



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



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.:**

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 _____
- Gastritis or Peptic Ulcer Disease _____
- GERD (reflux) _____
- Celiac Disease _____
- Other _____

Cardiovascular

- Heart Attack _____
- Other Heart Disease _____
- Stroke _____
- Elevated Cholesterol _____
- Arrhythmia (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 _____
- Hemocult 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:

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

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	Muscle Twitches:	Digestion
<input type="checkbox"/> Cold Hands & Feet	<input type="checkbox"/> Around Eyes	<input type="checkbox"/> Anal Spasms
<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Arms or Legs	<input type="checkbox"/> Bad Teeth
<input type="checkbox"/> Low Body Temperature	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Neck Muscle Spasm	Bloating of:
<input type="checkbox"/> Daytime Sleepiness	<input type="checkbox"/> Tendonitis	<input type="checkbox"/> Lower Abdomen
<input type="checkbox"/> Difficulty Falling Asleep	<input type="checkbox"/> Tension Headache	<input type="checkbox"/> Whole Abdomen
<input type="checkbox"/> Early Waking	<input type="checkbox"/> TMJ Problems	<input type="checkbox"/> Bloating after meals
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Blood in Stools
<input type="checkbox"/> Fever	Mood/Nerves	<input type="checkbox"/> Burping
<input type="checkbox"/> Flushing	<input type="checkbox"/> Agoraphobia	<input type="checkbox"/> Canker Sores
<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Night Waking	<input type="checkbox"/> Auditory Hallucinations	<input type="checkbox"/> Constipation
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Black-out	<input type="checkbox"/> Cracking at Corner of Lips
<input type="checkbox"/> No Dream Recall	<input type="checkbox"/> Depression	<input type="checkbox"/> Cramps
	Difficulty	<input type="checkbox"/> Dentures w/ Poor Chewing
Head, Eyes & Ears	<input type="checkbox"/> Concentrating	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> With Balance	<input type="checkbox"/> Alternating Diarrhea and Constipation
	<input type="checkbox"/> With Thinking	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Distorted Sense of Smell	<input type="checkbox"/> With Judgment	<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Distorted Taste	<input type="checkbox"/> With Speech	<input type="checkbox"/> Excess Flatulence/Gas
<input type="checkbox"/> Ear Fullness	<input type="checkbox"/> With Memory	<input type="checkbox"/> Fissures
<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Dizziness (Spinning)	<input type="checkbox"/> Foods "Repeat" (Reflux)
<input type="checkbox"/> Ear Ringing/Buzzing	<input type="checkbox"/> Fainting	<input type="checkbox"/> Gas
<input type="checkbox"/> Lid Margin Redness	<input type="checkbox"/> Fearfulness	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Eye Crusting	<input type="checkbox"/> Irritability	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Light-headedness	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Other Phobias	<input type="checkbox"/> Upper Abdominal Pain
<input type="checkbox"/> Headache	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Migraine	<input type="checkbox"/> Paranoia	Intolerance to:
<input type="checkbox"/> Sensitivity to Loud Noises	<input type="checkbox"/> Seizures	<input type="checkbox"/> Lactose
<input type="checkbox"/> Vision problems (other than glasses)	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> All Dairy Products
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Tingling	<input type="checkbox"/> Wheat
<input type="checkbox"/> Vitreous Detachment	<input type="checkbox"/> Tremor/Trembling	<input type="checkbox"/> Gluten (Wheat, Rye, Barley)
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Visual Hallucinations	<input type="checkbox"/> Corn
		<input type="checkbox"/> Eggs
Musculoskeletal	Eating	<input type="checkbox"/> Fatty Foods
<input type="checkbox"/> Back Muscle Spasm	<input type="checkbox"/> Binge Eating	<input type="checkbox"/> Yeast
<input type="checkbox"/> Calf Cramps	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Liver Disease/Jaundice (Yellow Eyes or Skin)
<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Can't Gain Weight	<input type="checkbox"/> Abnormal Liver Function Tests
<input type="checkbox"/> Foot Cramps	<input type="checkbox"/> Can't Lose Weight	<input type="checkbox"/> Lower Abdominal Pain
<input type="checkbox"/> Joint Deformity	<input type="checkbox"/> Can't Maintain Healthy Weight	<input type="checkbox"/> Mucus in Stools
<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Frequent Dieting	<input type="checkbox"/> Periodontal Disease
<input type="checkbox"/> Joint Redness	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Sore Tongue
<input type="checkbox"/> Joint Stiffness	<input type="checkbox"/> Salt Cravings	<input type="checkbox"/> Strong Stool Odor
<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Carbohydrate Cravings (breads, pastas)	
<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Sweet Cravings (candy, cookies, cakes)	<input type="checkbox"/> Undigested Food in Stools
<input type="checkbox"/> Muscle Stiffness		
	<input type="checkbox"/> Chocolate Cravings	
	<input type="checkbox"/> Caffeine Dependent	

Skin Problems	<input type="checkbox"/> Hands	<input type="checkbox"/> Breathlessness
<input type="checkbox"/> Acne on Back	<input type="checkbox"/> Any Cracking?	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Acne on Chest	<input type="checkbox"/> Any Peeling?	<input type="checkbox"/> Irregular Pulse
<input type="checkbox"/> Acne on Face	<input type="checkbox"/> Mouth/Throat	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Acne on Shoulders	<input type="checkbox"/> Scalp	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Any Dandruff?	<input type="checkbox"/> Swollen Ankles/Feet
<input type="checkbox"/> Bumps on Back of Upper Arms	<input type="checkbox"/> Skin in General	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Cellulite		
<input type="checkbox"/> Dark Circles Under Eyes	Lymph Nodes	Urinary
<input type="checkbox"/> Ears Get Red	<input type="checkbox"/> Enlarged/neck	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Tender/neck	<input type="checkbox"/> Hesitancy (trouble getting started)
<input type="checkbox"/> Lack of Sweating	<input type="checkbox"/> Other Enlarged/Tender	<input type="checkbox"/> Infection
<input type="checkbox"/> Eczema	<input type="checkbox"/> Lymph Nodes	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Hives		<input type="checkbox"/> Leaking/incontinence
<input type="checkbox"/> Jock Itch	Nails	<input type="checkbox"/> Pain/Burning
<input type="checkbox"/> Lackluster Skin	<input type="checkbox"/> Bitten	<input type="checkbox"/> Prostate Infection
<input type="checkbox"/> Moles w/ Color/Size Change	<input type="checkbox"/> Brittle	<input type="checkbox"/> Urgency
<input type="checkbox"/> Oily Skin	<input type="checkbox"/> Curve Up	
<input type="checkbox"/> Pale Skin	<input type="checkbox"/> Frayed	Male Reproductive
<input type="checkbox"/> Patchy Dullness	<input type="checkbox"/> Fungus – Fingers	<input type="checkbox"/> Discharge From Penis
<input type="checkbox"/> Rash	<input type="checkbox"/> Fungus – Toes	<input type="checkbox"/> Ejaculation Problem
<input type="checkbox"/> Red Face	<input type="checkbox"/> Pitting	<input type="checkbox"/> Genital Pain
<input type="checkbox"/> Sensitive to Bites	<input type="checkbox"/> Ragged Cuticles	<input type="checkbox"/> Impotence
<input type="checkbox"/> Sensitive to Poison Ivy/Oak	<input type="checkbox"/> Ridges	<input type="checkbox"/> Prostate or Urinary Infection
<input type="checkbox"/> Shingles	<input type="checkbox"/> Soft	<input type="checkbox"/> Lumps in Testicles
<input type="checkbox"/> Skin Darkening	Thickening of:	<input type="checkbox"/> Poor Libido (Sex Drive)
<input type="checkbox"/> Strong Body Odor	<input type="checkbox"/> Finger Nails	
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Toenails	Female Reproductive
<input type="checkbox"/> Vitiligo	<input type="checkbox"/> White Spots/Lines	<input type="checkbox"/> Breast Cysts
		<input type="checkbox"/> Breast Lumps
Itching Skin	Respiratory	<input type="checkbox"/> Breast Tenderness
<input type="checkbox"/> Skin in General	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Ovarian Cyst
<input type="checkbox"/> Anus	<input type="checkbox"/> Bad Odor in Nose	<input type="checkbox"/> Poor Libido (Sex Drive)
<input type="checkbox"/> Arms	<input type="checkbox"/> Cough – Dry	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Ear Canals	<input type="checkbox"/> Cough – Productive	<input type="checkbox"/> Vaginal Odor
<input type="checkbox"/> Eyes	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Vaginal Itch
<input type="checkbox"/> Feet	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Vaginal Pain with Sex
<input type="checkbox"/> Hands	Hay Fever:	Premenstrual:
<input type="checkbox"/> Legs	<input type="checkbox"/> Spring	<input type="checkbox"/> Bloating Breast Tenderness
<input type="checkbox"/> Nipples	<input type="checkbox"/> Summer	<input type="checkbox"/> Carbohydrate Cravings
<input type="checkbox"/> Nose	<input type="checkbox"/> Fall	<input type="checkbox"/> Chocolate Cravings
<input type="checkbox"/> Penis	<input type="checkbox"/> Change of Season	<input type="checkbox"/> Constipation
<input type="checkbox"/> Roof of Mouth	<input type="checkbox"/> Nasal Stuffiness	<input type="checkbox"/> Decreased Sleep
<input type="checkbox"/> Scalp	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Throat	<input type="checkbox"/> Post Nasal Drip	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Sinus Fullness	<input type="checkbox"/> Increased Sleep
Skin, Dryness of	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Irritability
<input type="checkbox"/> Eyes	<input type="checkbox"/> Snoring	<input type="checkbox"/> Menstrual
<input type="checkbox"/> Feet	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cramps
<input type="checkbox"/> Any Cracking?	<input type="checkbox"/> Winter Stuffiness	<input type="checkbox"/> Heavy Periods
<input type="checkbox"/> Any Peeling?		<input type="checkbox"/> Irregular Periods
<input type="checkbox"/> Hair	Cardiovascular	<input type="checkbox"/> No Periods
<input type="checkbox"/> And Unmanageable?	<input type="checkbox"/> Angina/chest pain	<input type="checkbox"/> Scanty Periods
		<input type="checkbox"/> Spotting Between

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:
