, to help you make significant changes in your health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside for the answers.

Instructions: Please **TYPE** answers to the following questions with as much detail as possible. We will provide you with a Word document that you can fill in and email back or print and fax back.

PLEASE ANSWER ALL QUESTIONS INDEPENDENT OF EACH OTHER (for example, do not combine questions 2 and 3 below, but answer each one individually). Please do not leave any answers blank or answer, "I don't know" to any of these questions.

1) Have you made the decision to change and to do what it takes to get well?
2) What do you want to achieve from the care Dr. Vernon can provide?
3) If you had a magic wand and could erase three problems, what would they be?
4) Why do you think health care practitioners have failed with your case?
5) Do you think your condition can be cured or improved?
6) What are you looking for in a health care practitioner?
7) What things do you dislike about health care practitioners?
8) What do you consider a realistic amount of time to see changes in your health under the care of Dr. Vernon?
9) How long will it take for you to discontinue management under the care of Dr. Vernon if you see no improvements in your health?
10) Is there anyone you blame for your health condition?
11) What specific improvements in your health would you consider a successful outcome in your case?

12) Are you prepared to handle the financial costs of further assessment?
13) Do you feel our practice fee ($300 an hour) is fair and appropriate?
14) Are you emotionally and spiritually able to handle further care?
15) How would your feel if you spent more time, energy and money under the care of Dr. Vernon and had no improvements in your case?
16) Is there anything in your belief system that you think is holding back your health?
17) Are you willing to change your belief system to gain more health ((not religious beliefs; for example, if you are a vegetarian, are you willing to eat meat)?
18) Are there any emotional experiences that can be relating to your health condition?
19) Are there any patterns in childhood or adulthood that have contributed to your health problems?
20) Is your spouse and/or family supportive of you and your health condition?
21) Are your spouse and/or family supportive of you seeking care with Dr. Vernon?
22) In order to improve your health, are you willing to significantly modify your diet?
23) In order to improve your health, are you willing to significantly modify your lifestyle?
24) In order to improve your health, are you willing to take several supplements each day?

Health History Review Questions

25) List your chief complaints about your health in order of importance to you.
26) Provide your health history using a timeline sequence (earliest to most recent).
27) List all diagnosis given to you in a timeline. Also give your opinions about each diagnosis.
28) When was the last time you felt well? What do you think has happened to your health since then?
29) List all health care providers you have consulted, their opinions and their treatments.
30) List any treatments, medications, or supplements that have improved your health.
31) List any treatments, medications, or supplements that have caused reactions or decreased your health.
32) List all medications and dosages you are currently taking.
33) List all supplements & dosages you are currently taking.
34) List in a timeline all supplements and medications you have taken in the past.
35) List in a timeline any medical procedures or surgeries you have had.
36) List in a timeline any significant laboratory or imaging results.
37) List in a timeline any exposure to environmental, industrial, or toxic compounds.
38) List any history of infections (excluding common colds).
39) Is there anything you feel you should tell Dr. Vernon about yourself or your case not cover so far?
40) How did you feel about answering all of these questions and the intake forms?

General Patient Information

Date _____

Name _____ _____ _____ Preferred Name _____
First Middle Last

If Patient is a minor, list parent's name: _____ _____
Mother's Name Father's Name

Address _____ City _____ State ____ Zip _____

Cell Phone _____ Home Phone _____

Work Phone _____ Email _____

Best time to reach you: ☐ Morning ☐ Afternoon ☐ Evening Best place to reach you: ☐ Cell ☐ Home ☐ Work

Date of Birth _____ Age _____ Place of Birth _____ Sex: ○ Male ○ Female

Status: ○ Married ○ Separated ○ Divorced ○ Widowed ○ Single ○ Partnered ○ Minor

Occupation _____ Employer/School _____

Spouse's name _____ Spouse's Birth Date _____ Spouse's occupation _____

IN CASE OF EMERGENCY who should we contact? _____ Relationship? _____

Cell Phone _____ Home Phone _____ Work Phone _____

Genetic Background (Please check appropriate boxes):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other _____

Please list your **highest** level of education:

☐ High School ☐ GED ☐ Vocational School

☐ College _____ Major: _____ Year: _____

☐ Graduate School _____ Major: _____ Year: _____

☐ Professional School _____ Major: _____ Year: _____

Did you have any learning problems? ○ Yes ○ No If Yes, describe _____

_____

How do you hear about Dr. Vernon? ☐ Thyroid Book ☐ Media ☐ Website ☐ Friend/Family

Other _____ Whom may we thank for referring you? _____

Has another family member already been seen as a patient of Dr. Vernon? ○ Yes ○ No

Functional Diagnostic Questionnaire

Please complete the following Functional Diagnostic Questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help Dr. Vernon evaluate the root cause of your health concerns and determine an effective treatment program.

Note that we are interested in "so-called" minor symptoms as well as major problems. We know that in many doctor's offices there is a tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. The rules in our office are different. We are interested in any odd or unusual messages you get from your body even though it may seem irrelevant or of no consequence to your health. These symptoms may be useful clues in the kind of medical detective work we do.

Questions maybe repeated in several areas on the form. This is done on purpose and aids in the evaluation process. **Do not skip a question because you feel you have answered it somewhere else on the form.**

Please include as much information as you can on this form. Please do not skip any questions.

Please fill out the form electronically (preferred) or print legibly.

(Your Children)

Child #1 Name _____ Age _____ Sex: ○ Male ○ Female Health Issues _____

Child #2 Name _____ Age _____ Sex: ○ Male ○ Female Health Issues _____

Child #3 Name _____ Age _____ Sex: ○ Male ○ Female Health Issues _____

Child #4 Name _____ Age _____ Sex: ○ Male ○ Female Health Issues _____

Child #5 Name _____ Age _____ Sex: ○ Male ○ Female Health Issues _____

Number of your Sisters _____ (# deceased _____) Number of your Brothers _____ (# deceased _____)

With whom do you live? _____

Do you have any pets or farm animals? ○ Yes ○ No If Yes, List _____

Where do they live? ☐ Indoors ☐ Outdoors ☐ Both

Have you ever travelled outside the United States? ○ Yes ○ No If so, where? _____

How much time have you lost from work or school in the past year? ☐ 0-3 days ☐ 4-15 days ☐ >15 days

How many hours do sleep at night? _____ What time do you usually go to sleep at night? _____

Do you feel rested upon awakening? ○ Yes ○ No Do you snore? ○ Yes ○ No Do you use sleeping aids? ○ Yes ○ No

Describe any sleep problems you have: _____

Do you drink alcoholic beverages? ○ Never ○ Rarely ○ Monthly ○ Weekly ○ Daily How many per week? _____

Do you drink caffeinated beverages? ○ Never ○ Rarely ○ Monthly ○ Weekly ○ Daily How many per week? _____

Do you smoke cigarettes? ○ Never ○ Rarely ○ Monthly ○ Weekly ○ Daily Packs per week? _____ for _____ years

Do you have stress? ○ Yes ○ No Have you had stress in the past? ○ Yes ○ No Rate your stress from 1-10 _____

What currently stresses you most? _____

Exercise: ○ Never ○ Light ○ Moderate ○ Heavy Hours per week: _____ Type: _____

Physical Work: ○ Never ○ Light ○ Moderate ○ Heavy Hours per day: _____ Type: _____

Mental Work: ○ Never ○ Light ○ Moderate ○ Heavy Hours per day: _____ Type: _____

Dietary Evaluation

Please indicate how often you consume the following:

Fast Food: ○ Never ○ Monthly ○ Weekly ○ Daily
Fried Foods: ○ Never ○ Monthly ○ Weekly ○ Daily
Luncheon Meats: ○ Never ○ Monthly ○ Weekly ○ Daily
Canned Meats: ○ Never ○ Monthly ○ Weekly ○ Daily
Soda / Diet Soda: ○ Never ○ Monthly ○ Weekly ○ Daily
Natural Soda: ○ Never ○ Monthly ○ Weekly ○ Daily
Juice: ○ Never ○ Monthly ○ Weekly ○ Daily
Tea / Coffee: ○ Never ○ Monthly ○ Weekly ○ Daily
Energy Drinks: ○ Never ○ Monthly ○ Weekly ○ Daily
Water: ○ Never ○ Monthly ○ Weekly ○ Daily
Sugar, Candy, Desserts: ○ Never ○ Monthly ○ Weekly ○ Daily
Chocolate: ○ Never ○ Monthly ○ Weekly ○ Daily
Artificial Sweeteners: ○ Never ○ Monthly ○ Weekly ○ Daily
Margarine: ○ Never ○ Monthly ○ Weekly ○ Daily
Milk: ○ Never ○ Monthly ○ Weekly ○ Daily
Butter: ○ Never ○ Monthly ○ Weekly ○ Daily
Yogurt: ○ Never ○ Monthly ○ Weekly ○ Daily
Cottage Cheese: ○ Never ○ Monthly ○ Weekly ○ Daily
Cream Cheese: ○ Never ○ Monthly ○ Weekly ○ Daily
Cheese: ○ Never ○ Monthly ○ Weekly ○ Daily
Ice Cream: ○ Never ○ Monthly ○ Weekly ○ Daily
Other Milk based products: ○ Never ○ Monthly ○ Weekly ○ Daily
Gluten:
- White Flour: ○ Never ○ Monthly ○ Weekly ○ Daily
- Wheat Flour: ○ Never ○ Monthly ○ Weekly ○ Daily
- Oats / Oatmeal: ○ Never ○ Monthly ○ Weekly ○ Daily
- Rye: ○ Never ○ Monthly ○ Weekly ○ Daily
- Barley: ○ Never ○ Monthly ○ Weekly ○ Daily
- Spelt: ○ Never ○ Monthly ○ Weekly ○ Daily

Gluten Free Products: ○ Never ○ Monthly ○ Weekly ○ Daily
Fresh Vegetables: ○ Never ○ Monthly ○ Weekly ○ Daily
Frozen Vegetables: ○ Never ○ Monthly ○ Weekly ○ Daily
Canned Vegetables: ○ Never ○ Monthly ○ Weekly ○ Daily
Fish: ○ Never ○ Monthly ○ Weekly ○ Daily
Shell Fish: ○ Never ○ Monthly ○ Weekly ○ Daily
Raw nuts or Seeds: ○ Never ○ Monthly ○ Weekly ○ Daily
Avocados: ○ Never ○ Monthly ○ Weekly ○ Daily
Flaxseed / Flaxseed Oil: ○ Never ○ Monthly ○ Weekly ○ Daily
Fish Oils: ○ Never ○ Monthly ○ Weekly ○ Daily
Olive Oil: ○ Never ○ Monthly ○ Weekly ○ Daily
Coconut Oil: ○ Never ○ Monthly ○ Weekly ○ Daily
Fruit: ○ Never ○ Monthly ○ Weekly ○ Daily
Soy: ○ Never ○ Monthly ○ Weekly ○ Daily
Corn: ○ Never ○ Monthly ○ Weekly ○ Daily
Vitamins / Supplements: ○ Never ○ Monthly ○ Weekly ○ Daily

List the three healthiest foods you consume on a regular basis:

Healthy Food #1: _____

Healthy Food #2: _____

Healthy Food #3: _____

List the three worst foods you consume on a regular basis:

Worst Food #1: _____

Worst Food #2: _____

Worst Food #3: _____

Are you a vegetarian or vegan? ○ Yes ○ No
If Yes, are you willing to change? ○ Yes ○ No

Has there ever been a food that you have craved or really "pigged-out" on over a period of time? ○ Yes ○ No

List those foods: _____

_____

Do you have an aversion to certain foods? ○ Yes ○ No

List those foods: _____

_____

Do you have symptoms **immediately after** eating, such as burping, belching, sneezing, bloating, hives, etc.? ○ Yes ○ No

If yes, explain: _____

_____

Do you feel **worse** when you consume a lot of:

☐ High fat foods ☐ High protein foods
☐ Fried foods ☐ Alcoholic drinks
☐ Refined Sugar (Junk Food) ☐ Other _____
☐ High carbohydrate foods (breads, pasta, potatoes) _____

Do you feel **better** when you consume a lot of:

☐ High fat foods ☐ High protein foods
☐ Fried foods ☐ Alcoholic drinks
☐ Refined Sugar (Junk Food) ☐ Other _____
☐ High carbohydrate foods (breads, pasta, potatoes) _____

Does skipping meals greatly affect your symptoms? ○ Yes ○ No

Do you eat snacks between breakfast & lunch? ○ Yes ○ No

Do you eat snacks between lunch & dinner? ○ Yes ○ No

Do you eat snacks after you eat dinner? ○ Yes ○ No

Past Medical History

Illness	Timing	Comments
Chicken Pox	☐ Current ☐ Past	
German Measles	☐ Current ☐ Past	
Measles	☐ Current ☐ Past	
Mumps	☐ Current ☐ Past	
Polio	☐ Current ☐ Past	
Whooping cough	☐ Current ☐ Past	
Anemia	☐ Current ☐ Past	
Arthritis	☐ Current ☐ Past	
Asthma	☐ Current ☐ Past	
Bronchitis	☐ Current ☐ Past	
Cancer	☐ Current ☐ Past	
Chronic Fatigue Syndrome	☐ Current ☐ Past	
Crohn's Disease or Ulcerative Colitis	☐ Current ☐ Past	
Diabetes/Insulin Resistance	☐ Current ☐ Past	
Emphysema	☐ Current ☐ Past	
Epilepsy, convulsions	☐ Current ☐ Past	
Gallstones	☐ Current ☐ Past	
Gout	☐ Current ☐ Past	
Heart attack/Angina	☐ Current ☐ Past	
Heart failure	☐ Current ☐ Past	
Hepatitis	☐ Current ☐ Past	
High blood pressure	☐ Current ☐ Past	
Irritable bowel	☐ Current ☐ Past	
Kidney stones/disease	☐ Current ☐ Past	
Liver disease	☐ Current ☐ Past	
Pneumonia	☐ Current ☐ Past	
Rheumatic fever	☐ Current ☐ Past	
Sinusitis	☐ Current ☐ Past	
Sleep apnea	☐ Current ☐ Past	
Stroke	☐ Current ☐ Past	
Thyroid disease	☐ Current ☐ Past	
Head Injury	☐ Current ☐ Past	
Neck Injury	☐ Current ☐ Past	
Back Injury	☐ Current ☐ Past	
Fracture	☐ Current ☐ Past	
Other (describe)	☐ Current ☐ Past	

Review of Systems

Check only those items you identify with currently or in the past. Ignore anything that does not apply to you.

Current Past

GENERAL:
- ☐ ☐ Fevers
- ☐ ☐ Chills/Cold all over
- ☐ ☐ Aches/Pains
- ☐ ☐ General Weakness
- ☐ ☐ Difficulty sweating
- ☐ ☐ Excessive Sweating
- ☐ ☐ Swollen Glands
- ☐ ☐ Fatigue
- ☐ ☐ Nightmares
- ☐ ☐ No dream recall
- ☐ ☐ Early waking
- ☐ ☐ Daytime sleepiness

SKIN:
- ☐ ☐ Cuts Heal slowly
- ☐ ☐ Bruise Easily
- ☐ ☐ Rash
- ☐ ☐ Pigmentation
- ☐ ☐ Changing Moles
- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Dryness
- ☐ ☐ Oiliness
- ☐ ☐ Itching
- ☐ ☐ Acne
- ☐ ☐ Boils
- ☐ ☐ Hives
- ☐ ☐ Fungus on Nails
- ☐ ☐ Cracking skin
- ☐ ☐ Shingles
- ☐ ☐ Athletes Foot
- ☐ ☐ Cellulite
- ☐ ☐ Have bumps on the back of arms
- ☐ ☐ Skin Cancer
- ☐ ☐ Strong body odor

HEAD:
- ☐ ☐ Poor Concentration
- ☐ ☐ Confusion
- ☐ ☐ Headaches:
  - ☐ ☐ After Meals
  - ☐ ☐ Migraine
  - ☐ ☐ Frontal
  - ☐ ☐ Morning
  - ☐ ☐ Afternoon
  - ☐ ☐ Evening
  - ☐ ☐ Occipital
  - ☐ ☐ Relieved by eating
- ☐ ☐ Concussion/Whiplash
- ☐ ☐ Mental Sluggishness
- ☐ ☐ Forgetfulness
- ☐ ☐ Face Twitch
- ☐ ☐ Poor Memory

Current Past

EYES:
- ☐ ☐ Sand in Eyes
- ☐ ☐ Double Vision
- ☐ ☐ Blurred Vision
- ☐ ☐ Poor Night Vision
- ☐ ☐ Bright Flashes
- ☐ ☐ Halo around Lights
- ☐ ☐ Eye Pains
- ☐ ☐ Dark Circles under Eyes
- ☐ ☐ Strong Light Irritates
- ☐ ☐ Cataracts
- ☐ ☐ Floaters in Eyes
- ☐ ☐ Visual hallucinations

EARS:
- ☐ ☐ Aches
- ☐ ☐ Wax buildup
- ☐ ☐ Pains
- ☐ ☐ Ringing
- ☐ ☐ Deafness/Hearing loss
- ☐ ☐ Itching
- ☐ ☐ Pressure
- ☐ ☐ Wear a hearing aid
- ☐ ☐ Frequent infections
- ☐ ☐ Tubes in ears
- ☐ ☐ Sensitive to loud noises
- ☐ ☐ Hearing Hallucinations

NOSE/SINUSES
- ☐ ☐ Stuffy
- ☐ ☐ Bleeding
- ☐ ☐ Running
- ☐ ☐ Congested
- ☐ ☐ Infection
- ☐ ☐ Polyps
- ☐ ☐ Acute smell (sensitive to scents)
- ☐ ☐ Drainage
- ☐ ☐ Sneezing spells
- ☐ ☐ Post nasal drip
- ☐ ☐ No sense of smell

MOUTH:
- ☐ ☐ Coated Tongue
- ☐ ☐ Sore Tongue
- ☐ ☐ Teeth Problems
- ☐ ☐ Bleeding Gums
- ☐ ☐ Canker Sores
- ☐ ☐ TMJ
- ☐ ☐ Cracked lips/ corners
- ☐ ☐ Chapped lips
- ☐ ☐ Fever blisters
- ☐ ☐ Wear dentures
- ☐ ☐ Grind teeth when sleeping
- ☐ ☐ Bad breath
- ☐ ☐ Dry mouth

Current Past

THROAT:
- ☐ ☐ Mucus
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Frequent Hoarseness
- ☐ ☐ Tonsillitis
- ☐ ☐ Enlarged Glands
- ☐ ☐ Constant clearing of throat
- ☐ ☐ Throat closes up

NECK:
- ☐ ☐ Stiffness
- ☐ ☐ Swelling
- ☐ ☐ Lumps
- ☐ ☐ Neck glands swell

CIRCULATION/RESPIRATION:
- ☐ ☐ Swollen Ankles
- ☐ ☐ Sensitive to Hot
- ☐ ☐ Sensitive to Cold
- ☐ ☐ Extremities Cold or Clammy
- ☐ ☐ Hands/Feet go to sleep/numb
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Chest Pain
- ☐ ☐ Pain between shoulders
- ☐ ☐ Dizziness upon standing
- ☐ ☐ Fainting Spells
- ☐ ☐ High Cholesterol
- ☐ ☐ High Triglycerides
- ☐ ☐ Wheezing
- ☐ ☐ Irregular Heartbeat
- ☐ ☐ Palpitations
- ☐ ☐ Low exercise tolerance
- ☐ ☐ Frequent coughs
- ☐ ☐ Breathing heavily
- ☐ ☐ Frequently Sighing
- ☐ ☐ Shortness of breath
- ☐ ☐ Night Sweats
- ☐ ☐ Varicose Veins
- ☐ ☐ Mitral valve prolapse
- ☐ ☐ Murmurs
- ☐ ☐ Skipped heartbeat
- ☐ ☐ Heart enlargement
- ☐ ☐ Angina pain
- ☐ ☐ Bronchitis/Pneumonia
- ☐ ☐ Emphysema
- ☐ ☐ Croup
- ☐ ☐ Frequent colds
- ☐ ☐ Heavy/tight chest
- ☐ ☐ Past Heart Attack
- ☐ ☐ Phlebitis (inflamed veins)
- ☐ ☐ Spider Veins

(Continued on next page)

Current Past

GASTROINTESTINAL

- ☐ ☐ Peptic/Duodenal Ulcer
- ☐ ☐ Poor Appetite
- ☐ ☐ Excessive Appetite
- ☐ ☐ Gallstones
- ☐ ☐ Gallbladder pain
- ☐ ☐ Nervous Stomach
- ☐ ☐ Full Feeling after meal
- ☐ ☐ Indigestion
- ☐ ☐ Heartburn
- ☐ ☐ Acid Reflux
- ☐ ☐ Hiatal Hernia
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Vomiting Blood
- ☐ ☐ Abdominal Pains/Cramps
- ☐ ☐ Gas
- ☐ ☐ Diarrhoea
- ☐ ☐ Constipation
- ☐ ☐ Changes in Bowels
- ☐ ☐ Rectal Bleeding
- ☐ ☐ Tarry Stools
- ☐ ☐ Rectal Itching
- ☐ ☐ Use laxatives
- ☐ ☐ Bloating
- ☐ ☐ Belch frequently
- ☐ ☐ Anal itching
- ☐ ☐ Anal fissures
- ☐ ☐ Bloody stools
- ☐ ☐ Undigested food in stools

MEN'S HISTORY (for men only)

Have you had a PSA done? ○ Yes ○ No

PSA Level:

- ☐ 0 – 2
- ☐ 2 – 4
- ☐ 4 – 10
- ☐ >10

- ☐ ☐ Prostate enlargement
- ☐ ☐ Prostate infection
- ☐ ☐ Change in libido
- ☐ ☐ Impotence
- ☐ ☐ Diminished libido
- ☐ ☐ Poor libido
- ☐ ☐ Infertility
- ☐ ☐ Lumps in testicles
- ☐ ☐ Sore on penis
- ☐ ☐ Genital pain
- ☐ ☐ Hernia
- ☐ ☐ Prostate cancer
- ☐ ☐ Low sperm count
- ☐ ☐ Difficulty Obtaining Erection
- ☐ ☐ Difficulty Maintaining an Erection
- ☐ ☐ Nocturia (urination at night)
  How many times at night? _____
- ☐ ☐ Urgency/Change in Urinary Stream
- ☐ ☐ Loss of Control of Urine

Current Past

WOMEN'S HISTORY (for women only)

- ☐ ☐ Fibrocystic Breasts
- ☐ ☐ Lumps in breast
- ☐ ☐ Fibroid Tumors/Breast
- ☐ ☐ Spotting
- ☐ ☐ Heavy Periods
- ☐ ☐ Fibroid Tumors/Uterus
- ☐ ☐ Painful periods
- ☐ ☐ Change in period
- ☐ ☐ Breast soreness before period
- ☐ ☐ Endometriosis
- ☐ ☐ Non-period bleeding
- ☐ ☐ Breast soreness during period
- ☐ ☐ Vaginal Dryness
- ☐ ☐ Vaginal discharge
- ☐ ☐ Had partial/total hysterectomy
- ☐ ☐ Hot Flashes
- ☐ ☐ Mood Swings
- ☐ ☐ Breast cancer
- ☐ ☐ Ovarian cysts
- ☐ ☐ Infertility
- ☐ ☐ Decreased Libido
- ☐ ☐ Loss of Control of Urine

☐ Are you pregnant? _____ (Due Date)

Contraception Type? _____

Age at first period? _____

Duration of cycle? _____ (Between 28-45 days)

Duration of Flow? _____ (Between 1-7 days)

Number of Pregnancies? _____

Number of Births? _____

Number of Miscarriages? _____

Number of Abortions? _____

Last Period? _____

Last Pap Smear? _____

Last Mammogram? _____

KIDNEY/URINARY TRACT:

- ☐ ☐ Burning during urination
- ☐ ☐ Frequent Urination
- ☐ ☐ Blood in Urine
- ☐ ☐ Night time Urination
- ☐ ☐ Problem Passing Urine
- ☐ ☐ Kidney Pain
- ☐ ☐ Kidney Stones
- ☐ ☐ Painful Urination
- ☐ ☐ Bladder infections
- ☐ ☐ Kidney infections
- ☐ ☐ Syphilis
- ☐ ☐ Bed-wetting
- ☐ ☐ Trichomonas infection

Current Past

JOINT/MUSCLES/TENDONS

- ☐ ☐ Pain wakes me up
- ☐ ☐ Weakness in Legs and arms
- ☐ ☐ Balance problems
- ☐ ☐ Muscle cramping
- ☐ ☐ Head injury
- ☐ ☐ Muscle Stiffness in Morning
- ☐ ☐ Damp weather bothers you

EMOTIONAL:

- ☐ ☐ Convulsions
- ☐ ☐ Dizziness
- ☐ ☐ Fainting Spells
- ☐ ☐ Blackouts
- ☐ ☐ Amnesia
- ☐ ☐ Had shock therapy
- ☐ ☐ Frequently keyed up and jittery
- ☐ ☐ Shaky
- ☐ ☐ Startled by sudden noises
- ☐ ☐ Often feel suddenly scared
- ☐ ☐ Go to pieces easily
- ☐ ☐ Forgetful
- ☐ ☐ Withdrawn feeling
- ☐ ☐ Feel "lost" in time
- ☐ ☐ Had nervous breakdown
- ☐ ☐ Had "burnout"
- ☐ ☐ Feel groggy
- ☐ ☐ Unable to concentrate
- ☐ ☐ Short attention span
- ☐ ☐ Vision changes
- ☐ ☐ Unable to reason
- ☐ ☐ Considered a nervous person
- ☐ ☐ Worried over little things
- ☐ ☐ Anxiety
- ☐ ☐ Unusual tension
- ☐ ☐ Frustration
- ☐ ☐ Numbness
- ☐ ☐ Often break out in cold sweats
- ☐ ☐ Profuse sweating
- ☐ ☐ Depressed
- ☐ ☐ Been admitted for psychiatric care
- ☐ ☐ Often awakened by frightening dreams
- ☐ ☐ Family member had nervous breakdown
- ☐ ☐ Use tranquillizers
- ☐ ☐ Aggressive
- ☐ ☐ Misunderstood by others
- ☐ ☐ Irritable
- ☐ ☐ Easily flare in anger
- ☐ ☐ Feelings of hostility
- ☐ ☐ Hyperactive
- ☐ ☐ Restless leg syndrome
- ☐ ☐ Considered clumsy
- ☐ ☐ Unable to coordinate muscles
- ☐ ☐ Have difficulty falling asleep
- ☐ ☐ Have difficulty staying asleep
- ☐ ☐ Daytime sleepiness
- ☐ ☐ I am a workaholic
- ☐ ☐ Have you had hallucinations
- ☐ ☐ Have you considered suicide

Family Medical History

Many health problems are hereditary in nature and may be handed down generation after generation.

Name _____ **Age** _____ **Sex** **Date** _____

Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply.

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age at death (if deceased)												
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALS or other Motor Neuron Diseases	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Diseases (such as Lupus, Hashimoto's, Multiple Sclerosis, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bladder disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clotting problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Digestive Disturbances	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Family Medical History (Continued)

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Environmental Sensitivities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food Intolerances, Allergies, Sensitivities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders												
Glaucoma												
Headache												
High Blood Pressure												
High Cholesterol												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease (IBD)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Insomnia												
Irritable Bowel Syndrome (IBS)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease												
Liver disease												
Migraines												
Nervous breakdown												
Obesity												
Osteoporosis												
Parkinson’s												
Pneumonia/Bronchitis												
Psoriasis												
Psychiatric disorders												
Schizophrenia												
Sleep Apnea												
Smoking addiction												
Substance abuse												
Thyroid Disorder												
Ulcers												

Karisma For Life
Symptom Assessment Form

Name _____ **Age** _____ **Sex** **Date** _____

Please check the appropriate box "0 - 3" on ALL questions below. NO BLANK RESPONSES.
0 = Never / the least 1 = Sometimes 2 = Often 3 = Always / the most

Category I

Sweat has a strong odor	0☐ 1☐ 2☐ 3☐
Stomach upset by taking vitamins	0☐ 1☐ 2☐ 3☐
Feel like skipping breakfast	0☐ 1☐ 2☐ 3☐
Feel better if you don't eat (eating makes you feel worse)	0☐ 1☐ 2☐ 3☐
Stomach pain or cramping	0☐ 1☐ 2☐ 3☐
Nausea	0☐ 1☐ 2☐ 3☐
Fingernails chip, peel or break easily	0☐ 1☐ 2☐ 3☐

Category II

Excessive belching, burping and/or bloating	0☐ 1☐ 2☐ 3☐
Heartburn or acid reflux	0☐ 1☐ 2☐ 3☐
Gas immediately following a meal	0☐ 1☐ 2☐ 3☐
Difficulty digesting proteins (meats)	0☐ 1☐ 2☐ 3☐
Offensive breath (halitosis)	0☐ 1☐ 2☐ 3☐
Sense of fullness during and after meals	0☐ 1☐ 2☐ 3☐
Anemia unresponsive to iron supplementation	0☐ 1☐ 2☐ 3☐
Difficult bowel movements	0☐ 1☐ 2☐ 3☐
Difficulty digesting fruits and vegetables	0☐ 1☐ 2☐ 3☐
Undigested foods found in stools	0☐ 1☐ 2☐ 3☐

Category III

Stomach burning or aching 1-4 hours after eating	0☐ 1☐ 2☐ 3☐
Use antacids or reflux medications?	0☐ 1☐ 2☐ 3☐
Feeling hungry an hour or two after eating	0☐ 1☐ 2☐ 3☐
Heartburn when lying down or bending forward	0☐ 1☐ 2☐ 3☐
Temporary relief from antacids, eating food, drinking milk or carbonated beverages	0☐ 1☐ 2☐ 3☐
Digestive problems subside with rest and relaxation	0☐ 1☐ 2☐ 3☐
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0☐ 1☐ 2☐ 3☐
Black or tarry colored stools	0☐ 1☐ 2☐ 3☐

Category IV

Roughage and fiber cause constipation	0☐ 1☐ 2☐ 3☐
Indigestion and fullness last 2-4 hours after eating	0☐ 1☐ 2☐ 3☐
Pain, tenderness, soreness on left side under rib cage	0☐ 1☐ 2☐ 3☐
Excessive passage of gas	0☐ 1☐ 2☐ 3☐
Nausea and/or vomiting	0☐ 1☐ 2☐ 3☐
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0☐ 1☐ 2☐ 3☐
Frequent urination	0☐ 1☐ 2☐ 3☐
Increased thirst and appetite	0☐ 1☐ 2☐ 3☐
Difficulty losing weight	0☐ 1☐ 2☐ 3☐

Category V

Feeling that bowels do not empty completely	0☐ 1☐ 2☐ 3☐
Lower abdominal pain relieved by passing stool or gas	0☐ 1☐ 2☐ 3☐
Alternating constipation and diarrhea	0☐ 1☐ 2☐ 3☐
Diarrhea	0☐ 1☐ 2☐ 3☐
Constipation	0☐ 1☐ 2☐ 3☐
Hard, dry, or small stool	0☐ 1☐ 2☐ 3☐
Coated tongue or "fuzzy" debris on tongue	0☐ 1☐ 2☐ 3☐
Pass large amount of foul smelling gas	0☐ 1☐ 2☐ 3☐
More than 3 bowel movements daily	0☐ 1☐ 2☐ 3☐
Use laxatives frequently	0☐ 1☐ 2☐ 3☐

How many ounces of WATER do you drink per day? _____

Category VI

Eating greasy or high fat foods causes discomfort	0☐ 1☐ 2☐ 3☐
Difficulty taking fish oil, flax oil or other oils	0☐ 1☐ 2☐ 3☐
Lower bowel gas and/or bloating several hours after eating	0☐ 1☐ 2☐ 3☐
Bitter metallic taste in mouth, especially in the morning	0☐ 1☐ 2☐ 3☐
Pain between shoulder blades	0☐ 1☐ 2☐ 3☐
Unexplained itchy skin	0☐ 1☐ 2☐ 3☐
Yellowish cast to eyes	0☐ 1☐ 2☐ 3☐
Stool color alternates from clay-colored to normal brown	0☐ 1☐ 2☐ 3☐
Reddened skin, especially palms	0☐ 1☐ 2☐ 3☐
Dry or flaky skin and/or hair	0☐ 1☐ 2☐ 3☐
History of gallbladder attacks or stones	0☐ 1☐ 2☐ 3☐
Have you had your gallbladder removed?	Yes☐ No☐

Category VII

Do you become sick if you were to drink wine/alcohol	0☐ 1☐ 2☐ 3☐
Are you easily intoxicated when drinking wine/alcohol	0☐ 1☐ 2☐ 3☐
How often do get hung over when drinking wine/alcohol	0☐ 1☐ 2☐ 3☐
Sensitive to chemicals/smells (perfume, cleaning agents, etc)	0☐ 1☐ 2☐ 3☐
Chemical exposure (diesel, paint, solvents, etc.)	0☐ 1☐ 2☐ 3☐
Sensitive to tobacco smoke	0☐ 1☐ 2☐ 3☐
Pain under right side of rib cage	0☐ 1☐ 2☐ 3☐
Hemorrhoids or varicose veins	0☐ 1☐ 2☐ 3☐
Sensitivity to Nutrasweet (aspartame)	0☐ 1☐ 2☐ 3☐
Do you have a history of hepatitis	Yes☐ No☐
Long term use of prescription drugs (including antibiotics)	Yes☐ No☐
History of drug or alcohol abuse	Yes☐ No☐
Are you a recovering alcoholic / drug user	Yes☐ No☐

Category VIII

How often do you crave sweets during the day	0☐ 1☐ 2☐ 3☐
How often are you irritable if you miss a meal	0☐ 1☐ 2☐ 3☐
Depend on coffee to keep yourself going or to get started	0☐ 1☐ 2☐ 3☐
Function better or feel energized after eating?	0☐ 1☐ 2☐ 3☐
How often do you feel like skipping breakfast	0☐ 1☐ 2☐ 3☐
How often do you have difficulty eating large meals or protein based meals (meats) in the morning?	0☐ 1☐ 2☐ 3☐
Get light-headed and/or shaky if meals are missed	0☐ 1☐ 2☐ 3☐
How often do you feel shaky, jittery or have tremors	0☐ 1☐ 2☐ 3☐
How often are you agitated, easily upset or nervous	0☐ 1☐ 2☐ 3☐
How often do you have poor memory or are forgetful	0☐ 1☐ 2☐ 3☐
How often do you have blurred vision	0☐ 1☐ 2☐ 3☐
How often does your energy level drop in the afternoon	0☐ 1☐ 2☐ 3☐
How often do you wake up in the middle of the night?	0☐ 1☐ 2☐ 3☐
How often do you have difficulty concentrating before eating	0☐ 1☐ 2☐ 3☐
Eat large amounts of fruit / Prefer eating fruits	0☐ 1☐ 2☐ 3☐

Category IX

Fatigue / sleepy after meals	0☐ 1☐ 2☐ 3☐
Crave sweets during the day	0☐ 1☐ 2☐ 3☐
Binge or uncontrolled eating / excessive appetite	0☐ 1☐ 2☐ 3☐
Eating sweets does not relieve cravings for sugar	0☐ 1☐ 2☐ 3☐
Must have sweets after meals	0☐ 1☐ 2☐ 3☐
Waist girth is equal or larger than hip girth	0☐ 1☐ 2☐ 3☐
Frequent urination	0☐ 1☐ 2☐ 3☐
Increased thirst and appetite	0☐ 1☐ 2☐ 3☐
Difficulty losing weight	0☐ 1☐ 2☐ 3☐
Do you have diabetes?	Yes☐ No☐
Do you have any family members with diabetes?	Yes☐ No☐

Karisma For Life

Symptom Assessment Form

PART II (Continued) **Please check the appropriate box "0 - 3" on ALL questions below. NO blank responses.**
0 = Never / the least 1 = Sometimes 2 = Often 3 = Always / the most

Category X
Cannot stay asleep 0☐ 1☐ 2☐ 3☐
Crave salty foods 0☐ 1☐ 2☐ 3☐
Salt your food before tasting it 0☐ 1☐ 2☐ 3☐
Slow starter in the morning 0☐ 1☐ 2☐ 3☐
Afternoon fatigue 0☐ 1☐ 2☐ 3☐
Dizziness when standing up quickly 0☐ 1☐ 2☐ 3☐
Afternoon headaches 0☐ 1☐ 2☐ 3☐
Headaches with exertion or stress 0☐ 1☐ 2☐ 3☐
Weak nails 0☐ 1☐ 2☐ 3☐

Category XI
Difficulty falling asleep 0☐ 1☐ 2☐ 3☐
Tend to be a night person 0☐ 1☐ 2☐ 3☐
Perspire easily 0☐ 1☐ 2☐ 3☐
Under high amounts of stress 0☐ 1☐ 2☐ 3☐
High blood pressure 0☐ 1☐ 2☐ 3☐
Weight gain when under stress 0☐ 1☐ 2☐ 3☐
Wake up tired even after 6 or more hours of sleep 0☐ 1☐ 2☐ 3☐
Excessive perspiration or perspiration with little or no activity 0☐ 1☐ 2☐ 3☐

Category XII
Pain in mid-back region 0☐ 1☐ 2☐ 3☐
Puffy around the eyes or dark circles under eyes 0☐ 1☐ 2☐ 3☐
How many times have you had kidney stones 0☐ 1☐ 2☐ 3☐
Cloudy, bloody or darkened urine 0☐ 1☐ 2☐ 3☐
Urine has a strong odor 0☐ 1☐ 2☐ 3☐

Category XIII
Tired, Sluggish 0☐ 1☐ 2☐ 3☐
Sensitive to iodine 0☐ 1☐ 2☐ 3☐
Feel cold - hands, feet, all over 0☐ 1☐ 2☐ 3☐
Require excessive amounts of sleep to function properly 0☐ 1☐ 2☐ 3☐
Increase in weight gain even with low-calorie diet 0☐ 1☐ 2☐ 3☐
Gain weight easily 0☐ 1☐ 2☐ 3☐
Difficult, infrequent bowel movements 0☐ 1☐ 2☐ 3☐
Depression, lack of motivation 0☐ 1☐ 2☐ 3☐
Morning headaches that wear off as the day progresses 0☐ 1☐ 2☐ 3☐
Outer third of eyebrow thins 0☐ 1☐ 2☐ 3☐
Thinning of hair on scalp/face/genitals or hair falling out 0☐ 1☐ 2☐ 3☐
Dryness of skin and/or scalp 0☐ 1☐ 2☐ 3☐
Mental sluggishness 0☐ 1☐ 2☐ 3☐

Category XIV
Heart palpitations 0☐ 1☐ 2☐ 3☐
Intolerance for high temperatures 0☐ 1☐ 2☐ 3☐
Inward trembling 0☐ 1☐ 2☐ 3☐
Increased pulse even at rest 0☐ 1☐ 2☐ 3☐
Nervous and emotional 0☐ 1☐ 2☐ 3☐
Insomnia 0☐ 1☐ 2☐ 3☐
Night sweats 0☐ 1☐ 2☐ 3☐
Difficulty gaining weight 0☐ 1☐ 2☐ 3☐

Category XV
Diminished sex drive / libido 0☐ 1☐ 2☐ 3☐
Menstrual disorders or lack of menstruation 0☐ 1☐ 2☐ 3☐
Excessive thirst 0☐ 1☐ 2☐ 3☐
Increased ability to eat sugars without symptoms like hyperactivity, headaches, stomach pain, sugar crash 0☐ 1☐ 2☐ 3☐
Height under 4' 10"? Yes☐ No☐
Delayed sexual development? Yes☐ No☐

Category XVI
Increased sex drive / libido 0☐ 1☐ 2☐ 3☐
Eating sugar causes symptoms like hyperactivity, headaches, stomach pain, sugar crash 0☐ 1☐ 2☐ 3☐
"Splitting" type headaches 0☐ 1☐ 2☐ 3☐
Discharge from nipples 0☐ 1☐ 2☐ 3☐
Height over 6' 6"? Yes☐ No☐
Early sexual development? Yes☐ No☐

Category XVII (MALES ONLY)
Prostate problems 0☐ 1☐ 2☐ 3☐
Urination difficulty or dribbling 0☐ 1☐ 2☐ 3☐
Difficult to start and stop urine stream 0☐ 1☐ 2☐ 3☐
Interruption of stream during urination 0☐ 1☐ 2☐ 3☐
Pain or burning with urination 0☐ 1☐ 2☐ 3☐
Urination frequent 0☐ 1☐ 2☐ 3☐
Pain inside of legs or heels 0☐ 1☐ 2☐ 3☐
Feeling of incomplete bowel evacuation 0☐ 1☐ 2☐ 3☐
Leg nervousness at night 0☐ 1☐ 2☐ 3☐

Category XVIII (MALES ONLY)
Decrease in libido 0☐ 1☐ 2☐ 3☐
Decrease in spontaneous morning erections 0☐ 1☐ 2☐ 3☐
Decrease in fullness of erections 0☐ 1☐ 2☐ 3☐
Difficulty in maintaining erections 0☐ 1☐ 2☐ 3☐
Spells of mental fatigue 0☐ 1☐ 2☐ 3☐
Inability to concentrate 0☐ 1☐ 2☐ 3☐
Episodes of depression 0☐ 1☐ 2☐ 3☐
Muscle soreness 0☐ 1☐ 2☐ 3☐
Decreased physical stamina 0☐ 1☐ 2☐ 3☐
Unexplained weight gain 0☐ 1☐ 2☐ 3☐
Increase in fat distribution around chest and hips 0☐ 1☐ 2☐ 3☐
Sweating attacks 0☐ 1☐ 2☐ 3☐
More emotional than in the past 0☐ 1☐ 2☐ 3☐

Category XIX (MENSTRUATING FEMALES ONLY)
Are you perimenopausal? Yes☐ No☐
Do you have alternating menstrual cycle lengths? Yes☐ No☐
Extended menstrual cycle, greater than 32 days? Yes☐ No☐
Shortened menses, less than every 24 days? Yes☐ No☐
Pain and cramping during periods 0☐ 1☐ 2☐ 3☐
Scanty (light, spotting) blood flow 0☐ 1☐ 2☐ 3☐
Heavy blood flow 0☐ 1☐ 2☐ 3☐
Breast pain and swelling during menses 0☐ 1☐ 2☐ 3☐
Irritable and depressed during menses 0☐ 1☐ 2☐ 3☐
Acne breakouts 0☐ 1☐ 2☐ 3☐
Facial hair growth 0☐ 1☐ 2☐ 3☐
Hair loss/thinning 0☐ 1☐ 2☐ 3☐

Category XX (MENOPAUSAL FEMALES ONLY)
How many years have you been menopausal? _____
Since menopause, do you ever have uterine bleeding? Yes☐ No☐
Hot flashes 0☐ 1☐ 2☐ 3☐
Mental fogginess 0☐ 1☐ 2☐ 3☐
Disinterest in sex 0☐ 1☐ 2☐ 3☐
Mood swings 0☐ 1☐ 2☐ 3☐
Depression 0☐ 1☐ 2☐ 3☐
Painful intercourse 0☐ 1☐ 2☐ 3☐
Shrinking breasts 0☐ 1☐ 2☐ 3☐
Facial hair growth 0☐ 1☐ 2☐ 3☐
Acne 0☐ 1☐ 2☐ 3☐
Increased vaginal pain, dryness and/or itching 0☐ 1☐ 2☐ 3☐

Karisma For Life
Symptom Assessment Form

PART III **Please check the appropriate box "0 - 3" on ALL questions below. NO blank responses.**
(Continued) 0 = Never / the least 1 = Sometimes 2 = Often 3 = Always / the most

SECTION XXI

Is your memory noticeably declining? . . . . . 0☐ 1☐ 2☐ 3☐
Do you have a hard time remembering names & phone numbers? 0☐ 1☐ 2☐ 3☐
Is your ability to focus noticeably declining? . . . . . 0☐ 1☐ 2☐ 3☐
Has it become harder for you to learn things? . . . . . 0☐ 1☐ 2☐ 3☐
Do you have a hard time remembering your appointments? 0☐ 1☐ 2☐ 3☐
Is your temperament getting worse in general? . . . . . 0☐ 1☐ 2☐ 3☐
Are you losing your attention span endurance? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you find yourself down or sad? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you fatigue when driving compared to the past? 0☐ 1☐ 2☐ 3☐
How often do you fatigue when reading compared to the past? 0☐ 1☐ 2☐ 3☐
How often do you walk into rooms and forget why? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you pick up your cell phone and forget why? 0☐ 1☐ 2☐ 3☐

SECTION XXII

How high is your stress level? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel that you have something that must be done? 0☐ 1☐ 2☐ 3☐
Do you feel you never have time for yourself? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel you are **not** getting enough sleep or rest? 0☐ 1☐ 2☐ 3☐
Do you find it difficult to get regular exercise? . . . . . 0☐ 1☐ 2☐ 3☐
Do you feel uncared for by the people in your life? . . . . . 0☐ 1☐ 2☐ 3☐
Do you feel you are **not** accomplishing your life's purpose? 0☐ 1☐ 2☐ 3☐
Is sharing your problems with someone difficult for you? . . 0☐ 1☐ 2☐ 3☐

SECTION XXIII

Are you losing your pleasure in hobbies and interests? . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel overwhelmed with ideas to manage? . . 0☐ 1☐ 2☐ 3☐
How often do you have feeling of inner rage (anger)? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have feelings of paranoia? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel sad or down for no reason? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel like you are **not** enjoying life? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel you lack artistic appreciation? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel depressed in overcast weather? . . . . 0☐ 1☐ 2☐ 3☐
Are you losing your enthusiasm for your favorite activities? . . 0☐ 1☐ 2☐ 3☐
How much are you losing enjoyment for you favorite foods? . 0☐ 1☐ 2☐ 3☐
Are you losing your enjoyment for friendships & relationships? 0☐ 1☐ 2☐ 3☐
How often do you have difficulty falling into deep restful sleep? 0☐ 1☐ 2☐ 3☐
How often do you have feelings of dependency on others? . . 0☐ 1☐ 2☐ 3☐
How often do you feel more susceptible to pain? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have feelings of unprovoked anger? . . . . 0☐ 1☐ 2☐ 3☐
How much are you losing interest in life? . . . . . 0☐ 1☐ 2☐ 3☐

SECTION XXIV

How often do you have feelings of hopelessness? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have self-destructive thoughts? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have an inability to handle stress? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have anger and aggression while under stress? 0☐ 1☐ 2☐ 3☐
How often do you feel you are not rested even after long hours of sleep? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you prefer to isolate yourself from others? . . 0☐ 1☐ 2☐ 3☐
How often do you have unexplained lack of concern for family and friends? . . . . . 0☐ 1☐ 2☐ 3☐
How easily are you distracted from your tasks? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have an inability to finish tasks? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel the need to consume caffeine to stay alert? 0☐ 1☐ 2☐ 3☐
How often do you feel your libido has been decreased? . . . . 0☐ 1☐ 2☐ 3☐
How often do you lose you temper for minor reasons? . . . . 0☐ 1☐ 2☐ 3☐
How often do you have feelings of worthlessness? . . . . . 0☐ 1☐ 2☐ 3☐

SECTION XXV

How often do you feel anxious or panic for no reason? . . . . 0☐ 1☐ 2☐ 3☐
How often do you have feelings of dread or impending doom? . 0☐ 1☐ 2☐ 3☐
How often do you feel knots in your stomach? . . . . . 0☐ 1☐ 2☐ 3☐
Do you have feelings of being overwhelmed for no reason? . 0☐ 1☐ 2☐ 3☐
How often do feel guilty about everyday decisions? . . . . . 0☐ 1☐ 2☐ 3☐
How often does your mind feel restless? . . . . . 0☐ 1☐ 2☐ 3☐
How difficult is it to turn your mind off when you want to relax? . 0☐ 1☐ 2☐ 3☐
How often do you have disorganized attention? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you worry about things you were not worried about before? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have feelings of inner tension and inner excitability? . . . . . 0☐ 1☐ 2☐ 3☐

SECTION XXVI

Do you feel your visual memory (shapes & images) is decreased? . 0☐ 1☐ 2☐ 3☐
Do you feel your verbal memory is decreased? . . . . . 0☐ 1☐ 2☐ 3☐
Do you have memory lapses? . . . . . 0☐ 1☐ 2☐ 3☐
Has your creativity been decreased? . . . . . 0☐ 1☐ 2☐ 3☐
Has your comprehension been diminished? . . . . . 0☐ 1☐ 2☐ 3☐
Do you have difficulty calculating numbers? . . . . . 0☐ 1☐ 2☐ 3☐
Do you have difficulty recognizing objects & faces? . . . . . 0☐ 1☐ 2☐ 3☐
Do you feel like your opinion about yourself has changed? . . 0☐ 1☐ 2☐ 3☐
Are you experiencing excessive urination? . . . . . 0☐ 1☐ 2☐ 3☐
Are you experiencing slower mental response? . . . . . 0☐ 1☐ 2☐ 3☐

SECTION XXVII

Do you have food allergies / sensitivities? . . . . . 0☐ 1☐ 2☐ 3☐
How often does your pulse speed after eating? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have airborne allergies? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you experience hives? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have sinus congestion upon waking? . . . 0☐ 1☐ 2☐ 3☐
How often do you crave bread and/or pasta? . . . . . 0☐ 1☐ 2☐ 3☐
Do you have a wheat (gluten) or other grain sensitivity? . . . 0☐ 1☐ 2☐ 3☐
Do you have a dairy sensitivity? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have bizarre vivid dreams / nightmares? . 0☐ 1☐ 2☐ 3☐
How often do you have sinus infections / stuffy nose? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you have dark circles under you eyes? . . . . . 0☐ 1☐ 2☐ 3☐
How often do specific foods make you tired or bloated? . . . 0☐ 1☐ 2☐ 3☐
How often do you have alternating constipation & diarrhea? . 0☐ 1☐ 2☐ 3☐
How often does eating certain foods make you feel better? . 0☐ 1☐ 2☐ 3☐
Are there foods you feel you cannot give up? . . . . . 0☐ 1☐ 2☐ 3☐
How often do certain foods make you feel worse? . . . . . 0☐ 1☐ 2☐ 3☐
How often after eating do you feel better? . . . . . 0☐ 1☐ 2☐ 3☐
How often after eating do you feel worse? . . . . . 0☐ 1☐ 2☐ 3☐
How often do you feel spacey or unreal? . . . . . 0☐ 1☐ 2☐ 3☐

Please continue to next page

Karisma For Life
Symptom Assessment Form

Please check any of the following phycotrophic medications you have taken in the past or are currently taking. (Please note that these are only phycotrophic medications)

- ☐ Abilify
- ☐ Acuphase
- ☐ Adapin
- ☐ Adlegiine
- ☐ Ambien
- ☐ Anafranil
- ☐ Aropax
- ☐ Asendin
- ☐ Asendis
- ☐ Ativan
- ☐ Atracurium
- ☐ Atropine
- ☐ Aurorix
- ☐ Avanza
- ☐ Aventyl
- ☐ Axit
- ☐ Azilect
- ☐ Carbamate Insecticides
- ☐ Celexa
- ☐ Cipralex
- ☐ Cipramil
- ☐ Cisatracurium
- ☐ Clopixol
- ☐ Clozaril
- ☐ Coaxil
- ☐ Compazine
- ☐ Dalcipran
- ☐ Dalmane
- ☐ Dapoxetine
- ☐ Defanyl
- ☐ Demolox
- ☐ Depixol
- ☐ Deroxat
- ☐ Despiramin
- ☐ Donepezil
- ☐ Dormicum
- ☐ Doxacurium
- ☐ Duloxetine
- ☐ Echotiophate
- ☐ Edrophonium
- ☐ Effexor
- ☐ Elavil
- ☐ Elepryl
- ☐ Emocal
- ☐ Endep
- ☐ Esteria
- ☐ Fluanxol
- ☐ Fluetin
- ☐ Flumazenil
- ☐ Fontex
- ☐ Galatamine
- ☐ Gamanil
- ☐ Geodon
- ☐ Halcion
- ☐ Haldol
- ☐ Hemicholinium
- ☐ Hexamethonium
- ☐ Imovane
- ☐ Invega
- ☐ Ipratopium
- ☐ Ipronid
- ☐ Iprozid
- ☐ Isoflurophate
- ☐ Janamine
- ☐ Klonopin
- ☐ Laxapro
- ☐ Lexotanil
- ☐ Lexotanil
- ☐ Librium
- ☐ Loramet
- ☐ Lunesta
- ☐ Lustral
- ☐ Luvox
- ☐ Manerix
- ☐ Marplan
- ☐ Marsilid
- ☐ Mecamylamine
- ☐ Megadon
- ☐ Mellaril
- ☐ Meridia
- ☐ Metocurine
- ☐ Mirapex
- ☐ Mivacurium
- ☐ Moclodura
- ☐ Moxadil
- ☐ Nardil
- ☐ Navane
- ☐ Neostigmine
- ☐ Nicotine (high dose)
- ☐ Norpramin
- ☐ Norset
- ☐ Nozinan
- ☐ Opipramol
- ☐ Orap
- ☐ Organophosphate Insecticides
- ☐ Organophosphate nerve agents
- ☐ Pamelor
- ☐ Pancuronium
- ☐ Paroxat
- ☐ Paxil
- ☐ Pertofrane
- ☐ Physostigmine
- ☐ Popilniazida
- ☐ Pralidoxime
- ☐ Pristiq
- ☐ Prolixin
- ☐ ProSom
- ☐ Prothiaden
- ☐ Prozac
- ☐ Pyridostigmine
- ☐ Remergil
- ☐ Remeron
- ☐ Requip
- ☐ Restoril
- ☐ Rexetin
- ☐ Rhotrimine
- ☐ Rivastigmine
- ☐ Rivivol
- ☐ Rocuronium
- ☐ Rohypnol
- ☐ Sarafem
- ☐ Scopolamine
- ☐ Sedoxil
- ☐ Serax
- ☐ Serlain
- ☐ Seromex
- ☐ Seronil
- ☐ Seropram
- ☐ Seroquel
- ☐ Seroxat
- ☐ Serzone
- ☐ Sifrol
- ☐ Sinequan
- ☐ Solian
- ☐ Sonata
- ☐ Stablon
- ☐ Stelazine
- ☐ Succinylcholine
- ☐ Surmontil
- ☐ Tacrine
- ☐ Tatinol
- ☐ THC
- ☐ Thorazine
- ☐ Tiotropium
- ☐ Tofranil
- ☐ Trepiline
- ☐ Trilafon
- ☐ Trimethaphan
- ☐ Tryptanol
- ☐ Tubocurarine
- ☐ Valium
- ☐ Vecuronium
- ☐ Vesprin
- ☐ Vivactil
- ☐ Wellbutrin (bupropion)
- ☐ Xanax
- ☐ Zispin
- ☐ Zoloft
- ☐ Zydis
- ☐ Zyprexa
- ☐ Zyvox
- ☐ Zyvoxid

Notice of Privacy Practices

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read this information carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us.

Contact Person:
Dr. Kari Vernon
8140 E. Cactus Rd., Suite 730
Scottsdale, AZ., 85260
(480) 905-1883

I, _____ Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

Credit Card Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that fees for professional services, products and shipping charges rendered to me will be immediately due and payable. If there is any unpaid balance on my account at any time, it will be charged to my credit card if no other payment arrangements have been agreed upon.

Authorization to debit a credit card:

Patients name: _____ File # _____

Card Holder's Name: _____

16 Digit Card Number: _____ ○ Visa ○ MasterCard

Billing Address: _____
(Street Number Only - Do not include street name)

3-Digit Security Code: _____
(3 digit code on back of card)

Expiration Date: _____
(mm/yy)

Billing Zip Code: _____

Please bill charges I incur to the card listed above for services, supplies and shipping. I understand written notification of the dates of service and itemized charges will be sent to me for my records.

I have read and understand the above.

Signature: _____ Date: _____

Instructions for Requesting Medical Records

Your medical records are very important in Dr. Vernon's's evaluation of your case. Gather as much information as possible, going as far back as possible, even if you saw a doctor only once. Diagnostic testing, including blood tests, MRI's and CAT scans, medications, treatment notes and reports are just a few examples. You may have been told you that your test results were "normal" but Dr. Vernon may see something different in the results as her evaluation methods are far different than other practitioners.

Here are some tips to help you gather your medical records:

1. IT IS YOUR RIGHT to obtain a copy of your medical records. On the next page is a Medical Records Release Authorization form. Print out a copy for each doctor you have seen and complete each form with their information.

2. Enclose or send a copy of your driver's license, government I.D. or your passport with the Medical Records Request Authorization form.

3. It is recommended that you go into the doctor's office personally to submit the form. Have the records sent directly to you, this way you know which records have been released and which records you need to follow up on to get them released. If you have records sent directly to us, please follow up with us to make sure we have received ALL your records.

4. Often a request for records will be put on the "back burner" and forgotten. Follow up frequently with each doctor's office until they send your records.

5. If you are having a difficult time obtaining any records, please do not hesitate to contact our office for assistance.

MEDICAL RECORDS RELEASE AUTHORIZATION

Doctor / Hospital: _____

Address: _____

Patient Information:

Date: _____

Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

☐ Karisma For Life
Dr. Kari Vernon
8140 E. Cactus Rd. Suite 730
Scottsdale, AZ. 85260
Phone: (480) 905-1883; Fax: (208) 263-9077

☐ Me personally. Send my records to:

_____

_____

Delivery Method: ☐ Fax ☐ Mail Copies ☐ Discuss Medical Information

Purpose of Request: ☐ Medical Care ☐ Personal ☐ Legal ☐ Continuing Care

Information to be Released:

☐ Please provide a complete copy of my medical history including all diagnostic and/or laboratory test results

☐ Please provide a complete copy of my all diagnostic and/or laboratory test results only

☐ Other: _____

Authorization to Release Protected Information:

☐ I DO ☐ I DO NOT want Mental Health information released Initials: _____

☐ I DO ☐ I DO NOT want information about HIV Tests & Related information released Initials: _____

☐ I DO ☐ I DO NOT want information about Alcohol and/or Substance Abuse released Initials: _____

☐ I DO ☐ I DO NOT want information about Genetic Testing released Initials: _____

☐ I DO ☐ I DO NOT want information about _____ released Initials: _____

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Patient's Signature: _____ Date: _____

Patient's Name: _____
(Please Print)

_____ _____ _____
If Patient Is a Minor Signature of Parent or Legal Guardian | Relationship to Patient | Date