

ROSELLE CENTER FOR HEALING

METABOLIC SCREENING QUESTIONNAIRE

Patient Name: _____ Social Security: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Age: _____ Date of Birth: _____ Sex: M / F Marital Status M S W D

Email: _____ Cell Phone: _____ Shoe size: _____

Occupation: _____ Employer: _____

Address: _____ Office Number: _____

Insurance Company: _____ Address: _____

Name of Spouse: _____ Occupation: _____

Patients nearest relative: _____ Phone Number: _____

How did you hear about us? _____ (Please put in name of person or media)

Female: Are you pregnant: ___ Yes ___ No Date of last Physical: _____

What operations have you had? _____

Purpose for this appointment (Major Complaint): _____

Read each of the following symptoms based upon your typical health profile for:

___ INITIAL TEST: The past 30 day's ___ RETEST: The past 48 hours

POINT SCALE

0= Never

1= Occasionally have it, **effect is not severe**

2= Occasionally have it, **effect is severe**

3= Frequently have it, **effect is not severe**

4= Frequently have it, **effect is severe**

HEAD

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision

(does not include near or far-sightedness)

Total _____

EARS

- _____ Itchy ears
- _____ Earaches, ear infections
- _____ Drainage from ears
- _____ Ringing in ears, hearing loss

Total _____

NOSE

- _____ Stuffy nose
- _____ Sinus Problems
- _____ Hay fever
- _____ Sneezing attacks
- _____ Excessive mucus formation

Total _____

MOUTH
THROAT

- _____ Chronic coughing
- _____ Gagging, frequent need to clear throat
- _____ Sore throat, hoarseness, loss of voice
- _____ Swollen or discolored tongue, gums, lips
- _____ Canker sores

Total _____

SKIN

- _____ Acne
- _____ Hives, rashes, dry skin
- _____ Hair Loss
- _____ Flushing, hot flashes
- _____ Excessive sweating

Total _____

HEAT

- _____ Irregular or skipped heartbeat
- _____ Rapid or pounding heartbeat
- _____ Chest Pain

Total _____

LUNGS

- _____ Chest congestion
- _____ Asthma
- _____ Shortness of Breath
- _____ Difficulty Breathing

Total _____

DIGESTIVE
TRACT

- _____ Nausea, vomiting
- _____ Diarrhea
- _____ Constipation
- _____ Bloating feeling
- _____ Belching, passing gas
- _____ Heartburn
- _____ Intestinal/Stomach pain

Total _____

JOINT MUSCLE	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pain in arches or joint Arthritis Stiffness or limitation of movement	Total _____
WEIGHT	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Binge eating/drinking Craving certain foods Excessive weight Compulsive eating Underweight	Total _____
ENERGY ACTIVITY	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fatigue Apathy, lethargy Hyperactivity Restlessness	Total _____
MIND	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Poor memory Confusion, poor comprehension Poor concentration Poor physical coordination Difficulty in making decisions Stuttering or stammering Slurred speech Learning disabilities	Total _____
EMOTIONS	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mood swings Anxiety, fear nervousness Anger, irritability, aggressiveness Depression	Total _____
OTHER	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Frequent illness Frequent or urgent urination Genital itch or discharge	Total _____
GRAND TOTAL			TOTAL _____

PAYMENT IS EXPECTED AT TIME OF VISIT:

Name of person Responsible for Payment: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged **DIRECTLY** to me and that I am personally responsible for payment. I also understand that all outstanding balances 90 days and over will be subject to 9.5% interest. I further understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I further agree and understand that If I fail to pay this bill and it is turned over to any attorney or (collection agency) for collections that I will be responsible for all legal fees, court fees and collection agency fees.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____