HUDSON VALLEY
WHOLE LIFE CENTER

Dear

Hello and welcome to the Hudson Valley Whole Life Center. Your nutritional consultation has been scheduled for

____.

Please arrive **15 minutes** prior to your appointment time to allow for check in.

In addition to this initial appointment, we have also scheduled your follow up appointment. That follow up appointment is scheduled for ______________________________.

If you are unable to keep this appointment, please call us at 845-567-9190 at least 24 hours prior to your appointment to reschedule or cancel.

Your fee for the Initial Consultation is $75 in addition to any whole food nutritional supplementation that may be recommended to address your specific nutritional weaknesses. Please read the "Whole Food Concentrates verses Synthetic Supplements" article enclosed before your appointment so that you will know what to expect on your first visit.

Before your first appointment there will be a few things that you need to do. **Please mail or drop off to the office at least 72 hours before your scheduled appointment**:

- ◊ The Initial Intake form completed.
- ◊ The Systems Survey form completed.
- ◊ The 7 Day Diet Diary completed.
- ◊ A copy of any recent blood work

We have enclosed directions to the Center.

We look forward to meeting you and working with you.

Sincerely,

Dr. Chad Weinstein
Dr. Suzanne Tamlyn

•254 Route 17K•Suite 203•Newburgh NY 12550•
•Phone:(845)567-9190•Fax:(845)567-9197•

HUDSON VALLEY
WHOLE LIFE CENTER

Welcome to Hudson Valley Whole Life Center

In order for us to give you the attention you deserve on your path to wellness, we ask you to please be aware of the Center's Mission, Philosophy, and Policies:

Our Mission is to assist you in achieving physical, spiritual, and emotional well-being.

Our Philosophy is to educate and empower you to live in optimal wellness. This approach is comprehensive and compliments any existing health care program.

Tardiness Please be courteous and arrive on time for your scheduled appointment. Late arrivals force us to deduct time from your appointment in order to keep the schedule for other clients throughout the day.

Anyone arriving more than five minutes past their scheduled time will need to rebook their appointment.

Cancellations We do request a minimum of 24 hours advance notice for any cancellation or rescheduling of your appointment. Short notice or no notice will result in an office visit charge.

Payment of Services Payment in full is expected at the time of service. The Center receives payment in cash, check and credit form.

Returned Checks A standard fee of $35.00 will be charged for any returned checks.

I have read and understand the Center's mission, philosophy and policies.

Print Name: ______________________________

Signature: ______________________________

Date: ________________

HUDSON VALLEY WHOLE LIFE CENTER
254 ROUTE 17K, SUITE 203 • NEWBURGH NY 12550 • TEL 845.567.9190 • FAX 845.567.9197

HUDSON VALLEY
WHOLE LIFE CENTER

Patient Name:______________________ Patient Date of Birth:____/____/____

Past Medical History

Please include any of your previous conditions.
If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls or Traumas ☐No ☐Yes Explain:
Illnesses/Hospitalizations: ☐No ☐Yes Explain:
Surgeries: ☐No ☐Yes Explain:

Motor Vehicle Accidents ☐No ☐Yes Explain:
Work Injuries ☐No ☐Yes Explain:

Females Only: Menopausal Symptoms ☐None ☐Yes Explain:

Habits

Cigarettes/Cigars	☐None ☐Yes How much per week?
Alcohol	☐None ☐Yes How many drinks per week?
Coffee	☐None ☐Yes How many cups per week?
Exercise	☐None ☐Yes Hours/days per week?
Water	☐None ☐Yes How many glasses per week?
Soft Drinks	☐None ☐Yes Amount per week?
Sleep	☐None ☐Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desired per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? ☐No ☐Yes Explain:

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?

☐Diabetes ☐Heart Disease ☐Stroke ☐Neurological Disorders______________________
☐Autoimmune Disorders______________ ☐Cancer______________________
☐Other______________________

HUDSON VALLEY
WHOLE LIFE CENTER

Patient Name:______________________________ Patient Date of Birth:____/____/____

Personal Health History

Medications: Please list your current medications and what they are taken for,
Vitamins and Minerals: Please list your current supplements and by who prescribed.

Check the left box for any condition YOU had in the PAST and the right box for any condition this is CURRENT.

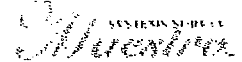
General Health History

P C	P C	P C	P C
☐ ☐ Mental Disorders	☐ ☐ Diabetes	☐ ☐ Pneumonia	☐ ☐ Infective Disease
☐ ☐ Epilepsy	☐ ☐ Anemia	☐ ☐ Tuberculosis	☐ ☐ Fungal Infection
☐ ☐ Tumors	☐ ☐ Glaucoma	☐ ☐ Hepatitis	☐ ☐ Herpes
☐ ☐ Alcoholism	☐ ☐ Heart Disease	☐ ☐ Thyroid Disease	☐ ☐ Arthritis
☐ ☐ Drug Addiction	☐ ☐ Rheumatic Fever	☐ ☐ Parasites	☐ ☐ Autoimmune Disease
☐ ☐ Cancer	☐ ☐ Scarlet Fever	☐ ☐ Asthma	☐ ☐ Chicken Pox

Nervous System	Eyes/Ears/Nose/Throat	Gastrointestinal	☐ ☐ Venereal Infection
P C	P C	P C	**Musculoskeletal**
☐ ☐ Depression	☐ ☐ Vision Problems	☐ ☐ Poor/Excess Appetite	P C
☐ ☐ Memory	☐ ☐ Flashing Lights	☐ ☐ Excessive Thirst	☐ ☐ Jaw Pain
☐ ☐ Confusion	☐ ☐ Black Spots	☐ ☐ Frequent Nausea	☐ ☐ Difficulty Chewing
☐ ☐ Dizziness	☐ ☐ Blurriness	☐ ☐ Hemorrhoids	☐ ☐ Face Pain
☐ ☐ Fainting	☐ ☐ Hearing Loss	☐ ☐ Black/Bloody Stools	☐ ☐ Neck Pain
☐ ☐ Convulsions	☐ ☐ Ringing in Ears	☐ ☐ Digestive Problems	☐ ☐ Arm/Elbow Pain
☐ ☐ Weakness	☐ ☐ Swallowing Difficulty	☐ ☐ Abdominal Cramping	☐ ☐ Wrist/Hand Pain
☐ ☐ Poor Balance	**Cardiovascular**	☐ ☐ Gas/Bloating	☐ ☐ Mid Back Pain
☐ ☐ Twitches/Tremor	☐ ☐ Chest Pain	☐ ☐ Heartburn	☐ ☐ Lower Back Pain
☐ ☐ Cold/Tingle Extremities	☐ ☐ Irregular Heartbeat	☐ ☐ Weight Problems	☐ ☐ Thigh/Knee Pain
☐ ☐ Sleeping Difficulties	☐ ☐ High Blood Pressure	☐ ☐ Gall Bladder Problems	☐ ☐ Ankle/Foot Pain
☐ ☐ Headaches	☐ ☐ Shortness of Breath	☐ ☐ Liver Problems	☐ ☐ Difficulty Walking
Genitourinary	☐ ☐ Lung/Congestion Prob.	**Reproductive**	☐ ☐ Leg/Arm Fatigue
☐ ☐ Bladder Trouble	☐ ☐ Varicose Veins	☐ ☐ Erectile Difficulties	
☐ ☐ Painful Urination	☐ ☐ Ankle Swelling	☐ ☐ Sexual Dysfunction	
☐ ☐ Incontinence		☐ ☐ Menstrual Irregularity	
☐ ☐ Discolored Urine		☐ ☐ Menstrual Cramping	

Females Only: When did your menses first begin?	
How often do you have a bowel movement?	How many times per day do you urinate?
Do your stools ☐Float or ☐Sink?	Do you experience any urgency, dribbling, or incontinence?
Are your bowel movements consistent?	Is this urination pattern consistent? ☐Yes ☐No

SYSTEMS SURVEY FORM



Patient ______________________ Doctor ______________________ Date ______________

Birth Date ___/___/___ Approx Weight ______________ Vegetarian: Yes ☐ No ☐

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).

○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).

○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).

○○○ **Leave circles BLANK if they don't apply to you!**

GROUP 1

1 2 3

1 ○○○ Acid foods upset
2 ○○○ Get chilled often
3 ○○○ "Lump" in throat
4 ○○○ Dry mouth-eyes-nose
5 ○○○ Pulse speeds after meal
6 ○○○ Keyed up - fail to calm
7 ○○○ Cut heals slowly
8 ○○○ Gag easily
9 ○○○ Unable to relax; startles easily
10 ○○○ Extremities cold, clammy
11 ○○○ Strong light irritates
12 ○○○ Urine amount reduced
13 ○○○ Heart pounds after retiring
14 ○○○ "Nervous" stomach
15 ○○○ Appetite reduced
16 ○○○ Cold sweats often
17 ○○○ Fever easily raised
18 ○○○ Neuralgia-like pains
19 ○○○ Staring, blinks little
20 ○○○ Sour stomach often

GROUP 2

1 2 3

21 ○○○ Joint stiffness on arising
22 ○○○ Muscle-leg-toe cramps at night
23 ○○○ "Butterfly" stomach, cramps
24 ○○○ Eyes or nose watery
25 ○○○ Eyes blink often
26 ○○○ Eyelids swollen, puffy
27 ○○○ Indigestion soon after meals
28 ○○○ Always seems hungry; feels "lightheaded" often
29 ○○○ Digestion rapid
30 ○○○ Vomiting frequent
31 ○○○ Hoarseness frequent
32 ○○○ Breathing irregular
33 ○○○ Pulse slow; feels "irregular"
34 ○○○ Gagging reflex slow
35 ○○○ Difficulty swallowing
36 ○○○ Constipation, diarrhea alternating
37 ○○○ "Slow starter"
38 ○○○ Get "chilled" infrequently
39 ○○○ Perspire easily
40 ○○○ Circulation poor, sensitive to cold
41 ○○○ Subject to colds, asthma, bronchitis

GROUP 3

1 2 3

42 ○○○ Eat when nervous
43 ○○○ Excessive appetite
44 ○○○ Hungry between meals
45 ○○○ Irritable before meals
46 ○○○ Get "shaky" if hungry
47 ○○○ Fatigue, eating relieves
48 ○○○ "Lightheaded" if meals delayed
49 ○○○ Heart palpitates if meals missed or delayed
50 ○○○ Afternoon headaches
51 ○○○ Overeating sweets upsets
52 ○○○ Awaken after few hours sleep - hard to get back to sleep
53 ○○○ Crave candy or coffee in afternoons
54 ○○○ Moods of depression - "blues" or melancholy
55 ○○○ Abnormal craving for sweets or snacks

GROUP 4

1 2 3

56 ○○○ Hands and feet go to sleep easily, numbness
57 ○○○ Sigh frequently, "air hunger"
58 ○○○ Aware of "breathing heavily"
59 ○○○ High altitude discomfort
60 ○○○ Opens windows in closed rooms
61 ○○○ Susceptible to colds and fevers
62 ○○○ Afternoon "yawner"
63 ○○○ Get "drowsy" often
64 ○○○ Swollen ankles, worse at night
65 ○○○ Muscle cramps, worse during exercise; get "charley horses"
66 ○○○ Shortness of breath on exertion
67 ○○○ Dull pain in chest or radiating into left arm, worse on exertion
68 ○○○ Bruise easily, "black and blue" spots
69 ○○○ Tendency to anemia
70 ○○○ "Nose bleeds" frequent
71 ○○○ Noises in head, or "ringing in ears"
72 ○○○ Tension under the breastbone, or feeling of "tightness", worse on exertion

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

(Rating columns: 1 2 3)

73 ○○○ Dizziness
74 ○○○ Dry skin
75 ○○○ Burning feet
76 ○○○ Blurred vision
77 ○○○ Itching skin and feet
78 ○○○ Excessive falling hair
79 ○○○ Frequent skin rashes
80 ○○○ Bitter, metallic taste in mouth in mornings
81 ○○○ Bowel movements painful or difficult
82 ○○○ Worrier, feels insecure
83 ○○○ Feeling queasy; headache over eyes
84 ○○○ Greasy foods upset
85 ○○○ Stools light colored
86 ○○○ Skin peels on foot soles
87 ○○○ Pain between shoulder blades
88 ○○○ Use laxatives
89 ○○○ Stools alternate from soft to watery
90 ○○○ History of gallbladder attacks or gallstones
91 ○○○ Sneezing attacks
92 ○○○ Dreaming, nightmare type bad dreams
93 ○○○ Bad breath (halitosis)
94 ○○○ Milk products cause distress
95 ○○○ Sensitive to hot weather
96 ○○○ Burning or itching anus
97 ○○○ Crave sweets

GROUP 6

(Rating columns: 1 2 3)

98 ○○○ Loss of taste for meat
99 ○○○ Lower bowel gas several hours after eating
100 ○○○ Burning stomach sensations, eating relieves
101 ○○○ Coated tongue
102 ○○○ Pass large amounts of foul-smelling gas
103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ○○○ Mucous colitis or "irritable bowel"
105 ○○○ Gas shortly after eating
106 ○○○ Stomach "bloating" after

GROUP 7

(A)

(Rating columns: 1 2 3)

107 ○○○ Insomnia
108 ○○○ Nervousness
109 ○○○ Can't gain weight
110 ○○○ Intolerance to heat
111 ○○○ Highly emotional
112 ○○○ Flush easily
113 ○○○ Night sweats
114 ○○○ Thin, moist skin
115 ○○○ Inward trembling
116 ○○○ Heart palpitates
117 ○○○ Increased appetite without weight gain
118 ○○○ Pulse fast at rest
119 ○○○ Eyelids and face twitch
120 ○○○ Irritable and restless
121 ○○○ Can't work under pressure

(B)

(Rating columns: 1 2 3)

122 ○○○ Increase in weight
123 ○○○ Decrease in appetite
124 ○○○ Fatigue easily
125 ○○○ Ringing in ears
126 ○○○ Sleepy during day
127 ○○○ Sensitive to cold
128 ○○○ Dry or scaly skin
129 ○○○ Constipation
130 ○○○ Mental sluggishness
131 ○○○ Hair coarse, falls out
132 ○○○ Headaches upon arising, wear off during day
133 ○○○ Slow pulse, below 65
134 ○○○ Frequency of urination
135 ○○○ Impaired hearing
136 ○○○ Reduced initiative

(C)

(Rating columns: 1 2 3)

137 ○○○ Failing memory
138 ○○○ Low blood pressure
139 ○○○ Increased sex drive
140 ○○○ Headaches, "splitting or rending" type
141 ○○○ Decreased sugar tolerance

(D)

(Rating columns: 1 2 3)

142 ○○○ Abnormal thirst
143 ○○○ Bloating of abdomen
144 ○○○ Weight gain around hips or waist
145 ○○○ Sex drive reduced or lacking
146 ○○○ Tendency to ulcers, colitis
147 ○○○ Increased sugar tolerance
148 ○○○ Women: menstrual disorders
149 ○○○ Young girls: lack of menstrual function

(E)

(Rating columns: 1 2 3)

150 ○○○ Dizziness
151 ○○○ Headaches
152 ○○○ Hot flashes
153 ○○○ Increased blood pressure
154 ○○○ Hair growth on face or body (female)
155 ○○○ Sugar in urine (not diabetes)
156 ○○○ Masculine tendencies (female)

(F)

(Rating columns: 1 2 3)

157 ○○○ Weakness, dizziness
158 ○○○ Chronic fatigue
159 ○○○ Low blood pressure
160 ○○○ Nails weak, ridged
161 ○○○ Tendency to hives
162 ○○○ Arthritic tendencies
163 ○○○ Perspiration increase
164 ○○○ Bowel disorders
165 ○○○ Poor circulation
166 ○○○ Swollen ankles
167 ○○○ Crave salt
168 ○○○ Brown spots or bronzing of skin
169 ○○○ Allergies - tendency to asthma
170 ○○○ Weakness after colds, influenza
171 ○○○ Exhaustion - muscular and nervous
172 ○○○ Respiratory disorders

GROUP 8

#	1 2 3	Symptom
173	○○○	Apprehension
174	○○○	Irritability
175	○○○	Morbid fears
176	○○○	Never seems to get well
177	○○○	Forgetfulness
178	○○○	Indigestion
179	○○○	Poor appetite
180	○○○	Craving for sweets
181	○○○	Muscular soreness
182	○○○	Depression; feelings of dread
183	○○○	Noise sensitivity
184	○○○	Acoustic hallucinations
185	○○○	Tendency to cry without reason
186	○○○	Hair is coarse and/or thinning
187	○○○	Weakness
188	○○○	Fatigue
189	○○○	Skin sensitive to touch
190	○○○	Tendency toward hives
191	○○○	Nervousness
192	○○○	Headache
193	○○○	Insomnia
194	○○○	Anxiety
195	○○○	Anorexia
196	○○○	Inability to concentrate; confusion
197	○○○	Frequent stuffy nose; sinus infections
198	○○○	Allergy to some foods
199	○○○	Loose joints

FEMALE ONLY

#	1 2 3	Symptom
200	○○○	Very easily fatigued
201	○○○	Premenstrual tension
202	○○○	Painful menses
203	○○○	Depressed feelings before menstruation
204	○○○	Menstruation excessive and prolonged
205	○○○	Painful breasts
206	○○○	Menstruate too frequently
207	○○○	Vaginal discharge
208	○	Hysterectomy / ovaries removed
209	○○○	Menopausal hot flashes
210	○○○	Menses scanty or missed
211	○○○	Acne, worse at menses
212	○○○	Depression of long standing

MALE ONLY

#	1 2 3	Symptom
213	○○○	Prostate trouble
214	○○○	Urination difficult or dribbling
215	○○○	Night urination frequent
216	○○○	Depression
217	○○○	Pain on inside of legs or heels
218	○○○	Feeling of incomplete bowel evacuation
219	○○○	Lack of energy
220	○○○	Migrating aches and pains
221	○○○	Tire too easily
222	○○○	Avoids activity
223	○○○	Leg nervousness at night
224	○○○	Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

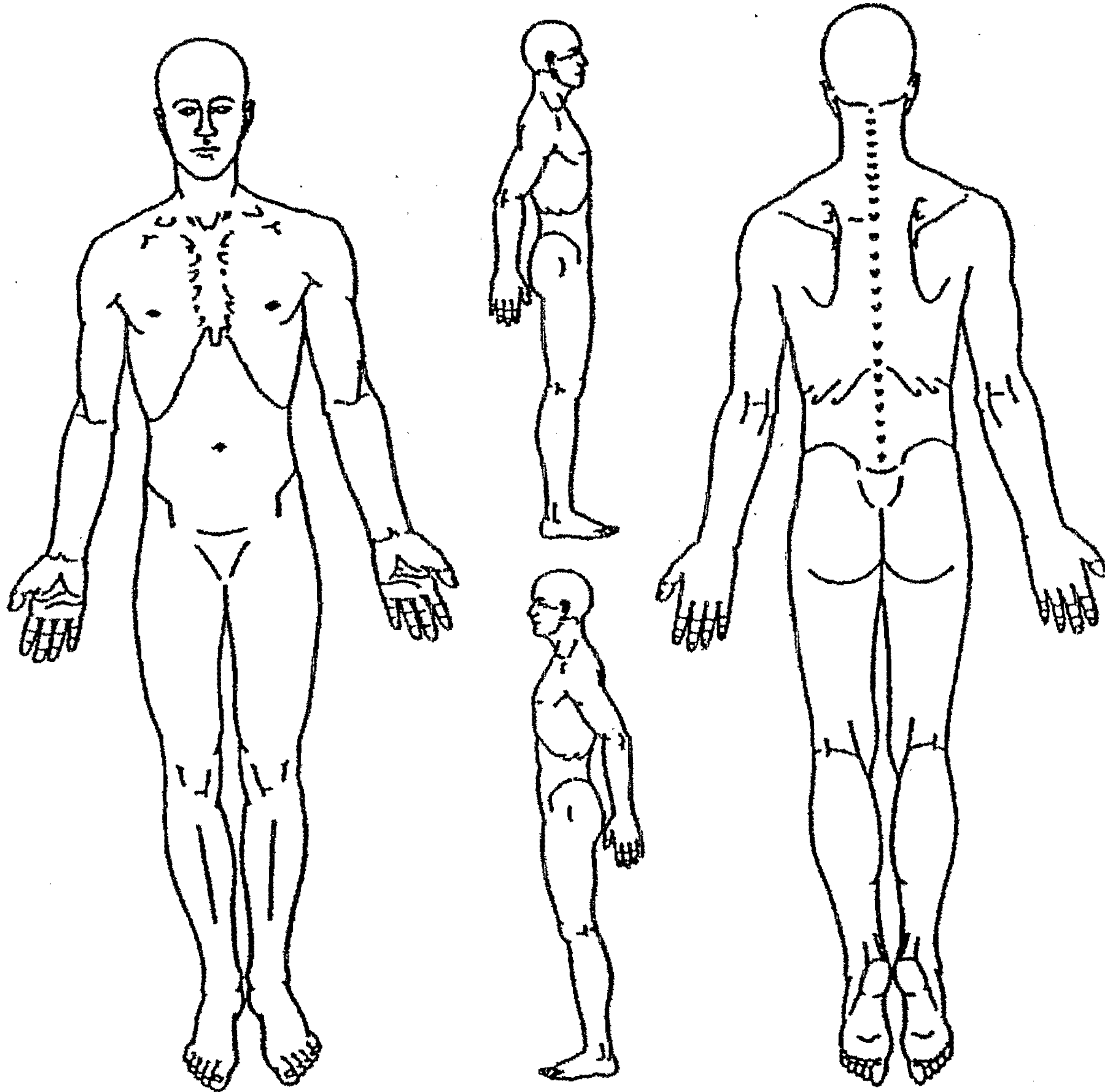
5. ______________________________

SYSTEMS SURVEY FORM - PAGE 4

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN ... SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature ______________________ Date ______________

Daily Record of Food Intake | *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Name:

Day 1 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Day 2 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Day 3 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Notes:

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Day 4 - Date:

BREAKFAST Time:

Meat & Dairy:

Vegetables & Fruits:

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, & Junk Food:

Water Intake (fl. oz.):

Other Drinks:

LUNCH Time:

DINNER Time:

MID-MORNING SNACK Time:

Snack:

MID-DAY SNACK Time:

NIGHTTIME SNACK Time:

Bowel Movements (# and consistency):

Hours of Sleep:

Quality of Sleep: (good) 1 2 3 4 5 (poor)

Day 5 - Date:

BREAKFAST Time:

Meat & Dairy:

Vegetables & Fruits:

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, & Junk Food:

Water Intake (fl. oz.):

Other Drinks:

LUNCH Time:

DINNER Time:

MID-MORNING SNACK Time:

Snack:

MID-DAY SNACK Time:

NIGHTTIME SNACK Time:

Bowel Movements (# and consistency):

Hours of Sleep:

Quality of Sleep: (good) 1 2 3 4 5 (poor)

Day 6 - Date:

BREAKFAST Time:

Meat & Dairy:

Vegetables & Fruits:

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, & Junk Food:

Water Intake (fl. oz.):

Other Drinks:

LUNCH Time:

DINNER Time:

MID-MORNING SNACK Time:

Snack:

MID-DAY SNACK Time:

NIGHTTIME SNACK Time:

Bowel Movements (# and consistency):

Hours of Sleep:

Quality of Sleep: (good) 1 2 3 4 5 (poor)

Day 7 - Date:

BREAKFAST Time:

Meat & Dairy:

Vegetables & Fruits:

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, & Junk Food:

Water Intake (fl. oz.):

Other Drinks:

LUNCH Time:

DINNER Time:

MID-MORNING SNACK Time:

Snack:

MID-DAY SNACK Time:

NIGHTTIME SNACK Time:

Bowel Movements (# and consistency):

Hours of Sleep:

Quality of Sleep: (good) 1 2 3 4 5 (poor)