

WHAT TO EXPECT ON YOUR FIRST VISIT



Your first visit includes several different tests and services. Below is a list of the tests and services that will be provided to you on your first visit. Some services are an additional charge which is listed for your review.

- ❖ **Arterial Stiffness Index (ASI)** – Measures the stiffness of the brachial artery in the arm. The result is a number that ideally should be below 80 meaning the vessel is of normal stiffness.
- ❖ **Total Body Composition** – Measures total fat, body mass index (BMI), water percentage, lean mass weight and ideal body weight. A height is also measured along with a waist measurement to look at the height/waist ratio.
- ❖ **Visual Contrast Sensitivity (VCS)** – An evaluation of the visual contrast which may indicate an issue with either biotoxins or neurologic infections. If this has a fail score, an Environmental Questionnaire will be filled out to explore further possibilities of illness.
- ❖ **Positional Vital Signs** – Taking blood pressure and pulse while supine and standing can give important information about mineral and water status.
- ❖ **Saliva Testing** – Evaluation of pH level.
- ❖ **Zinc Tally Testing** – Evaluation of zinc needs and requirements.
- ❖ **Iodine Spot Test** – To evaluate for the bioavailability of Iodine which is important for thyroid function.
- ❖ **Urine Dipstick** – This is a \$15.00 fee that evaluates pH, infection, sugar, protein and liver imbalance in the first morning urine.
- ❖ **Computer Entry** – All prescription and nutritional supplements will be entered to be filed in your permanent record.
- ❖ **Physician Evaluation** – This may take between 60 – 120 minutes as the history, medical records, physical exam and laboratory testing will be evaluated. A treatment plan may be initiated at this step.
- ❖ **RN Education and Consultation** – This will include handouts, computer printout of the days visit, possible injections or IV therapy and instructions.
- ❖ **Blood Draw** – Any blood drawn at FVWC will have a \$40.00 draw fee for all blood drawn each visit.
- ❖ **Nutritional Counseling** – A one hour nutritional consultation will be done on every new patient. This is a one-time \$75.00 fee that can be done as an individual, family or group. The importance of nutrition in our program is critically important. A follow-up microscopy evaluation to individualize the nutritional status of the patient can be scheduled in follow-up.

PLEASE NOTE: There are additional charges for any other provider services, IV administration and lab charges.

WELCOME TO FOX VALLEY WELLNESS CENTER / MIDWEST HYPERBARICS

It is our desire to accommodate both you and your medical needs with professional medical services. Your initial appointment with Dr. Meress will begin a medical process to develop an ITP (Individual Treatment Plan) specifically for you. We welcome and encourage our patients to become an integral part of their healthcare at Fox Valley Wellness.

2 (TWO) WEEKS BEFORE YOUR FIRST APPOINTMENT

We require the following be mailed to Fox Valley Wellness Center 2 (Two) weeks prior to your first appointment.

- 1. Your past medical records. These records provide valuable information critical to evaluating you and developing your ITP. Your records may include laboratory test results, radiological testing results, etc. The records you provide will become part of your ITP medical documentation at Fox Valley Wellness.**
- 2. Pre-appointment paperwork. This allows us an opportunity to prepare and ready your chart for your initial appointment with Dr. Meress.**

BLOOD TESTS AND RESULTS

During your appointment, Dr. Meress may order blood tests. You may have your blood drawn at our clinic or take the lab orders to a clinic/laboratory of your choice. It is your responsibility to have doctor ordered blood testing done. If you choose to have your blood tests done at a lab other than Fox Valley Wellness, please have the blood drawn at least 8-10 days prior to your scheduled appointment. This allows for test processing time and fax/mail delivery to our office. If you choose to use the services at Fox Valley Wellness be assured we utilize the services of several reputable laboratories that we feel meet the specific needs of your health conditions.

We ask that you not call the office to check the status of your test results. If your results are within normal ranges they will be discussed with you at your next scheduled appointment. If abnormal results are reported, our office will contact you and our nursing staff will discuss Dr. Meress' recommendations.

FOLLOW UP VISITS

Your medical condition and/or tests may require follow-up appointments. We ask that you schedule your appointment before you leave the office. By doing this you are assured a return visit in the time frame requested by Dr. Meress.

The nurses assist our doctors with scheduled patient appointments. We ask you respect Dr. Meress and our nursing staff's time with scheduled appointments. Thus, it would be greatly appreciated if you reserve your questions for your scheduled follow-up appointment and not utilize a "walk-in basis" to have your questions answered.

TIMELY ARRIVALS

Your scheduled appointment time as well as other patients scheduled times will be honored by your timely arrival for your appointment. Early arrival allows our staff adequate time to perform in-office procedures. This request provides for a full utilization of your scheduled time with Dr. Meress. Late arrivals may cause your appointment to be cancelled.

TELEPHONE CALLS

The following issues relate to telephone calls frequently received by our office. We ask you follow these recommendations:

- If you have a condition that is life threatening, please dial 911 or go to the nearest emergency room.
- If you have an issue that relates to care provided by your primary care physician, please contact that physician.

PAYMENT POLICY

Fox Valley Wellness Center/Midwest Hyperbarics is a cash-based facility. Payment must be paid in FULL at time of service. Upon request, we will complete and mail a claim form to you which you can use to submit to your insurance company for reimbursement directly to you. FVWC does not offer payment plans. FVWC accepts cash, personal check, Visa, MasterCard & Discover.

LABORATORY AND INTRAVENOUS SCHEDULE

Lab blood draws must be completed before 3:00 P.M. to allow adequate processing time and same day shipment to the appropriate lab.

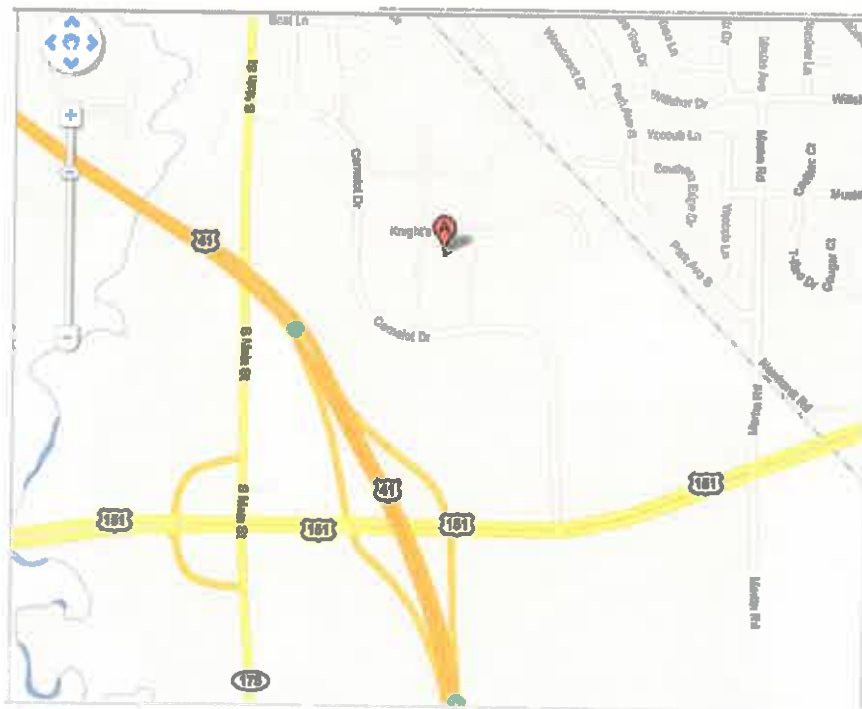
Intravenous therapy appointments are available after 9:30 A.M. unless prior arrangements have been made.

Thank you
Steven G. Meress, M.D.
Staff of Fox Valley Wellness Center/Midwest Hyperbarics



Fox Valley Wellness Center/Midwest Hyperbarics is located at

180 Knights Way
Fond du Lac, WI 54935



For people coming from the north: Take Hwy 41 south to the south side of Fond du Lac. Exit 151 North (also known as the bypass or exit 95). Turn left at the end of the off ramp. Follow 151 North for about ¼ mile and turn left on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the east and northeast: Take the 151 bypass around the east and south portions of Fond du Lac to Camelot Drive. Turn right on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the south (up Hwy 41): Exit at US 151 North (bypass/ exit 95). Turn right off the exit ramp. Go about ¼ mile and turn on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the west: Take Hwy 151 North (going east) connecting with Hwy 41 (southbound). Follow 151 North for about ¼ mile past Hwy 41 and turn left on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.



Fox Valley Wellness Center | 1600 Appleton Way Fond du Lac, WI 54935 | 920-825-6784 LIFE 04307 | 920-922-4111 04307

PATIENT REGISTRATION 01/01/2016

PATIENT

Patient Name : _____ **DOB** __/__/__

Address: _____ **Phone#** _____

City/State/Zip: _____ **County** _____ **Cell #** _____

Marital Status: S / M / D **Sex:** Male / Female **Maiden Name:** _____

Social Security # _____ **Email Address:** _____

Responsible Party for Medical Expenses

Parent Self Spouse *(if self go to insurance section)* **Phone** _____

Parent or Spouse's Name _____ **DOB** __/__/__ **SS#** _____

Address _____ **Employer** _____

Medical Insurance Company

Primary Insurance: _____ **Group#** _____ **ID#** _____

Date of Birth of Insured: __/__/__

Subscriber Name: _____ **Covers:** Self Family **Effective Date:** __/__/__

Secondary Insurance: _____ **Group#** _____ **ID#** _____

Subscriber Name: _____ **Covers:** Self Family **Effective Date:** __/__/__

Date of Birth of Insured: __/__/__

Emergency Contact

Name: _____ **Relationship:** _____

Street: _____ **Phone:** _____

City/State/Zip: _____

Authorization for Release of Information

Authorization is hereby granted to release to the above named Insurance Company. Such information may be necessary for the completion of my clinic claims. I understand I am financially responsible for charges not covered by insurance and assign any insurance benefits to above said clinic.

Signature _____ **Date:** _____

Who do we thank for referring you to us today? _____

FOX VALLEY WELLNESS CENTER
180 KNIGHTS WAY
FOND DU LAC, WI 54935

FAX: 920-273-0480
TELEPHONE: 920-922-5433

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME _____ DOB _____

ADDRESS _____ PHONE (____) _____

**ORGANIZATION AUTHORIZED TO DISCLOSE
PATIENT'S HEALTH INFORMATION**

**ORGANIZATION or INDIVIDUAL AUTHORIZED TO
RECEIVE PATIENT'S HEALTH INFORMATION**

Fox Valley Wellness Center
NAME OF HEALTH CARE PROVIDER/OTHER

NAME OF PERSON/ORGANIZATION/FACILITY

180 Knights Way

STREET ADDRESS

Fond du Lac, WI 54935

CITY/STATE/ZIP

CITY/STATE/ZIP

Fax Number _____

HEALTH INFORMATION TO BE DISCLOSED _____

PURPOSE FOR NEED OF DISCLOSURE (Check applicable information)

Further Medical Care Legal Investigations At the risk of the individual
 Insurance eligibility/benefits Other _____

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION ARE SET FORTH ON THE BACK
OF THIS AUTHORIZATION**

EXPIRATION DATE: This authorization is good until the following date(s)/event _____
If there is no date or event specified, this authorization will expire one (1) year from the date signed

PROHIBITION OF RE-DISCLOSURE: This information is protected by Federal and Wisconsin Confidentiality laws. Such laws prohibit making any further disclosure of this information unless further Disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise Permitted by such laws. A general authorization for the release of medical or other information is **NOT** Sufficient for this purpose. The Federal rules (42C.F.R. Part 2) restrict any use of the information to Criminally investigate or prosecute any alcohol or drug abuse patient.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP. _____ **DATE** _____

Relationship or authority to act for the patient _____

(If you are signing as a parent of a minor patient listed above, you are declaring that you have not Been denied physical placement of the child because such a placement would endanger the child's Physical, mental or emotional health)

WITNESS (when applicable) _____ Date _____

For office use only: Records picked up by _____ Date _____ Time _____ Initials _____

**AUTHORIZATION FOR DISCLOSURE OF
HEALTH INFORMATION INSTRUCTION SHEET**

This authorization is not valid if one or more required elements are omitted.
Failure to complete this Authorization in its entirety will result in the denial of your request for us to disclose your/the patient's health information.

PATIENT INFORMATION: Fill in the complete name, address, date of birth and telephone number of the individual whose health information you are requesting to be disclosed.

PERSONS/ORGANIZATIONS AUTHORIZED TO DISCLOSE PATIENT'S HEALTH INFORMATION:
Fill in the name of the person or organization and their address.

PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE PATIENT'S HEALTH INFORMATION:
Fill in the name of the person or organization and their address.

HEALTH INFORMATION TO BE DISCLOSED: You are not obligated to authorize a disclosure of your/the Patient's health information. You may wish authorized disclosure of as much or as little of your/the patient's Health information as you wishes.

PURPOSE FOR NEED OF DISCLOSURE: Check applicable category or provide other reason if not listed.

EXPIRATION DATE: This Authorization will be good for one (1) year unless otherwise specified. A valid Authorization must be signed and dated after the date of service or event has taken place

SIGNATURE AND DATE: It is your responsibility to review and understand this Authorization. If you have Any further questions about this Authorization, please contact Medical Records Department.

WITNESS (when applicable): When patient is physically unable to sign his/her entire signature.

You are required to sign and date this Authorization.

If you request health information that has been created after the date of this Authorization, you will Be required to complete another Authorization.

If you are a parent and have been denied physical placement of your child because it would endanger The child's physical, mental or emotional health, the law denies you access to obtain the child's health information.

A legal representative is a person authorized to obtain the patient's health information. This may include the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person who would be authorized in writing by the patient. Proof of such authority is required.

if no spouse survives a deceased patient, an adult member of the deceased patient's immediate family May qualify.

A court appointed temporary guardian to consent to the release of health information may also qualify. Proof of such guardianship is required.

Power of Attorney for Health Care takes effect upon finding that the patient is incapacitated. Two (2) Physicians or one (1) physician and one (1) psychologist, who personally examine that patient and sign a statement that the patient is incapacitated, make this determination. Proof of such Power of Attorney for Health Care is required.

**PATIENT RESPONSIBILITY & COMPLIANCE AT FOX VALLEY WELLNESS
CENTER/MIDWEST HYPERBARICS™**

**STEVEN G. MERESS MD, FACP
JENNI SCHEEL, DNP, FNP-BC, APNP
DONNA J. ABFALL ND
BRIAN BORDEN ND
ROBERT COLEMAN, JR ND**

- Dr. Meress/Dr. Scheel/Dr. Abfall/Dr. Borden/Dr. Coleman and the entire staff at Fox Valley Wellness Center strives to provide you the educational tools to understand your healthcare issues. Help us by being an integral part of your care. Be proactive, read the information we provide and seek out additional resources to foster your ability to understand your illness. Compliance with these recommendations will maximize your healing response.
- Elimination of all caffeine and stimulants.
- Cessation of all nicotine products.
- A light amount of exercise is encouraged. Work at your own pace and try not to overdue. Prefer no sweating activities except Far InfraRed Sauna.
- Compliance relative to dietary recommendations are strongly encouraged.
- Compliance relative to supplements are strongly encouraged.
- You, the patient, are responsible for obtaining your laboratory blood draws at the time your doctor has ordered them. A consequence of non compliance to ordered blood draw times is the absence of blood test results on the day of your appointment. This may influence the intended care plan your doctor would have discussed with you.
- When late blood draw test results are received, a second followup appointment will be scheduled. The doctor will discuss your test results at the appointment. A followup appointment charge may be assessed.
- If urine and saliva samples are needed prior to a doctor visit, you, the patient, are responsible for obtaining your first morning urine at home and fasting per directions until able to provide saliva samples at time of visit. Directions will be mailed.
- Questions relating to prescription medication should be directed to your pharmacy. Refill requests are usually generated from your pharmacy. FVWC will refill prescriptions upon pharmacy fax/telephone requests. Exceptions to this will be antibiotic/pain medications.
- More than five (5) calls between appointments will result in a \$50.00 charge.
- In an effort to meet your immediate concerns, we will schedule a telephone consult with your provider if you have multiple/complex questions between scheduled appointments but you will be responsible for our phone consult fee.
- Maximization of proper sleep and nutrition will positively impact your body's ability to heal.

Patient Signature: _____ Date: _____

FVWC Policies

Initials	Item #	Policy
	1	Emergencies: FVWC will make every attempt to address your health care needs. In the event of an emergency, please dial 911 or seek medical attention at the nearest Emergency Room.
	2	Prescription refills: It is our policy that you should be responsible to know when your medications must be refilled at least one week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. We cannot take weekend, after hours or phone call refill requests. Refills cannot be made if the provider has not seen you for an extended period of time.
	3	Telephone encounters and sick patients: We do not treat new patients or new illnesses over the telephone. Dr. Meress may elect to treat an existing patient seeking continuing care for an existing straightforward illness over the telephone. Telephone consults are provided for a fee starting at \$245.00. Payment by credit card is due at the time of service.
	4	Information: You agree to provide your correct name, current address, cell, work and home telephone number, e-mail address, Social Security number, up-to-date insurance information and a picture at the time of registration. You are responsible to update FVWC with any changes.
	5	Financial responsibility: By your initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If the patient is a minor, the parent or guardian assumes the financial liability.
	6	Payment methods: We accept cash, check and several major credit cards.
	7	Appointments: Our office will schedule appointments as a common courtesy for patients and in consideration of your time. We require a minimum of 48 hours (or the Wednesday before a Monday appointment) notice of cancellation for established patients. A fee of half the scheduled office visit will be charged for non-cancelled and missed appointments. A pattern of non-cancelled appointments may result in discharge from the practice.
	8	Form fees: Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply: (a) single page forms--\$25.00; (b) multi-page forms--\$50.00; (c) FMLA, disability and driver's license forms--\$75.00. Additional fees may apply at the discretion of the practice.
	9	Medical records: The medical chart is the property of FVWC. However, copies of your pertinent medical information are available upon request. FVWC does charge a fee for copies of the records & needs a HIPPA form signed before records can be sent.
	10	Accident & Worker's Compensation: Although our office is happy to treat your medical conditions, if the cause is related to an auto or work accident you will be required to pay full fees at the time of your visit.
	11	Statement policy: Our office sends patient statements each month. Payment is due upon receipt. Delay in insurance processing or payment does not release your responsibility for payment.

FVWC Policies

	12	Collection and bank fees: Banks charge us for a check that does not clear or cannot be cashed. You agree to be liable for all charges levied against FVWC by our financial institution. Additionally, FVWC will charge you a fee of \$25.00.
	13	Patient discharge: FVWC reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of quality care conditions, the practice may discharge you for failure to comply with treatment plan(s) as outlined by Dr. Meress. Discharge may also result if profanities, inappropriate language or threats are made against FVWC or any members of its staff.
	14	Payment: FVWC is a cash-based facility meaning that payment must be made in full at time of service. NO EXCEPTIONS! Upon request, we will complete and mail a claim form to you which you can use to submit to your insurance company for reimbursement. Any payment made by your insurance company would be mailed directly to you. FVWC has chosen to "Opt Out" of Medicare so this does not apply to patients that have Medicare or governmental insurance.
	15	Laboratory order charges: FVWC assumes no responsibility for charges incurred for ordered laboratory testing. In choosing to have tests run, the patient accepts all financial responsibilities.

I have read and understand all the terms of this policy. My initials and signature below indicate I fully understand each item and agree to all of the above stated terms.

Signature: _____

Printed Name: _____ Date: _____

PRESCRIPTION MEDICATION & SUPPLEMENT DATA SHEET
EXAMPLES ARE USED

NAME:

TODAY' S DATE:

YOUR PHARMACY:

YOUR PHARMACY'S TELEPHONE NUMBER:

ALLERGIES: FOOD, DRUG, ENVIRONMENTAL ETC

PRESCRIPTION MEDICATIONS

NAME	STRENGTH	NUMBER PER DAY	AM/PM
Lasix EXAMPLE	10mg	2	PM
Etc			

SUPPLEMENTS

NAME	STRENGTH	NUMBER PER DAY	AM/PM
Calcium EXAMPLE	500mg	1	AM

For Fish Oil supplements please include the following: EPA= mg/serving
DHA= mg/serving

If you choose to have blood tests drawn outside of Fox Valley Wellness please provide the name and telephone number of the laboratory you would use

LABORATORY:

TELEPHONE:

NAME _____ DATE _____

LIFESTYLE HISTORY

DIET

(list specific foods)

- | | | | |
|---------------|-------|------|-------|
| 1. Breakfast | _____ | Time | _____ |
| 2. A.M. Snack | _____ | Time | _____ |
| 3. Lunch | _____ | Time | _____ |
| 4. P.M. Snack | _____ | Time | _____ |
| 5. Dinner | _____ | Time | _____ |
| 6. Late Snack | _____ | Time | _____ |
| 7. Other | _____ | Time | _____ |

- Do you or have you eaten diet foods or drank diet soda on a regular basis? _____
- What is your largest meal? _____
- How many B.M.'s per day? _____
- Have you ever had a Colonoscopy? _____ If yes, when? _____

SLEEP

1. What time do you go to bed? _____
2. How long to fall asleep? _____
3. Do you wake up during the night? _____ How many times? _____
4. Do you dream? _____
5. What time do you wake up? _____ Do you feel refreshed? _____

FEMALES ONLY

1. Menarche age (age of your first period) _____
2. Menopause age _____
3. Days between periods _____ Days of flow _____
4. Symptoms associated (cramping, PMS, etc.) _____
Severity (0-10) _____
5. How many pregnancies? _____ Live births? _____
6. Have you ever taken birth control pills? _____ When & how long? _____
7. When was you last Pap Smear? _____ Last Mammogram? _____

EXERCISE

1. What type of exercise do you do? _____
 2. How many times per week on average _____
 3. What length of time per episode? _____
 4. Have you ever had a bone density (DEXA) test? _____ If yes when? _____
- What type of vaccinations have you had (childhood included) _____
- _____
- _____

MEDICAL HISTORY FORM

NAME _____ AGE _____ TODAY'S DATE _____

1. MEDICAL HISTORY

A. List past or present illnesses, injuries, surgeries, hospitalizations:

TYPE	DATES	TREATMENTS
-------------	--------------	-------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Any physical limitations?

C. List any prescription or OTC medications, vitamins, minerals, or supplements on a daily basis

D. List allergies (ex-hay fever, bee sting, foods, medications, molds, dust, animals, latex, etc.)

E. Family History

History of premature sudden death, heart attack, stroke, diabetes, cancer, hypertension or asthma?

F. Have you had any metal devices placed in your body? I.e. dental amalgams or restorations, prosthetic joints, IUD's, vascular stents or have you reacted to any metal- jewelry, buttons, cosmetics

YES	NO	DESCRIBE
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G. Habits

	<u>YES</u>	<u>NO</u>	<u>AMOUNT</u>
--	-------------------	------------------	----------------------

Cigarettes	_____	_____	_____
Alcohol	_____	_____	_____
Caffeine	_____	_____	_____

H. Social History

Marital Status _____	Children _____
Occupation _____	Frequent travel _____

I. Do you now have, or have you sought medical care for any of the following?

<u>MENTAL HEALTH</u>	<u>NO</u>	<u>YES</u>	<u>DESCRIBE</u>
-----------------------------	------------------	-------------------	------------------------

Depression	_____	_____	_____
Insomnia	_____	_____	_____
Fatigability	_____	_____	_____
Eating Disorders	_____	_____	_____
Other	_____	_____	_____

<u>HEAD AND NECK</u>	<u>NO</u>	<u>YES</u>	<u>DESCRIBE</u>
-----------------------------	------------------	-------------------	------------------------

Frequent headaches	_____	_____	_____
Chronic Sinus	_____	_____	_____
Glasses/Contacts	_____	_____	_____
Hearing Difficulty	_____	_____	_____
Sores of the mouth	_____	_____	_____
Root Canal	_____	_____	_____
Other _____	_____	_____	_____

<u>LUNGS/BREATHING</u>	<u>NO</u>	<u>YES</u>	<u>DESCRIBE</u>
Wheezing	_____	_____	_____
Shortness of breath	_____	_____	_____
Chronic Cough	_____	_____	_____
Asthma	_____	_____	_____
 <u>HEART AND CIRCULATION</u>			
Chest pains	_____	_____	_____
Irregular heart beats	_____	_____	_____
Leg/feet swelling	_____	_____	_____
High blood pressure	_____	_____	_____
Exertional	_____	_____	_____
Heart murmur	_____	_____	_____
<u>DIGESTIVE</u>			
Recent weight changes	_____	_____	_____
Diarrhea/Constipation	_____	_____	_____
Nausea/Vomiting	_____	_____	_____
Jaundice (yellow skin or eyes)	_____	_____	_____
<u>KIDNEY/BLADDER REPRODUCTIVE</u>			
Abnormally colored urine	_____	_____	_____
Kidney disease	_____	_____	_____
Frequent urine infections	_____	_____	_____
Severe menstrual cramps	_____	_____	_____
<u>CANCER</u>			
Precancerous condition	_____	_____	_____
Cancer	_____	_____	_____
<u>HEMATOLOGICAL</u>			
Blood Transfusions	_____	_____	_____
HIV, Hepatitis	_____	_____	_____
<u>BONE/JOINT/MUSCLE</u>			
Hernia	_____	_____	_____
Carpal Tunnel Syndrome	_____	_____	_____
Joint pain/arthritis	_____	_____	_____
Strain/sprain	_____	_____	_____
<u>SKIN</u>			
Rashes	_____	_____	_____
Other skin problems	_____	_____	_____
<u>NEUROLOGIC</u>			
Seizures	_____	_____	_____
Tremors	_____	_____	_____
Loss of consciousness	_____	_____	_____
<u>ENDOCRINE</u>			
Diabetes	_____	_____	_____
Thyroid problems	_____	_____	_____
Unexplained weight changes	_____	_____	_____
Other glandular problems	_____	_____	_____

PATIENT SIGNATURE _____ DATE _____



YEAST QUESTIONNAIRE

ADULT

NAME: _____

In Section A, circle the score for each YES answer. For Sections B and C scores are indicated. Record total scores at the end of the questions. Add the totals to get your GRAND TOTAL.

SECTION A - HISTORY

1. Have you taken tetracyclines (Sumycin, Permycin, Vebramycin, Minocin, etc.) or other antibiotics for acne for one month or longer? 35
2. Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory or other infections for two months or longer or in shorter courses four or more times in a one year period? 35
3. Have you ever taken a "broad spectrum" antibiotic drug? 5
4. Have you ever been bothered by persistent prostatitis, vaginitis or other productive organ problems? 25
5. Have you been pregnant: two or more times? 5
one time? 3
6. Have you taken birth control pills for more than two years? 15
For six months to two years? 5
7. Have you taken prednisone, Decadron or other cortisone-type drugs for more than two weeks? 15
for two weeks or less? 5
8. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke:
Moderate to severe symptoms 20
Mild symptoms 5
9. Are symptoms worse on damp, muggy day or in moldy places? 20
10. Have you had athlete's foot, ring worm, "jock itch" or other chronic fungus infections of the skin or nails?
Severe or persistent 20
Mild to moderate 10
11. Do you crave sugar? 10
12. Do you crave breads? 10
13. Do you crave alcoholic beverages? 10
14. Does tobacco smoke really bother you? 10

SECTION B - MAJOR SYMPTOMS

- Enter the appropriate score each symptom below
- | | |
|---|----------------|
| If a symptom is occasional or mild | Score 3 points |
| If a symptom is frequent or moderately severe | Score 5 points |
| If a symptom is severe or disabling | Score 9 points |
1. Fatigue or lethargy _____
 2. Feeling of being "drained" _____
 3. Poor memory _____
 4. Feeling "spacey" or "unreal" _____
 5. Depression _____
 6. Numbness, burning or tingling _____
 7. Muscle aches _____
 8. Muscle weakness or paralysis _____
 9. Joint pain _____
 10. Abdominal pain _____
 11. Constipation _____
 12. Diarrhea _____
 13. Bloating _____
 14. Troublesome vaginal discharge _____
 15. Persistent vaginal burning or itching _____
 16. Prostatitis _____
 17. Impotence _____

18. Loss of sexual desire _____
19. Endometriosis _____
20. Cramps and/or other menstrual irregularities _____
21. Premenstrual tension _____
23. Erratic vision _____

SECTION C - OTHER SYMPTOMS

- Enter the appropriate score for each symptom below
- | | |
|---|----------------|
| If a symptom is occasional or mild | Score 1 point |
| If a symptom is frequent or moderately severe | Score 2 points |
| If a symptom is severe or disabling | Score 3 points |
1. Drowsiness _____
 2. Irritability or jitteriness _____
 3. Incoordination _____
 4. Inability to concentrate _____
 5. Frequent mood swing _____
 6. Headache _____
 7. Dizziness/loss of balance _____
 8. Pressure above ears, feeling of head tingling _____
 9. Itching _____
 10. Other rashes _____
 11. Heartburn _____
 12. Indigestion _____
 13. Belching and intestinal gas _____
 14. Mucus in stool _____
 15. Hemorrhoids _____
 16. Dry Mouth _____
 17. Rash or blisters in mouth _____
 18. Bad breath _____
 19. Joint swelling or arthritis _____
 20. Nasal congestion or discharge _____
 21. Postnasal drip _____
 22. Nasal itching _____
 23. Sore or dry throat _____
 24. Cough _____
 25. Pain or tightness in chest _____
 26. Wheezing or shortness of breath _____
 27. Urgency or urinary frequency _____
 28. Burning on urination _____
 29. Falling vision _____
 30. Burning or tearing of eyes _____
 31. Recurrent infections or fluid in ears _____
 32. Ear pain or deafness _____

Scores: Section A _____ Section B _____ Section C _____
 The GRAND TOTAL SCORE will help determine if your health problems are yeast connected. Scores in women will run higher because more questions apply to women than to men.

Yeast connected health problems are almost **CERTAINLY PRESENT** in women with scores over 180 and men with scores over 140.

Yeast connect with health problems are almost **PROBABLY PRESENT** in women with scores over 120 and in men with scores over 90.

Yeast connected health problems are almost **POSSIBLY PRESENT** in women



"An integrated medical approach to complement your lifestyle"

SYMPTOM QUESTIONNAIRE

Name _____

If you have amalgam fillings please check how often you have encountered the symptoms below that could possibly signify mercury toxicity. Rate them accordingly to the following scale:

0 = never
1 = rarely

2 = often
3 = always

Central Nervous System

- _____ Irritability.
- _____ Anxiety/nervousness
- _____ Restlessness
- _____ Exaggerated response to stimulation
- _____ Fearfulness
- _____ Emotional instability
- _____ Lack of self control
- _____ Mood swings
- _____ Fits of anger
- _____ Violent behavior
- _____ Loss of self-confidence
- _____ Indecision
- _____ Shyness or timidity
- _____ Easily embarrassed
- _____ Loss of memory
- _____ Insomnia
- _____ Depression/despondency
- _____ Withdrawal
- _____ Suicidal tendencies
- _____ Manic depression
- _____ Numbness/tingling of hands, feet, fingers, or toes
- _____ Muscle weakness
- _____ Tremors/trembling of hands
- _____ Headache
- _____ Confusion
- _____ Poor physical coordination
- _____ Slurred speech

Digestive Tract

- _____ Nausea or vomiting
- _____ Colitis
- _____ Bloating
- _____ Heartburn
- _____ Constipation
- _____ Blood in stool
- _____ Crohns disease
- _____ Diarrhea
- _____ Abdominal pain
- _____ Belching, passing gas
- _____ Poor appetite
- _____ Food sensitivities
- _____ Binge eating & drinking
- _____ Craving certain foods
- _____ Excessive weight gain
- _____ Weight loss
- _____ Compulsive eating

Head, neck & Oral Cavity

- _____ Bleeding gums
- _____ Loosening of teeth
- _____ Excessive salivation
- _____ Foul breath
- _____ Metallic taste
- _____ Burning sensation lip & tongue
- _____ Canker sores
- _____ Gagging
- _____ Frequent need to clear throat

**FOX VALLEY WELLNESS CENTER / MIDWEST HYPERBARICS
180 KNIGHTS WAY
FOND DU LAC, WI 54935**

REQUIRED DISCLOSURE AND CONSENT FOR DIAGNOSIS AND TREATMENT OF PERSISTENT LYME DISEASE

There is considerable uncertainty regarding the diagnosis and treatment of Lyme disease. No single diagnostic and treatment program for Lyme disease is universally successful or accepted. Current testing for Lyme disease can be problematic and may lead to false results. If you are tested for Lyme disease and the results are positive, this does not necessarily mean that you have contracted Lyme disease. In the alternative, if the results are negative, this does not necessarily mean that you have not contracted Lyme disease. If you continue to experience symptoms or have other health concerns, you should contact your health care provider and inquire about the appropriate of additional testing or treatment.

Medical opinion is divided, and two schools of thought regarding diagnosis and treatment exist. Each of the two schools of thought is described in peer-reviewed, evidence-based treatment guidelines. Until we know more, patients must weigh the risks and benefits of treatment in consultation with their doctor.

My Diagnosis. The diagnosis of Lyme disease is primarily a clinical determination made by my doctor based on my exposure to ticks, my report of symptoms, and my doctor's observation of signs of the disease, with diagnostic tests playing a supportive role.

Doctors differ in how they diagnose Lyme disease.

- Some physicians rely on the surveillance case criteria of the CDC for clinical diagnosis. These physicians may fail to diagnose some patients who actually have Lyme disease. For these patients, treatment will either not occur or will be delayed.
- Other physicians use broader clinical criteria for diagnosing Lyme disease. These physicians believe it is better to err on the side of treatment because of the serious consequences of failing to treat active Lyme disease. These physicians sometimes use the antibiotic responsiveness of a patient to assist in their diagnosis. Since no treatment is risk-free, use of broader clinical criteria to diagnose disease could in some cases expose patients to increased treatment complications. This approach may result in a tendency to over diagnose and over treat Lyme disease.

My Treatment Choices. The medical community is divided regarding the best approach for treating persistent Lyme disease. (1) Many physicians follow the treatment guidelines of the Infectious Diseases Society of America (IDSA) that recommend short-term treatment only and view the long-term effects of Lyme disease as an autoimmune process or permanent damage that is unaffected by antibiotics. (2) Other physicians believe that the infection persists, is often associated with other tick-borne co-infections, is difficult to eradicate, and therefore requires long-term treatment with intravenous, intramuscular, or oral antibiotics, frequently in high and/or combination or pulsed dosing. These physicians follow the guidelines promulgated by the International Lyme and Associated Diseases Society (ILADS), which recognize that commercial diagnostic tests may be insensitive and that diagnosis and treatment must be based on the physician's clinical judgment and that the risk/benefit of any treatment must be individualized.

Potential Benefits of Treatment. Some clinical studies support longer term treatment approaches, while others do not. The experience in this office is that although most patients improve with continued treatment, some do not.

Risks of Treatment. There are potential risks involved in using any treatment, just as there are in foregoing treatment entirely. Some of the problems with antibiotics may include (a) allergic reactions, which may manifest as rashes, swelling, and difficulty with breathing, (b) stomach or bowel upset, or (c) yeast infections. Long term antibiotic treatment can have serious, irrevocable consequences. Severe allergic reactions may require emergency treatments, while other problems may require suspension of treatment, or adjustment of medication. Other problems such as adverse effects on liver, kidneys, gallbladder, or other organs may occur.

Factors to Consider in my Decision. No one knows the optimal treatment of symptoms that persist after a patient is diagnosed with Lyme disease and treated with a simple short course of antibiotic therapy. The appropriate treatment may be supportive therapy without the administration of any additional antibiotics. Or, the appropriate treatment might be additional antibiotic therapy. If additional antibiotic therapy is warranted, no one knows for certain exactly how long to give the additional therapy. By taking antibiotics for longer periods of time, I place myself at greater risk of developing side effects. By stopping antibiotic treatment, I place myself at greater risk that a potentially serious infection will progress. Antibiotics are the only form of treatment shown to be effective for Lyme disease, but not all patients respond to antibiotic therapy and antibiotic therapy has the risks discussed above. There is no currently available diagnostic test that can demonstrate the eradication of the Lyme bacteria from my body. Other forms of treatment designed to strengthen my immune system also may be important. Some forms of treatment are only intended to make me more comfortable by relieving my symptoms and do not address any underlying infection.

My decision about continued treatment may depend on a number of factors and the importance of these factors to me. Some of these factors include (a) the severity of my illness and degree to which it impairs my quality of life, (b) whether I have co-infections, which can complicate treatment, (c) my ability to tolerate antibiotic treatment and the risk of major and minor side effects associated with the treatment, (d) whether I have been responsive to antibiotics in the past, (e) whether I relapse or my illness progresses when I stop taking antibiotics, and (f) my willingness to accept the risk that, left untreated, a bacterial infection potentially may get worse.

For example, if my illness is severe, significantly affects the quality of my life, and I have been responsive to antibiotic treatment in the past, I may wish to continue my treatment. However, if I am not responsive to antibiotics, I may wish to terminate treatment. I will ask my doctor if I need any more information to make this decision and am aware that I have the right to obtain a second opinion at any time if I think this would be helpful.

My doctor has made no written or verbal agreement with me and has made no promise or warranties outside of those outlined in this consent document and has not pressured me as regards my decision. I make this decision as regards my treatment for Lyme disease of my own free will. All of my questions have been answered and I fully understand the decision I must make and the significance of my decision to my health care. _____ Initial

I am over the age _____ (age of consent in my state) and I realize that the choice of treatment approach to use in treating my condition is mine to make in consultation with my physician. After weighing the risks and benefits of the two treatment approaches, I have decided: **(CHECK ONE)**

- To treat my Lyme disease through a treatment approach that relies heavily on clinical judgment and may use antibiotics until my clinical symptoms resolve. I recognize that this treatment approach does not conform to IDSA guidelines and that insurance companies may not cover the cost of some or all of my treatment.
- Only to treat my Lyme disease with antibiotics for thirty days, even if I still have symptoms.
- Not to pursue antibiotic therapy.

I understand the benefits and risks of the proposed course of treatment, and of the alternatives to it, including the risks and benefits of foregoing treatment altogether. My questions have all been answered in terms I understand. All blanks on this document have been filled in as of the time of my signature.

Signature: _____

Date: _____

Print Name: _____

Witness: _____

SYMPTOM OR SIGN	CURRENT SEVERITY					CURRENT FREQUENCY			
	NONE	MILD	MODERATE	SEVERE	NA	NEVER	OCCASSIONAL	OFTEN	CONSTANT
Light Sensitivity									
Sound sensitivity									
Vision: double, blurry, floaters									
Rash, new stretch marks									
Hearing, buzzing, ringing, decreased hearing									
increased motion sickness vertigo, spinning									
Off balance, "tippy" feeling									
Lightheadedness wooziness, unavoidable need to sit or lie									
Tingling, numbness, burning stabbing sensations shooting pains, skin hypersensitivity									
Facial paralysis-bell's palsy									
Dental pain									
Chronic cough									
Neck creaks and cracks stiffness, neck pain									
Fatigue, tired poor stamina									
Insomnia, fractioned sleep early awaking									
Excessive night time sleep									
Napping during the day									
Unexplained weight gain									
Unexplained weight loss									
Unexplained hair loss									
Pain in genital area									
Menstrual irregularity									
Loss of Libido									
Unexplained milk production breast pain									
Irritable bladder or bladder dysfunction									
Erectile dysfunction									
Queasy stomach or nausea									
Heartburn, stomach pain									
Constipation									
Ear Pain									
Diarrhea									
Abdominal pain, cramps									
Abdominal bloating after eating or taking Probiotics									
Heart murmur or valve prolapse?									
Heart palpitations or skips									
Heart block on EKG									
Chest wall pain or ribs sore									
Head congestion									
Unexplained chronic cough									
Night sweats									
Symptoms flare every 4wks									
Degree of disability									