INSTITUTE FOR PEAK HEALTH

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Welcome!

Steps for your consultation:

1) Please fill out all New Patient forms in their entirety.

2) If you have any recent labs (within 12 months), please bring them to your appointment.

3) If you are married or in a relationship, **please bring your spouse or significant other** with you to your appointment. (*There will be much information covered concerning your unique condition as well as the fundamentals of the program.)*

4) Please arrive on time.

5) We require a 24 business-hour notice to change or cancel your appointment.

Note: *If these steps are followed we will kindly reschedule your appointment. If not, it may compromise the full value of your consultation.*

10 Objections to Creating a Healthy, Abundant Life

1) **I don't have the personal knowledge to make the correct lifestyle choices.**

A You have the power to choose to learn. If you are open to learning, our personal mentoring program will guide you along an easy to follow path. Our programs are structured in a manner that gives each and every patient the information needed to bring independence to their life. You do have the choice to avoid the all too common dependency of a caregiver or assisted living environment.

2) **I don't have the time to take appropriate care of myself.**

A We all live in a world that gives each of us 24 hours /day. What we do with that time is a personal decision based on values (real or perceived). If you do not take time to care for yourself, you will have to take time to try and repair yourself. Pro- activity and maintenance are required for optimized health. It takes no more time to eat correctly than poorly. Proper exercise requires no more than approximately 30-40 minutes 3 times per week. If you're honest with yourself, you recognize it really is based on what you judge as a valuable use of your time; TV or a thriving, abundant life.

3) **My family won't be on board with the changes I will need to make.**

A I recognize this sounds like a silly thought, but also realize it is a real concern for some. You would certainly think that all family members would be on board, however, in infrequent situations a spouse or family member may be negative toward your new enthusiasm. This usually comes down to a lack of understanding of what your lifestyle program entails, as well as some distrust of whether this approach will really work. It may help to steer these family members to our site, and view some of the incredible testimonials from our patients. Without taking the time to learn about our programs and proven success it is only human nature to be cautious. Once familiarizing themselves, you will not only get support, but an accountability partner to help ensure your success.

4) **Eating right is too hard and expensive.**

A If you have not been eating right, you should already understand how expensive eating wrong can be. Health deteriorates and medical bills escalate with each year that these poor choices are made. Like any habits, there are good and bad. Once you develop a habit it can be a challenge to change or alter. Once the good or correct habit is developed it will be hard to break. I would challenge anyone to compare grocery bills of a cart full of healthy food compared to one full of junk. And speaking of expense, this is not just a financial term. Losing out on the joys and experience in life because you're not feeding your body nutritious foods is a terrible, unnecessary expense.

5) **I can't afford a lifestyle program or hire a health coach.**

A Most people recognize the importance of an education, whether this is a high- school, college or even an online education. It's widely accepted that this is an investment that must be made in order to have the best insurance of meeting our financial needs. The return on this financial investment can materialize into a very secure and abundant life. Although there are situations in life where funding higher education can seem impossible, we witness people everyday finding solutions to "get it done". These individuals simply think differently. They do not accept anything less than their God given potential. I am suggesting that your health should be viewed as at least as valuable as your financial situation. What value is wealth if you do not have the health and vitality to enjoy it. At Cole Optimal Health Solutions, we work with each individual to overcome any financial obstacles. We have solutions to allow those on fixed budgets and retired to easily move forward.

6) **I'm afraid that proper lifestyle changes might isolate me from my friends and family.**

A It is true that not all of your friends will share your newly found optimism toward taking control of your health. Friends who do not place high priority on their health often play down healthy lifestyle choices. Although they may not mean any negative intent, this behavior is sabotaging. The bottom line is those who truly care for you will support your decision to place your health as a priority.

7) **My doctor may not approve.**

A I will always be open and willing to work with any doctor or health professional you currently have. They also, should be open and willing to do the same if the goal is to optimize health and improve lifestyle choices. This includes reducing and/or eliminating unnecessary medications. A doctor's main concern and intent should always be to aid in the optimization of health in his/her patients. This begins with "Do No Harm". I am always cautious of a physician that dismisses any holistic and natural approach to health. In summary, you are ultimately responsible for your health and therefore, the final decision and direction you wish to pursue.

8) **I don’t have the self-discipline to make permanent changes.**

A Self discipline is not a trait that we are born with, but one that is developed over time through life experience. Discipline coincides with positive experience. In other words, as your actions result in positive changes you will be inclined to continue these actions. One could look at this as positive habits or simply, discipline. Self discipline is also strengthened through accountability held by loved ones, a friend or a mentor.

9) **What happens if I commit to a lifestyle program and then hate the experience and give up?**

A Life is a series of ups and downs. We do not always enjoy the duties required for the end result we are seeking. It’s funny how these duties or actions can initially seem to be difficult or “no fun”, but later take on an uplifting emotion. This is because we come to recognize the most meaningful successes we have in life came from such actions. Having a successful marriage; raising children; optimizing our health and becoming financially independent all require discipline and actions that sometimes have us wanting to “give up and quit”. Those of us who continue to play the game are allowed the pleasures of earned rewards.

10) **I don’t have the personal confidence to take action.**

A Very few of us have a natural born instinct of confidence. This comes from continually taking action even when we are fearful. The actual definition for this is courage. As we continue to develop skills from taking these bold steps, we become less fearful or confident. Like a child lacking confidence as they enter a new sport, they are often hesitant to even give it a try. Once they jump in, regardless of the fear, they begin to develop skills that ultimately lead to enjoyment and yes, confidence! We are here to mentor you and support you. We do not judge or chastise. We offer an environment that anyone at any level can feel comfortable and genuinely cared for. As you become a veteran in the art of wellness, you too will become very confident.

PATIENT INFORMATION

Please fill out completely DATE _____

NAME _____ HOME PHONE ( ) _____

ADDRESS _____ CELL PHONE ( ) _____

CITY _____ STATE _____ ZIP _____

E-MAIL _____

BIRTHDATE _____ AGE _____ SEX: M F SS# xxx - xx - _____
(MM/DD/YYYY) (circle one)

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS M S D W SPOUSE'S NAME _____
(circle one)

EMERGENCY CONTACT _____ PHONE # ( ) _____

CURRENT MEDICAL DOCTOR/PHYSICIAN _____

DOCTOR/PHYSICIAN PHONE # ( ) _____

Most of our clients are referred to our office by a caring family member or friend, if that is the case for you who referred you? _____

☐ Newspaper ☐ Presentation ☐ Mailing ☐ Website ☐ Sign ☐ Mailing ☐ Other

If other, Please specify: _____

INITIAL CONSULTATION

Main Complaints / Concerns:

1) _____ 2) _____

3) _____ 4) _____

How long have you suffered with these problems? _____

Any other complaints? _____

_____

Would you like improvement with any of the following:

- ☐ Digestion: Reflux, Gas or Constipation
- ☐ Sleep: Falling asleep or staying asleep
- ☐ Sense of Well Being
- ☐ Energy

What have you tried doing to resolve these problems that haven't worked?

Have you become discouraged or stressed about handling these problems?

When your problems are at their worst, how does it make you feel?

How do these problems interfere with the following areas in your life?

Work:

Family:

Hobbies:

Life:

When they are at their worst, how much older do you feel?

Do you know how these problems may have started?

What effects do these problems have on your body functions?

Are you here visiting us to:

- ☐ Resolve my immediate problems
- ☐ Lifestyle program for optimized living
- ☐ Both
- ☐ Other:

How have you taken care of your health in the past?

- ☐ Medications
- ☐ Routine medical
- ☐ Exercise
- ☐ Diet and Nutrition
- ☐ Holistic
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other:

How have these previous methods worked for you?

What are you afraid this might be or will be affecting without change?

- [ ] Job
- [ ] Kids
- [ ] Marriage
- [ ] Sleep
- [ ] Freedom
- [ ] Future abilities
- [ ] Finances
- [ ] Time

Are there any health conditions you are afraid or concerned this might turn into?

- [ ] Diminished future abilities
- [ ] Stress
- [ ] Weight gain
- [ ] Heart disease
- [ ] Depression
- [ ] Surgery
- [ ] Arthritis
- [ ] Cancer
- [ ] Diabetes
- [ ] Other: _____

Where do you see yourself in the next 3-5 years if these problems aren't taken care of?

Please be specific: _____

What would be different or better without these problems?

- [ ] Diminished stress
- [ ] More energy
- [ ] Outlook
- [ ] Confidence
- [ ] Relationship with partner
- [ ] Sleep
- [ ] Work
- [ ] Self esteem
- [ ] Family
- [ ] Sense of well-being

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and will enjoy a mentor in helping you?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Please check and/or number all of the symptoms that you are experiencing:

0=Never 1=mild/rare/occasional 2=moderate/regularly 3=severe/very/often

Section 1 - GI, Upper			
Belching or gas within 1 hour of a meal		Do you feel like skipping breakfast	
Heartburn or Acid Reflux		Do you feel better if you don't eat	
Bloating or gas shortly after eating		Often sleepy after meals	
Bad breath (Halitosis)		Fingernails which chip, peel, or break easily	
Stomach upset by taking vitamin supplements		Stomach pains or cramps	
Sense of excess fullness after meals		Do you use indigestion tablets	
Hurried eating habits		Undigested food in stools	
Anemia unresponsive to Iron		Diarrhea after meals	

Section 2 - LV, GB			
Pain between shoulder blades		History of drug or alcohol abuse	
Greasy or high fat foods cause distress		History of hepatitis	
Nausea		Long-term use of prescription medications	
Light or clay-coloured stools		Chronic Fatigue or Fibromyalgia	
Bitter metallic taste in mouth, especially in the morning		Sensitive to chemicals (*eg perfume, cleaning solvents, insecticides, car exhausts, etc)*	
Reddened skin, especially on palms		Dry of flaky skin and/or hair	
Easily intoxicated by alcohol		History of gallbladder attacks or stones	
Unexplained itchy skin		Gallbladder removed? YES or NO	

Section 3 - SI			
Food allergies		Are there foods you could not give up ?	
Abdominal bloating 1-2 hours after eating		Asthma, sinus infections, stuffy nose	
Specific foods make you tired or bloated		Sometimes feel 'spacey' or unreal	
Pulse speeds up after eating		Alternating constipation and diarrhea	
Frequent urination		Nausea and/or vomiting	
Airborne allergies ? (*e.g. hay fever*)		Do you suffer from Hives ?	
Stool undigested, foul smelling, mucous-like, greasy or poorly formed		Pain, tenderness, soreness on left side under rib cage, bloated	

Section 4 - LI			
Feeling bowels don't completely empty		Blood in stools	
Diarrhea, loose stools, not well-formed		Alternating constipation and diarrhea	
Constipation		More than 3 bowel movements per day	
Cramps in lower abdominal region		Less than 1 bowel movement per day	
Coated tongue, "fuzzy" debris		Use laxatives frequently	
Feel worse in musty or mouldy atmosphere		Irritable bowel or mucus colitis	
Fungus or yeast infections (*e.g. nail fungus, athletes foot, thrush*)		Lower abdominal pain relieved by passing stool or gas	
Stools hard or difficult to pass		Mucus in stools	
History of parasite infection		Pass large amounts of foul smelling gas	
Anus itches		Bad breath or strong body odors	

Section 5 - CV			
Blood pressure above 140/90		Are you overweight ?	
High cholesterol		Do you exercise vigorously ?	
Family history of heart disease		Do you smoke, drink, or use recreational drugs ?	

Section 6 Insomnia			
Never get sick		Itchy skin or dermatitis	
Runny nose		Cysts, boils or rashes	
Cough which produces mucus		Frequent colds or flu	
Frequent infections: ear, sinus, lung, skin, bladder kidney.		History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition	

Section 7 - Male Only (Prostate)			
Prostate problems		Waking regularly to urinate at night	
Difficult to start & stop urine stream		Decreased sexual function	
Pain or burning sensation when urinating		Constipation – chronic	

Section 7.1 - Male Only (Andropause)			
Decrease in libido		Spells of mental fatigue	
Decreased spontaneous morning erection		Inability to concentrate	
Decrease in fullness of erections		Episodes of depression	
Difficulty maintaining morning erections		Muscle soreness	
Decrease in physical stamina		Unexplained weight gain	
Increased fat distribution in chest and hips		Sweating attacks	
Decreased "drive" and motivation		More emotional than in the past	

Section 8 - Females Only (Menstruating)			
Depression during periods		Breast fibroids – benign masses	
Mood swings associated with periods – PMS, depressed, irritable		Vaginal discharge and itchiness	
Crave chocolate around periods		Vaginal dryness	
Alternating menstrual cycle lengths		Excess facial or body hair	
Excessive menstrual flow		Hot Flushes	
Minimal blood flow during periods		Endometriosis	
Occasional skipped periods		Uterine Fibroids	
Extended menstrual cycle, greater than 32 days		Breast pain and tenderness associated with cycle	
Shortened menses, less than every 24 days		Pain and cramping during periods	
Are you pre-menopausal or menopausal		Acne breakouts during periods	
Facial hair growth		Hair loss/thinning	

Section 8.1 Females Only (Menopausal)			
Hot flashes		Painful intercourse	
Mental fogginess		Shrinking breast	
Disinterested in sex; low libido		Facial hair growth	
Mood swings		Acne	
Depression		Increased vaginal pain, dryness or itching	

Section 9 - ADR			
Insomnia		Crave salty foods	
Slow starter in the morning		Muscles easily fatigued	
Feel wired or jittery when drinking coffee		Chronic fatigue, or feel drowsy often	
Clench or grind teeth		Afternoon yawning	
Calm on the outside, troubled inside		Afternoon headache	
Become dizzy when suddenly standing up		Allergies and /or hives	
Cannot fall asleep		Weight gain when under stress	
Perspire easily		Wake up tired even after 6+ hrs of sleep	
Under high amounts of stress		Excessive perspiration or perspiration with little or no activity	

Section 10 - THY			
Tired, sluggish		Outer third of eyebrow thins	
Increase in weight gain even with low-calorie diet		Thinning of hair on scalp, face or genitals or excessive falling hair	
Require excessive amounts of sleep to function properly		Morning headaches that wear off as the day progresses	
Depression, lack of motivation		Mental sluggishness	
Feel cold – hands, feel, all over		Dryness of skin and/or scalp	
Gain weight easily		Difficult, infrequent bowel movements	

Section 10.1 - THY2			
Heart palpations		Nervousness and emotional insomnia	
Inward trembling		Night sweats	
Increased pulse even at rest		Difficulty gaining weight	

Section 11 - PIT			
Diminished sex drive		Nervousness and emotional insomnia	
Menstrual disorders or lack of menstruation		Increased ability to eat sugars without symptoms	

Section 12 - Ins. Resist.			
Fatigue after meals		Waist girth is equal or larger than hip girth	
Crave sweets during the day		Frequent urination	
Eating sweets does not relieve cravings for sugar		Increased thirst & appetite	
Must have sweets after meals		Difficulty losing weight	

Section 13 - Hypoglyc			
Crave sweets during the day		Eating relieves fatigue	
Irritable if meals are missed		Feel shaky, jittery, tremors	
Depend on coffee to keep yourself going or get started		Agitated, easily upset, nervous	
Get lightheaded		Poor memory, forgetful	
Get lightheaded if meals are missed		Blurred vision	

FOODS

How many alcohol beverages do you consume per week? _____

How many caffeinated beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times do you eat fish a week? _____

List the three worst foods you eat during the average week? _____

_____

List the three healthiest foods you eat during the average week? _____

_____

Do you smoke? Y / N If yes, how many times per _____ day _____ week

Rate your stress levels on a scale of 1-10 during the average week: _____

How many times per week do you eat raw nuts or seeds? _____

How many times per week do you exercise? _____

MEDICATIONS/SUPPLEMENTS

Please list all medications (Including prescription, over-the-counter and supplements)

Medication Name	Dose	Frequency	Taken for:	Date Started

FAMILY HEALTH HISTORY

Please review the conditions listed below and indicate those that are current health problems of a family member.

C = Current problem P = Past problem Leave blank those spaces that do not apply.

	Father	Mother	Spouse	Children		
Condition	Age	Age	Age	Age	Age	Age
Allergies						
Anxiety						
Asthma						
ADHD						
Back Trouble						
Bed wetting						
Cancer						
Colic						
Colitis						
Constipation						
Depression						
Diabetes						
Disc problems						
Ear infections						
Emotional issues						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
Heart burn						
High blood pressure						
Irritable Bowel Syndrome (IBS)						
Indigestion						
Infertility						
Insomnia						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scoliosis						
Sinus trouble						
Stroke						
Other						

Additional Comments: _____

THYROID PATIENTS ONLY

1) How long did you have symptoms prior to being diagnosed? _____

2) If on thyroid medication, how long have you been on? _____

3) Has your medications been adjusted frequently? _____

4) Do you have symptoms of brain fog or memory difficulties? _____

5) Do you have joint inflammation? _____

6) Do you consume grains? Y / N Do these foods irritate your bowels? Y / N

7) Do you have heart palpitations? Y / N

8) Do you have hot flashes or sweat attacks? Y / N

9) Have you been diagnosed with an autoimmune condition? _____

HOSPITALIZATION

Date	Reason

SURGERIES

Date	Reason

ALLERGIES

Medications: _____

Food: _____

Environmental: _____