Natural Wellness Screening

IS YOUR HEALTH PROGRAM IMPROVING YOUR HEALTH?

Your Natural Wellness Screening (NWS) results, at the very least, will serve as a reality check for your present state of health. At best, they will serve as a valuable focusing tool for you and your health care provider to set the stage for improvements in your health which will both delight you and free you from many of your present health concerns.

TO YOUR GOOD HEALTH

At last estimate, more than 50% of consumers are integrating some form of alternative therapy into their healthcare program in hopes of living longer and healthier. In particular, whole foods, nutritional supplements and herbal therapies are gaining widespread recognition for their ability to prevent, control, or even reverse so many of the diseases that affect millions.

We are becoming more aware than ever of some of the health options available to us. The Natural Wellness Screening, and the information it reveals can help empower you to take more control of your own health.

HOW HEALTHY AM I?

Your Natural Wellness Screening, is designed to screen for key biomarkers which, if abnormal, could lead to accelerated aging and more serious illness.

*Natural Wellness Screening (NWS)**

Consists of the following assessments:

- ❑ Client Information Sheet
- ❑ Detoxification Questionnaire
- ❑ Context of Care Questionnaire
- ❑ Bioelectrical Impedance Analysis (BIA) ($30)
- ❑ Saliva pH & Zinc Tally ($5.00)
- ❑ Iodine Paint ($2.00)
- ❑ Blood Pressure and Pulse ($5.00)
- ❑ Adrenal Function Test ($5.00)
- ❑ Report of Findings* ($10.00)

The Natural Wellness Screening takes 15 minutes to complete and costs $30.00* ($57.00 Value)

**Natural Care Consultation and protocols are available at an additional cost. Please refer to the Natural Care Services professional fee sheet and ask for additional information.*

Pre-Test Protocols for the Natural Wellness Screening

To maximize the accuracy of your Natural Wellness Screening please do the following:

- Do not eat a **full meal** 4-5 hours prior to testing. A light/small meal is acceptable 2-3 hours prior to test.
- Do not exercise for at least 8 hours prior to testing.
- Do not consume caffeine (or decrease the amount) the day of testing.
- Do not consume alcohol 6-8 hours before testing.
- Be well hydrated, consuming 6-8 cups of water 24 hours prior to testing.
- Consume **only** water (no food, gum, candy, toothpaste, etc.) **for 1 hour prior to testing**.
- Wear shoes and socks that are easily removed.

The Natural Wellness Screening is available by appointment only. Call 405-936-3333.

Never Gamble With Something As Important As Your Health!

Keith D. Bishop, Clinical Nutritionist **HEALTH NUT *RX*™ *NATURAL CARE SOLUTION***

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Bioelectrical Impedance Analysis (BIA)

BIA is the study of the physical components of the body. This is accomplished with electrical impedance plethysmography, an FDA approved bio-impendence body composition and fluid analysis test. With body composition and fluid analysis, we can tell what is actually going on inside the body. Additional information is available at http://www.rjlsystems.com/research/bia-principles.html

Body Composition (BCM/ECM/Body Fat/FFM)

The human body is made up of two components, fat and fat free mass. The BIA evaluation has the ability to separate the fat free mass into two additional compartments, Body Cell Mass (BCM) and Extra-Cellular Mass (ECM). The ability to create these two compartments is known as three-compartment body composition. Body Fat is the storage of potential energy, storing 3500 calories per pound. BCM is where body fat is burned when doing work or exercise and includes your muscles and organs. ECM, like bone and plasma provide transportation of nutrients, waste and fluids and support for the body. FFM, Fat Free Mass is the total body weight minus body fat.

Body Fluids (ICW & ECW)

Total Body Water (TBW) is the sum of Intra-Cellular Water (ICW) and Extra-Cellular Water (ECW). Usually, about 60% of total body water in the healthy adult is Intra-Cellular Water and 40% is Extra Cellular Water.

Body Mass Index (BMI)

BMI stands for "Body Mass Index," a ratio between weight and height. It is a mathematical formula that correlates somewhat with body fat. In general, if your BMI is high, you may have an increased risk of developing certain diseases including hypertension, cardiovascular disease, dislipidemia, adult-onset diabetes (Type II), sleep apnea, osteoarthritis, female infertility, and others. Prevention of further weight gain is important and weight reduction may be desirable. BMI is a better predictor of disease risk than body weight alone. Competitive athletes, body builders, women who are pregnant or lactating, growing children or frail sedentary elderly individuals should not use BMI as the basis for estimating their body fat content.

Basal Metabolism Rate (BMR) Basal and Activity Calories (BAC)

BMR is how many calories your body uses when lying down at rest for 24 hours. BAC is how many calories your body uses in a day doing routine, personal activities. BAC does not include how many calories your body uses for exercise or physical labor.

Phase Angle (PA)

Phase angle is based on total body resistance and reactance and is independent of height, weight and body fat. Lower phase angles appear to be consistent with either cell death or a breakdown of the cell membrane. Higher phase angles appear to be consistent with large quantities of intact cell membranes and body cell mass. Phase angle is a predictor of outcome and indicates the course of disease or increases as the result of optimal health based on good nutrition and consistent exercise.

Capacitance (CAP)

All living things are made of cells. Cells are membrane bounded compartments filled with a concentrated solution of essential fatty acids, chemicals and salts. The cell membrane maintains a gradient difference across it which is essential to cell survival. The cell membrane functions as a permeable barrier separating the intra-cellular and extra-cellular components. Capacitance is not effected by weight or body fat. It is a measurement of cell membrane health and can change dramatically depending on disease or good health. This electrical gradient is necessary to support movement of oxygen, carbon dioxide, and nutrients. A person's electrical capacitance will increase or decrease depending on the health and number of cells.

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Confidential **Client Information Sheet** *Confidential*

This consultation is intended to improve the use of bio-identical hormones, prescription, non-prescription medicine and products, non-drug approaches to self-care and/or referral to other health care providers.

Name ____ Date____________________

Address ___________________________________ Age ______ Gender ☐ Male ☐ Female

City __________________________ State _____ Zip ____________ Birth Date ___/___/___

Day Phone (____) ____-______ Mobile Phone (____) ____-______ Night Phone (____) ____-______

Fax Number (____) ____-______ Best time to call ____________________________________

E-mail Address ____

Would your prefer test results be mailed, faxed or emailed to you? _______________________

Height _________ Weight ______ Race _____________ Marital Status ☐ Married ☐ Single

Occupation ____

Whom may we thank for your referral? ____

Blood Type__________________

Do you use tobacco? ☐ Smoke ☐ Chew ☐ Other ☐ None

Do you use alcohol? ☐ None ☐ Occasionally How much? ____________________

Which do you consume most often? ☐ Home Cooking ☐ Low fat ☐ Fast food

How many servings of fruits and vegetables do you consume each day? ☐ None ☐ 1-3 ☐ 4-6 ☐ 7 Plus

How often do you exercise? ☐ None ☐ Occasional ☐ 2-3 Times a week ☐ 4-5 Times a week

Pregnant? ☐ Yes ☐ No Breast Feeding? ☐ Yes ☐ No

Do you drink filtered or bottled water? ☐Yes ☐ No

Food Allergies ____

Supplement Allergies (Vitamins, minerals, herbs, etc.) __________________________________

____

Medication Allergies ____

Medication Reactions____

Medical History

- ☐ Arthritis
- ☐ Bronchitis
- ☐ Asthma
- ☐ Allergies / Hay Fever
- ☐ Emphysema
- ☐ Cancer _______________
- ☐ Chronic Tiredness / Fatigue
- ☐ Thyroid dysfunction
- ☐ Digestion problems
- ☐ Glaucoma
- ☐ Angina / Heart Attack
- ☐ Heart Disease ___________
- ☐ Do you have a pacemaker?
- ☐ Do you have a defibrillator?
- ☐ High Cholesterol
- ☐ High Homocysteine
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Osteoporosis
- ☐ Hormone Imbalances
- ☐ Prostate
- ☐ Depression
- ☐ Headaches / Migraine
- ☐ Kidney Disease
- ☐ Kidney / Bladder disorders
- ☐ Liver Disease
- ☐ Chronic Infections

Please turn this sheet over and complete the next page

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Other health concerns ____

____

____

____

Health Care Providers

Primary Care Physician ______________________ Phone (____) ____-______

Dentist ______________________ Phone (____) ____-______

Chiropractor ______________________ Phone (____) ____-______

Pharmacy ______________________ Phone (____) ____-______

May I contact your health care provider(s) for additional information or to inform them of health concerns that I may have? ☐ Yes ☐ No

Today's Health Concern(s)

____

____

Current Prescription Medications

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Current Non-Prescription Medications, Vitamins, Minerals, Herbal Supplements, and Self-Care

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Certification Statement of Client: To the best of my knowledge, the information I have entered on this form is correct.

Client Signature ______________________ Date: ____/____/_____

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DETOXIFICATION QUESTIONNAIRE

Patient Name: ______________________ **Date:** ____________

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

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 **TOTAL** ____

EARS
- ____ Itchy ears
- ____ Earaches, ear infections
- ____ Drainage from ear
- ____ Ringing in ears, hearing loss **TOTAL** ____

NOSE
- ____ Stuffy nose
- ____ Sinus problems
- ____ Hay fever
- ____ Sneezing attacks
- ____ Excessive mucus formation **TOTAL** ____

MOUTH/ THROAT
- ____ Chronic coughing
- ____ Gagging, frequent need to clear throat
- ____ Sore throat, hoarseness, loss of voice
- ____ Swollen or discolored tongue, gums, lips
- ____ Canker sores **TOTAL** ____

SKIN
- ____ Acne
- ____ Hives, rashes, dry skin
- ____ Hair loss
- ____ Flushing, hot flashes
- ____ Excessive sweating **TOTAL** ____

HEART
- ____ Chest pain
- ____ Irregular or skipped heartbeat
- ____ Rapid or pounding heartbeat **TOTAL** ____

LUNGS
- ____ Chest congestion
- ____ Asthma, bronchitis
- ____ Shortness of breath
- ____ Difficulty breathing **TOTAL** ____

DIGESTIVE TRACT
- ____ Nausea, vomiting
- ____ Diarrhea
- ____ Constipation
- ____ Bloated feeling
- ____ Belching, passing gas
- ____ Heartburn
- ____ Intestinal/stomach pain **TOTAL** ____

JOINTS/ MUSCLE
- ____ Pain or aches in joints
- ____ Arthritis
- ____ Stiffness or limitation of movement
- ____ Feeling of weakness or tiredness
- ____ Pain or aches in muscles **TOTAL** ____

WEIGHT
- ____ Binge eating/drinking
- ____ Craving certain foods
- ____ Excessive weight
- ____ Water retention
- ____ Underweight
- ____ Compulsive eating **TOTAL** ____

ENERGY/ ACTIVITY
- ____ Fatigue, sluggishness
- ____ Apathy, lethargy
- ____ Hyperactivity
- ____ Restlessness **TOTAL** ____

MIND
- ____ Poor memory
- ____ Confusion, poor comprehension
- ____ Difficulty in making decisions
- ____ Stuttering or stammering
- ____ Slurred speech
- ____ Learning disabilities
- ____ Poor concentration
- ____ Poor physical coordination **TOTAL** ____

EMOTIONS
- ____ Mood swings
- ____ Anxiety, fear, nervousness
- ____ Anger, irritability, aggressiveness
- ____ Depression **TOTAL** ____

OTHER
- ____ Frequent illness
- ____ Frequent or urgent urination
- ____ Genital itch or discharge **TOTAL** ____

GRAND TOTAL **TOTAL** ____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? _____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: __________

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?
❒ Yes ❒ No

2. Have you ever been diagnosed with a condition known as hyperkalemia?
❒ Yes ❒ No

3. Are you currently on diuretics or blood pressure medication?
❒ Yes ❒ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE __________ (High >50; moderate 15-49: Low <14)
XTT SCORE __________ (High >10; moderate 5-9: Low <4)
URINARY pH __________

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

Context of Care

Name________ ________________________ _ **Date____________**

1. Why did you choose our clinic to support your health needs?

____
____
____

2. For your care to be a true win for you, what do you want to take place over the course of your care here?

____
____
____
____
____

3. How long do you feel this will take?

____
____

4. Do you think the signs and symptoms that you are experiencing could be purposeful? (i.e. Could they be your body's wisdom saying, "I need some help… let's change some things here!")

____
____

5. Do you feel your signs and symptoms are a reflection of *short term superficial circumstances* or *longer term, potentially deeper seated challenges*? (Please circle your inclination here.)

6. What are the areas of your lifestyle that you would like to improve:
(Circle, then prioritize #1, 2, 3, etc.)

___ My level of anxiety
___ My pace of living
___ Not enough quiet time and rest
___ My diet and nutrition program
___ My exercise program
___ Self-destructive lifestyle habits: (Please list)
___ Time spent in nature
___ My creative expression
___ My feelings around career
___ My social and family life
___ My communication skills

____
____
____

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Context of Care (continued)

7. **What might it cost you if you don't significantly improve your lifestyle and any underlying contributions to compromised health? (e.g. Percentage of vitality and/or longevity, percentage of joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)**

____

____

____

____

8. **What is your present level of commitment to address any underlying causes of your signs and symptoms which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed.)**

____

____

9. **Reflect on your highest priorities in life and list the top 3 which come to your mind and speak to your heart. Where does your health and vitality factor in?**

____

____

____

10. **What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?**

____

____

____

11. **How confident are you that you will follow through on the healthy lifestyle changes (e.g. nutrition and exercise) that it will take to achieve your wellness goals? (Rate 1 to 10, where 1 is "not at all" and 10 is "100% certainty".)**

____

____

____

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Keith D. Bishop

Clinical Nutritionist, B.Sc. Pharmacy, Health Coach

- **B.Sc. in Pharmacy 1981**
- **Registered Pharmacist 1982**
- **Owner Medic Pharmacy, Mustang, Oklahoma 1983-1998**
- **Member Professional Compounding Centers of America 1993-Present**
- **Recipient of the 1995 Oklahoma Pharmacist Association "Innovative Pharmacy Practice Award"**
- **Owner HEALTH NUT *RX*™, NATURAL WELLNESS CENTER, 1998-Present**
- **Training and Certification:**
  - **"Phytomedicinals and Alternative Treatments"**
  - **"Applied Clinical Nutrition"**
  - **"Respiratory Disease Management"**
  - **"Asthma Management"**
  - **"Pharmaceutical Patient Care"**
- **Speaker at state and national pharmacy association conventions on Pharmaceutical Patient Care**
- **Speaker at local and national conferences on Natural Care**
- **Member of the Association of Natural Medicine Pharmacists**

Natural Wellness Mission

"To assist my clients establish vibrant health by integrating innovative, high quality, natural products, self care, and natural treatment plans, medical treatment plans, and professional service."

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Natural Care Services

Consultations are intended to improve the use of bio-identical hormones, natural products, natural hormones, prescription, non-prescription medicine and products, non-drug approaches to self-care and/or referral to other health care providers.

Natural Wellness Screening

Appointment Required

- Nutritionist Report of Findings of Bioelectrical Impedance Analysis, Detoxification Questionnaire, Context of Care Questionnaire, Blood Pressure, Pulse, Adrenal Function Test, Saliva pH, Zinc Tally™, and Iodine Paint is **$30.00***

*Natural Care Consultation and protocols are available at extra cost.

Natural Care and Health Coach Consultations May Include

Appointment Required (In Office, Telephone and Email)

- Natural Care protocols based on Natural Wellness Screening, Medical Symptoms Questionnaire, Medical History, Health Appraisal Questionnaire, Nutrition Physical, Laboratory, Meridian Stress Assessment and Genetic Screenings
- Protocols of Prescription and Non-Prescription Medications, Vitamins, Minerals, Herbs, Alternative Treatments, Laboratory Reports, Natural Hormones, Natural Thyroids, Drug-Induced Nutrient Depletion, Drug-Food Interactions and Drug-Supplement Interactions
- Natural Product, Natural Treatment Plan, Self-Care, Dietary and Lifestyle Recommendations
- Monitoring Mechanisms, Follow-up Schedule and Referral Recommendation

Natural Care Consultation in Office, Telephone and Email Professional Fees:

5 Minute Consultation: $15.00
15 Minute Consultation: $45.00
30 Minute Consultation: $90.00
45 Minute Consultation: $135.00
60 Minute Consultation: $180.00
(or fraction thereof)

Natural Wellness Screening: $30.00

Nutrition Physical: $45.00

Meridian Stress Assessment Basic Screening: $65
Meridian Stress Assessment Consult: 30 min $60

Laboratory Screenings: Ask for details

Note: Laboratory screenings, medical foods and dietary supplements are not included in the professional fees. Many additional services and products are available. Please ask for additional information.

Keith D. Bishop, Clinical Nutritionist, B.Sc. Pharmacy, is certified in:
Applied Clinical Nutrition, Phytomedicinals and Alternative Treatments,
Respiratory Disease Management, Asthma Management, and Pharmaceutical Patient Care.

Kris Lyn is certified in:
Life Style Education, FistLine Therapy, Meridian Stress Assessment

PLEASE TELL YOUR FRIENDS, FAMILY AND ASSOCIATES ABOUT OUR NATURAL HEALTH SERVICES.

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PAYMENT AGREEMENT AND CANCELLATION POLICY

Please be aware that by making an appointment with any associate of Health Nut Rx Natural Care Solution, you are agreeing to abide by the billing policies of our office. There will be a fee, billed to your credit card, if you do not provide at least 24 hours notice of a cancellation or change in your appointment date or time. This policy will be enforced for both new clients as well as established clients. In addition, there will be a fee, billed to your credit card, if you do not show for your appointment. Or, you may make an appointment deposit by providing a check or cash in the amount of $60.00.

Our staff will be happy to answer any further questions regarding this policy or provide you a copy of this policy, upon your request.

By signing this *Payment Agreement & Cancellation Policy*, you are indicating that you understand and agree to the terms of service explained in said Policy. You are also indicating that you have given Health Nut Rx Natural Care Solution your permission to charge your credit card, deposit your deposit check or deposit your cash deposit, if any of the above stipulations apply.

I understand and accept this *Payment Agreement & Cancellation Policy*.

Signature: ___________________________________ Date: __________________

Type of Payment: Visa MC AmEx Discover Check Cash

Name of Client or Legal Guardian:

____

Billing Address: ____

____

Credit Card Number:____

Expiration Date :_______________________ Security Code:_________________

Signature: ___________________________________ Date: __________________

Deposit by Check No. ____________ in the amount of $_____________________

Deposit by Cash in the amount of $_______________________________________

Would you like a copy of the "*Payment Agreement and Cancellation Policy*" for your records?
Yes________ No ________

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PAYMENT AGREEMENT & CANCELLATION POLICY

The following *Payment Agreement & Cancellation Policy* explains your financial obligations while under our care and our policies regarding cancellations.

Payment is always due at the time of service. We accept the following forms of payment: Cash, Check, Visa, MasterCard, American Express, and Discover.

We do not accept insurance.

New Client Appointments:

- All new clients are required to provide a valid credit card number, including expiration date and billing address in order to schedule a new client appointment or a check or cash deposit.
- If you cancel your appointment with less than 24 hours notice, or fail to show for your appointment, your credit card will be charged $60 or your check or cash deposit will be deposited.
- If you call to cancel your appointment with less than 24 hours notice and reschedule another appointment at that time, your credit card will be charged $30.
- If you reschedule your appointment and then cancel with less than 24 hours notice, or fail to show for your appointment, your credit card will be charged for the full price of the visit.

Follow-Up Visits:

- If you cancel a follow-up visit with less than 24 hours notice, or fail to show for your appointment, your credit card will be charged $30.

Phone Consultations:

- We bill for phone consultations. They require the same time and expertise as office visits.
- Your practitioner may choose not to bill you if the nature of the phone consultation is uncomplicated, such as taking a minute to answer a simple question about your treatment protocol. If any type of extended discussion ensues or if a number of questions need to be addressed, it is likely, your practitioner will bill for the phone consultation.

E-Mail Consultations:

- We bill for e-mail consultations. They require the same time and expertise as office visits.
- Your practitioner may choose not to bill you if the nature of the e-mail consultation is uncomplicated, such as taking a minute to answer a simple question about your treatment protocol. If any type of extended discussion ensues or if a number of questions need to be addressed, it is likely, your practitioner will bill for the e-mail consultation.

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