VOLITION
WELLNESS SOLUTIONS
Integral Approach to Mastery

Our Center Guidelines

182 Tamarack Circle ▪ Skillman ▪ New Jersey ▪ 08558-2021 ▪ 609-688-8300 ▪ www.VolitionWellness.com

Welcome to Volition Wellness Solutions! It is our intention that these guidelines will familiarize you with some of our procedures and to facilitate a mutual working relationship between us.

- This paperwork needs to be completed and signed prior to your initial appointment.
- Payment for each appointment/group/workshop is required at the time of service.
- It is important that you understand that health insurance is a contract between you and your insurance company. We are out of network providers, check with your insurance provider whether you have out-of-network benefits. Please speak to our administrative staff regarding procedures for insurance reimbursement.
- Twenty-four hour notice is required to reschedule/cancel an appointment. For appointments cancelled within twenty-four hours, the full session fee will be charged. As a courtesy, your provider will allow you to reschedule an appointment. Individual therapy sessions will need to be rescheduled prior to the next occurring appointment.
- There will be a fee charged for any check returned from the bank. The charge will be assessed at the time of return.
- We recognize and believe that significant others and family members are an integral part of your healthcare. Please discuss with your practitioner how you can involve them in your treatment.

Volition Wellness Solutions Team members agree:

1. To practice an integral approach, and therefore, when appropriate, recommend additional complementary therapy to be provided by another Volition healthcare professional.
2. To continuously engage in your best interest. As a result, there may be time when your case is discussed at our clinical team meeting.
3. To require parental consent to engage in treatment or therapy with any one less than 18 years of age.
4. To uphold and respect the Federal Guidelines of Confidentiality. Your written and/or verbal permission is required before your case can be discussed, or information released to another person, therapist, institution or insurance company. However, there are legal requirements that limit your confidentiality in the case where someone is in imminent danger of hurting themselves or another person. In this case, we have a "duty to inform" the appropriate authorities.
5. To check their voice mail regularly so clients may call and leave a message anytime. Your call will be returned as soon as possible. However, should you have a medical/psychiatric emergency; you should immediately contact 911 or your local hospital emergency room.

I have read, understand and agree to the guidelines stated above:

Signature:_____
Date:_____

I understand that my credit card information listed below is kept on file as a convenience and will be billed automatically on the day of each appointment.

I have read and agree to the terms and conditions stated on the previous page of the Volition Center Guidelines.

Name:_____ □Amex □Visa □MC
(as it appears on Credit Card)

Card #:_____ Expiration

Date:_____

Signature:_____

Date:_____

Authorization to Release Information:

Your written permission is required before your case can be discussed or information released to another person, therapist, institution or insurance. Occasionally, insurance companies call to verify dates of service. In order to comply with the request, we need your permission to do so. Please read and sign the following:

I authorize the release of any medical or other information necessary to justify and to substantiate this statement and to process all associated insurance claims

Signature:_____

Date:_____

We are dedicated to cultivating a safe environment and support system that allows our clients to create health proactively. If you have any questions about any of our policies, please feel free to speak with any member of Volition's team. Please retain a copy of these procedures for your records.

Thank you.
The Volition Wellness Team

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CLIENT HEALTH INFORMATION

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Name *(Last, First, M.I.):* ☐ M ☐ F			**Date of Birth:**
Address:			
City:		**State:**	**Zip:**
Email:		**Would you like to be on our mailing list?** ☐ Y ☐ N	
Phone: (H)	**(W)**		**(Cell)**
Employer:	**Occupation:**		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Spouse/Partner:	☐ M ☐ F	**Age:**	**Date of Birth:**
Child:	☐ M ☐ F	**Age:**	
Child:	☐ M ☐ F	**Age:**	
Child:	☐ M ☐ F	**Age:**	
Child:	☐ M ☐ F	**Age:**	
Emergency Contact:	**Relationship:**	**Cell:** **Home Phone:**	
Previous or referring healthcare provider:		**Date of last physical exam:**	
Primary Physician:		**Phone:**	
Primary Physician Address:			
Clients primary reason for visit and your expectations:			
How did you hear about our center?			

BILLING INFORMATION

Person responsible for bill (if not the patient):				
Birth date:	Home phone :	Cell phone:		
Address (if different):	City:	State:	Zip:	

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

Is this patient covered by insurance?		❑ Yes ❑ No	
Primary Insurance Provider:		Type of Insurance Plan:	
Subscriber's name:			Birth date:
Policy/ID #:		Group #:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Subscriber's Occupation:		Employer:	
Employer address:			Employer phone:
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Complaints/Concerns

What do you hope to achieve in your visit with us? _____

If you had a magic wand and could erase three problems, what would they be?

1.
2.
3.

What was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority.

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success		
					Excellent	Good	Fair
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		

Medical History

□ = Past Condition ○ = Ongoing Condition

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset*

Gastrointestinal
□ ○ Irritable Bowel Syndrome _____
□ ○ Inflammatory Bowel Disease _____
□ ○ Crohn's _____
□ ○ Ulcerative Colitis _____
□ ○ Gastriltis or Peptic Ulcer Disease _____
□ ○ GERD (reflux) _____
□ ○ Celiac Disease _____
□ ○ Other _____

Cardiovascular
□ ○ Heart Attack _____
□ ○ Other Heart Disease _____
□ ○ Stroke _____
□ ○ Elevated Cholesterol _____
□ ○ Arrythmia (irregular heart rate) _____
□ ○ Hypertension (high blood pressure) _____
□ ○ Rheumatic Fever _____
□ ○ Mitral Valve Prolapse _____
□ ○ Other _____

Metabolic/Endocrine
□ ○ Type 1 Diabetes _____
□ ○ Type 2 Diabetes _____
□ ○ Hypoglycemia _____
□ ○ Metabolic Syndrome _____
(Insulin Resistance or Pre-Diabetes)
□ ○ Hypothyroidism (low thyroid) _____
□ ○ Hyperthyroidism (overactive thyroid) _____
□ ○ Endocrine Problems _____
□ ○ Polycystic Ovarian Syndrome (PCOS) _____
□ ○ Infertility _____
□ ○ Weight Gain _____
□ ○ Weight Loss _____
□ ○ Frequent Weight Fluctuations _____
□ ○ Bulimia _____
□ ○ Anorexia _____
□ ○ Binge Eating Disorder _____
□ ○ Night Eating Disorder _____
□ ○ Eating Disorder (non-specific) _____
□ ○ Other _____

Cancer
□ ○ Lung Cancer _____
□ ○ Breast Cancer _____
□ ○ Colon Cancer _____
□ ○ Ovarian Cancer _____
□ ○ Prostate Cancer _____
□ ○ Skin Cancer _____
□ ○ Other _____

Genital and Urinary Systems
□ ○ Kidney Stones _____
□ ○ Gout _____
□ ○ Interstitial Cystitis _____
□ ○ Frequent Urinary Tract Infections _____
□ ○ Frequent Yeast Infections _____
□ ○ Erectile Dysfunction
or Sexual Dysfunction _____
□ ○ Other _____

Musculoskeletal/Pain
□ ○ Osteoarthritis _____
□ ○ Fibromyalgia _____
□ ○ Chronic Pain _____
□ ○ Other _____

Inflammatory/Autoimmune
□ ○ Chronic Fatigue Syndrome _____
□ ○ Autoimmune Disease _____
□ ○ Rheumatoid Arthritis _____
□ ○ Lupus SLE _____
□ ○ Immune Deficiency Disease _____
□ ○ Herpes-Genital _____
□ ○ Severe Infectious Disease _____
□ ○ Poor Immune Function _____
(frequent infections)
□ ○ Food Allergies _____
□ ○ Environmental Allergies _____
□ ○ Multiple Chemical Sensitivities _____
□ ○ Latex Allergy _____
□ ○ Other _____

Respiratory Diseases
□ ○ Asthma _____
□ ○ Chronic Sinusitis _____
□ ○ Bronchitis _____
□ ○ Emphysema _____
□ ○ Pneumonia _____
□ ○ Tuberculosis _____
□ ○ Sleep Apnea _____
□ ○ Other _____

Skin Diseases
□ ○ Eczema _____
□ ○ Psoriasis _____
□ ○ Acne _____
□ ○ Melanoma _____
□ ○ Skin Cancer _____
□ ○ Other _____

Medical History (Continued)

□ = Past Condition ○ = Ongoing Condition

Neurologic/Mood

□ ○ Depression _____
□ ○ Anxiety _____
□ ○ Bipolar Disorder _____
□ ○ Schizophrenia _____
□ ○ Headaches _____
□ ○ Migraines _____
□ ○ ADD/ADHD _____
□ ○ Autism _____
□ ○ Mild Cognitive Impairment _____
□ ○ Memory Problems _____
□ ○ Parkinson's Disease _____
□ ○ Multiple Sclerosis _____
□ ○ ALS _____
□ ○ Seizures _____
□ ○ Other Neurological Problems _____

Preventive Tests and Date of Last Test

Check box if yes and provide date

□ Full Physical Exam _____
□ Bone Density _____
□ Colonoscopy _____
□ Cardiac Stress Test _____
□ EKG _____
□ Hemoccult Test-stool test for blood _____
□ MRI _____
□ CT Scan _____
□ Upper Endoscopy _____
□ Upper GI Series _____
□ Ultrasound _____

Surgeries

Check box if yes and provide date of surgery

□ Appendectomy _____
□ Hysterectomy +/- Ovaries _____
□ Gall Bladder _____
□ Hernia _____
□ Tonsillectomy _____
□ Dental Surgery _____
□ Joint Replacement – Knee/Hip _____
□ Heart Surgery – Bypass Valve _____
□ Angioplasty or Stent _____
□ Pacemaker _____
□ Other _____
□ None _____

Injuries

Check box if yes

□ Back Injury
□ Head Injury
□ Neck Injury
□ Broken Bones
□ Other

Hospitalizations □ None

Date	Reason

Comments

Nutrition History

Have you ever had a nutrition consultation? ○ Yes ○ No

Have you made any changes in your eating habits because of your health? ○ Yes ○ No Describe _____

Do you currently follow a special diet or nutritional program? ○ Yes ○ No

Check all that apply:

□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ No Dairy
□ Gluten Restricted □ Vegetarian □ Vegan □ Ultra-metabolism
□ Specific Program for Weight Loss/Maintenance Type: _____ □ Other _____

Height (feet/inches) _____	Current Weight _____
Usual Weight Range +/- 5 lbs _____	Desired Weight Range +/- 5 lbs _____
Highest adult weight _____	Lowest Adult Weight _____
Weight Fluctuations (> 10 lbs.) ○ Yes ○ No	Body Fat % _____

How often do you weigh yourself? ○ Daily ○ Weekly ○ Monthly ○ Rarely ○ Never

Do you avoid any particular foods? ○ Yes ○ No If yes, types of food and reason _____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? ○ Yes ○ No If no, who does the shopping? _____

Do you read food labels? ○ Yes ○ No

Do you cook? ○ Yes ○ No If no, who does the cooking? _____

How many meals do you eat out per week? ○ 0-1 ○ 1-3 ○ 3-5 ○ >5 meals per week

Check all that apply to your current lifestyle and eating habits:	
□ Fast eater	□ Significant other or family members have special dietary needs or food preferences
□ Erratic eating pattern	
□ Eat too much	□ Love to eat
□ Late night eating	□ Eat because I have to
□ Dislike healthy food	□ Have a negative relationship to food
□ Time constraints	□ Struggle with eating issues
□ Eat more than 50% meals away from home	□ Emotional eater (eat when sad, lonely, depressed, bored)
□ Travel frequently	
□ Non-availability of healthy foods	□ Eat too much under stress
□ Do not plan meals or menus	□ Eat too little under stress
□ Reliance on convenience items	□ Don't care to cook
□ Poor snack choices	□ Eating in the middle of the night
□ Significant other or family members don't like healthy foods	□ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:

_____

Symptom Review

Please check all current symptoms occurring or present in the past 6 months.

General

□ Cold Hands & Feet
□ Cold Intolerance
□ Low Body Temperature
□ Low Blood Pressure
□ Daytime Sleepiness
□ Difficulty Falling Asleep
□ Early Waking
□ Fatigue
□ Fever
□ Flushing
□ Heat Intolerance
□ Night Waking
□ Nightmares
□ No Dream Recall

Head, Eyes & Ears

□ Conjunctivitis
□ Distorted Sense of Smell
□ Distorted Taste
□ Ear Fullness
□ Ear Pain
□ Ear Ringing/Buzzing
□ Lid Margin Redness
□ Eye Crusting
□ Eye Pain
□ Hearing Loss
□ Hearing Problems
□ Headache
□ Migraine
□ Sensitivity to Loud Noises
□ Vision problems (other than glasses)
□ Macular Degeneration
□ Vitreous Detachment
□ Retinal Detachment

Musculoskeletal

□ Back Muscle Spasm
□ Calf Cramps
□ Chest Tightness
□ Foot Cramps
□ Joint Deformity
□ Joint Pain
□ Joint Redness
□ Joint Stiffness
□ Muscle Pain
□ Muscle Spasms
□ Muscle Stiffness

Muscle Twitches:
□ Around Eyes
□ Arms or Legs
□ Muscle Weakness
□ Neck Muscle Spasm
□ Tendonitis
□ Tension Headache
□ TMJ Problems

Mood/Nerves

□ Agoraphobia
□ Anxiety
□ Auditory Hallucinations
□ Black-out
□ Depression
Difficulty
□ Concentrating
□ With Balance
□ With Thinking
□ With Judgment
□ With Speech
□ With Memory
□ Dizziness (Spinning)
□ Fainting
□ Fearfulness
□ Irritability
□ Light-headedness
□ Numbness
□ Other Phobias
□ Panic Attacks
□ Paranoia
□ Seizures
□ Suicidal Thoughts
□ Tingling
□ Tremor/Trembling
□ Visual Hallucinations

Eating

□ Binge Eating
□ Bulimia
□ Can't Gain Weight
□ Can't Lose Weight
□ Can't Maintain Healthy Weight
□ Frequent Dieting
□ Poor Appetite
□ Salt Cravings
□ Carbohydrate Cravings (breads, pastas)
□ Sweet Cravings (candy, cookies, cakes)
□ Chocolate Cravings
□ Caffeine Dependent

Digestion

□ Anal Spasms
□ Bad Teeth
□ Bleeding Gums
Bloating of:
□ Lower Abdomen
□ Whole Abdomen
□ Bloating after meals
□ Blood in Stools
□ Burping
□ Canker Sores
□ Cold Sores
□ Constipation
□ Cracking at Corner of Lips
□ Cramps
□ Dentures w/ Poor Chewing
□ Diarrhea
□ Alternating Diarrhea and Constipation
□ Difficulty Swallowing
□ Dry Mouth
□ Excess Flatulence/Gas
□ Fissures
□ Foods "Repeat" (Reflux)
□ Gas
□ Heartburn
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Upper Abdominal Pain
□ Vomiting
Intolerance to:
□ Lactose
□ All Dairy Products
□ Wheat
□ Gluten (Wheat, Rye, Barley)
□ Corn
□ Eggs
□ Fatty Foods
□ Yeast
□ Liver Disease/Jaundice
(Yellow Eyes or Skin)
□ Abnormal Liver Function Tests
□ Lower Abdominal Pain
□ Mucus in Stools
□ Periodontal Disease
□ Sore Tongue
□ Strong Stool Odor
□ Undigested Food in Stools

Skin Problems

□ Acne on Back
□ Acne on Chest
□ Acne on Face
□ Acne on Shoulders
□ Athlete's Foot
□ Bumps on Back of Upper Arms
□ Cellulite
□ Dark Circles Under Eyes
□ Ears Get Red
□ Easy Bruising
□ Lack of Sweating
□ Eczema
□ Hives
□ Jock Itch
□ Lackluster Skin
□ Moles w/ Color/Size Change
□ Oily Skin
□ Pale Skin
□ Patchy Dullness
□ Rash
□ Red Face
□ Sensitive to Bites
□ Sensitive to Poison Ivy/Oak
□ Shingles
□ Skin Darkening
□ Strong Body Odor
□ Hair Loss
□ Vitiligo

Itching Skin

□ Skin in General
□ Anus
□ Arms
□ Ear Canals
□ Eyes
□ Feet
□ Hands
□ Legs
□ Nipples
□ Nose
□ Penis
□ Roof of Mouth
□ Scalp
□ Throat

Skin, Dryness of

□ Eyes
□ Feet
  □ Any Cracking?
  □ Any Peeling?
□ Hair
  □ And Unmanageable?
□ Hands
  □ Any Cracking?
  □ Any Peeling?
□ Mouth/Throat
□ Scalp
  □ Any Dandruff?
□ Skin in General

Lymph Nodes

□ Enlarged/neck
□ Tender/neck
□ Other Enlarged/Tender
□ Lymph Nodes

Nails

□ Bitten
□ Brittle
□ Curve Up
□ Frayed
□ Fungus – Fingers
□ Fungus – Toes
□ Pitting
□ Ragged Cuticles
□ Ridges
□ Soft
Thickening of:
  □ Finger Nails
  □ Toenails
□ White Spots/Lines

Respiratory

□ Bad Breath
□ Bad Odor in Nose
□ Cough – Dry
□ Cough – Productive
□ Hoarseness
□ Sore Throat
Hay Fever:
  □ Spring
  □ Summer
  □ Fall
  □ Change of Season
□ Nasal Stuffiness
□ Nose Bleeds
□ Post Nasal Drip
□ Sinus Fullness
□ Sinus Infection
□ Snoring
□ Wheezing
□ Winter Stuffiness

Cardiovascular

□ Angina/chest pain
□ Breathlessness
□ Heart Murmur
□ Irregular Pulse
□ Palpitations
□ Phlebitis
□ Swollen Ankles/Feet
□ Varicose Veins

Urinary

□ Bed Wetting
□ Hesitancy (trouble getting started)
□ Infection
□ Kidney Disease
□ Leaking/incontinence
□ Pain/Burning
□ Prostate Infection
□ Urgency

Male Reproductive

□ Discharge From Penis
□ Ejaculation Problem
□ Genital Pain
□ Impotence
□ Prostate or Urinary Infection
□ Lumps in Testicles
□ Poor Libido (Sex Drive)

Female Reproductive

□ Breast Cysts
□ Breast Lumps
□ Breast Tenderness
□ Ovarian Cyst
□ Poor Libido (Sex Drive)
□ Vaginal Discharge
□ Vaginal Odor
□ Vaginal Itch
□ Vaginal Pain with Sex
Premenstrual:
  □ Bloating Breast Tenderness
  □ Carbohydrate Cravings
  □ Chocolate Cravings
  □ Constipation
  □ Decreased Sleep
  □ Diarrhea
  □ Fatigue
  □ Increased Sleep
  □ Irritability
□ Menstrual
  □ Cramps
  □ Heavy Periods
  □ Irregular Periods
  □ No Periods
  □ Scanty Periods
  □ Spotting Between

Family History

Check family members that apply.	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Medical Check List

PLEASE COMPLETE THE FOLLOWING INFORMATION

List any know medication, supplement, or food allergies, check here if none: [ ]

Medication/ Supplement/Food	Reaction

List all medications you are currently taking, check here if none: [ ]

Medication	Dose	Reason	Began

Supplements:

List all previous hospitalizations, or check here if none: [ ]

Hospital	Year	Reason

Please provide the following dates:

Last tetanus: _____

Female: Last PAP test: _____ Last Mamo: _____

Do you consume alcohol: Y N if yes, how much? _____ per day.

Do you smoke: Y N if yes, how many? _____ per day.

Three-Day Diet Diary

List all food and drink that you typically have each day, including snacks.

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			
Snacks			

Comments:

_____

_____

_____

_____

_____