



Back To Life Natural Health Center

Holistic Natural Health Care

2960 Winnetka Ave. N. #110 Crystal, MN 55427

763-546-3736, Fax 763-546-3807

www.backtolifehealth.com

Welcome to Back To Life Natural Health Center!

We are happy that you have chosen Back To Life for your health care needs.

Before your first visit, please fill out all of the enclosed forms. Take time to answer all the questions and be specific. This is very important in helping the doctor evaluate your current health status.

Payment Policy

Please note that payment is due at the time of each visit. We regret that we are unable to make exceptions to this policy. However, we do accept Visa, MasterCard and Discover. If you wish to submit to insurance, we will give you a form to send in so that the insurance company can reimburse you. Our office will submit claims for auto accidents, Worker's Compensation, Personal Injury only. If you are covered under one of these please tell the receptionist.

Cancellation Policy

Please let us know at least 24 hours in advance if you need to cancel your appointment. If sufficient notice is not provided, a missed appointment fee will be charged. This time has been reserved especially for you, and if you cannot use it, please give us the opportunity to offer someone else our care.

What to Expect

The following paragraphs explain generally what you can expect in terms of treatment and cost. The treatment program does vary from person to person depending on the nature of the problem(s), so this is only an approximation of costs and frequency of treatment.

If you are coming in for treatment of muscular/skeletal problems only, the initial appointment will take about 30 minutes and will include an examination (usually \$45) and treatment (usually \$55-\$75). Additional treatments usually cost \$55-\$75 and vary in frequency depending on the severity of the problem (usually 1-2 times/week, initially).

If you are coming in for internal problems, the initial exam will take one hour. It will include a comprehensive examination (\$90) and occasionally a treatment (usually \$55-\$75). Treatments are often scheduled once or twice a week for the first few weeks, then once every other week or two for the next several weeks, and then continue to decrease as your health improves. Some patients will not need to come this frequently. Nutritional consultations are charged at a rate of \$150 per hour, prorated per minute (\$2.50 per minute). If you're scheduled for the Bio-Terrain lab assessment, the cost is \$250 for the first time and \$200 for any re-testing at a later date. Please review the instructions for the fasting involved carefully. The doctor will often recommend specific supplements for you and these would involve additional charges. We will be happy to answer any questions you may have. Thank you!



Back To Life Natural Health Center

Holistic Natural Health Care

2960 Winnetka Ave. N. #110 Crystal, MN 55407

763-546-3736, Fax 763-546-3807

www.backtolifehealth.com

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date _____

Patient Name _____ Birth date _____ Age _____ Sex _____

Address _____ City _____ State _____ Zip _____

Home phone number _____ Work phone _____

Cell Phone _____ Email address _____

Parents name (if pt. is a minor) _____

Married ___ Single ___ Divorced ___ Separated ___ Roommate ___ Ages of children _____

Employer _____ Occupation _____

Spouse's name _____

Whom may we thank for referring you to our office? _____

In case of emergency contact:

Name _____ Phone _____ Relationship _____

ALL FEES ARE PAYABLE ON THE DAY SERVICES ARE RENDERED

I understand I am financially responsible for all charges whether or not paid by insurance. I understand that Back To Life will prepare any necessary reports and forms to assist me in making collection from the insurance company.

I hereby authorize the Doctor and staff to test and treat my condition as they deem appropriate as long as I am consulted before any test or treatment is implemented.

Signature _____ Date _____

PERMISSION TO TREAT A MINOR (to be completed if the patient is under age 18)

I, (parent/ guardian) _____ give Back To Life Natural Health Center permission to examine, test and treat (child's name) _____

Signature _____ Date _____

INSURANCE INFORMATION (FILL OUT ONLY IF THIS VISIT IS DUE TO AN *AUTO ACCIDENT OR WORKMANS COMP. CLAIM*)

Insured's name _____ Social Security # _____

Insurance company name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Claim number _____ Policy number _____

If Workers Compensation, was an accident report filed? _____ Date _____

I authorize payment of medical benefits to Back To Life Natural Health Center for all services provided.

Signature _____ Date _____



Back To Life Natural Health Center

Holistic Natural Health Care

2960 Winnetka Ave. N. #110 Crystal, MN 55427

763-546-3736, Fax 763-546-3807

www.backtolifehealth.com

Confidential Patient Case History

Name: _____ Date: _____

Please Print

What is your major complaint? _____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate the condition? _____

Is the condition getting worse? ___ Yes ___ No ___ Constant ___ Comes and goes

Is this condition interfering with your ___ Work ___ Sleep ___ Daily routine ___ Other _____

*Please underline all of the following symptoms which you have now or have had previously. We want all the facts about your health before we treat you. Your health report is confidential and is treated as such by our staff.

General Symptoms

784.4- Headache
346.2- Allergic
346.9- Migraine
307.81- Tension
780.6- Fever
780.9- Chills
780.8- Sweats
780.2- Fainting
780.4- Dizziness
780.3- Convulsions
780.52- Loss of sleep
780.7- Fatigue
799.2- Nervousness
783- Loss of weight
278.0- Obesity
782- Numbness/pain
in arms, hands or legs
995.3- Allergies
785.09- Wheezing
729.2- Neuralgia

E.E.N.T.

368.9- Failing vision
367.1- Near sighted
367.0- Far sighted
378.9- Crossed eyes
379.91- Eye pain
389.9- Deafness
388.70- Earache
388.30- Ear noises
388.6- Ear discharge
784.7- Nose bleeds
478.1- Nasal obstruction
462- Sore throat
784.49- Hoarseness
477.9- Hay fever

493.9- Asthma
521- Dental decay
523.1- Gum trouble
460- Frequent colds
240.9- Enlarged thyroid
463- Tonsillitis
686.9- Sinus infection
478.1- Nasal drainage
785.6- Enlarged glands

Skin

782.1- Skin eruptions
696.1- Psoriasis
692.9- Eczema
698.8- Itching
287.8- Bruises easily
701.1- Dryness
454.9- Varicose veins
782- Sensitive skin
708.9- Hives or allergy

Respiratory

786.2- Chronic cough
933.1- Spitting up phlegm
786.3- Spitting up blood
788.5- Chest pain
786.09- Difficult breathing

Cardiovascular

785- Rapid heart beat
427.89- Slow heart beat
401.9- High blood pressure
458.9- Low blood pressure
786.51- Pain over heart
438- Previous heart stroke
440.9- Hardening of arteries
719.07- Swelling of ankles

459.9- Poor circulation
436- Paralytic stroke

Muscle & Joint Symptoms

716.9- Arthritis
847- Stiff Neck
722.10- Back ache
719- Swollen Joints
781- Tremors
719.4- Painful joints
724.79- Painful tailbone
729.5- Foot trouble
724.5- Pain between
shoulders
553.9- Hernia
737.3- Spinal Curvature
737.3- Faulty posture
728.85- Muscle spasms
724.8- Back spasms
722.10- Sciatica

Genito-urinary Symptoms

788.3- Frequent urination
788.1 Painful urination
599.7- Blood in urine
599- Pus in urine
592- Kidney infection or
stone
788.3- Bed wetting
788.1- Inability to control
urine
601.9- Prostate trouble

Gastro-intestinal Symptoms

783- Poor appetite
536.8- Difficult digestion
994.2- Excessive hunger
787.3- Belching or gas
787- Nausea
787- Vomiting
578- Vomiting blood
536.8- Pain over Stomach
787.3- Distention of
abdomen
564- Constipation
558.9- Diarrhea
789-Colon trouble
455.6- Hemorrhoids
785.1 Liver trouble
575.9- Gallbladder trouble
782.4- Jaundice
558.9 Colitis

For Women Only

625.3- Painful menstrual
periods
626.2- Excessive flow
627.2- Hot flashes
626.4- Irregular cycle
625.3- Cramps/backache
634.9- Miscarriage
623.5- Vaginal discharge
611.79- Congested breast
611.72- Lumps in breast
627.2- Menopausal symptoms

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

(Please Complete Reverse Side)

Medical Attention for Chief Complaint:

Name and address of doctor _____
 When attended _____ How long _____ Hospitalization _____
 Examination and x-rays made _____
 Diagnosis _____
 Type and duration of treatment _____
 Results of treatment ___ Good ___ Fair ___ Poor _____

Previous Chiropractic History:

Name and address of doctor _____
 What were you treated for _____
 Examinations and x-rays made _____
 Cause of problem as explained by doctor _____
 Treatment type & duration _____
 Results: ___good ___fair ___poor _____

List surgical operations and years: _____
 Drugs you now take: ___Blood pressure ___ Cholesterol ___ Pain killers ___ Muscle relaxants ___ Tranquilizers
 ___ Insulin ___ Birth control ___ "Pep" pills ___ Allergy ___ others _____
 Have you been in an auto accident? ___ Past year ___ Past 5 years ___ over 5 years ___ Never
 Describe _____
 Have you had any other personal injury or accident ___ Past year ___ Past 5 years ___ Over 5 years ___ Never
 Describe _____
 Were you ever knocked unconscious or stunned? ___ No ___ Yes When and how _____

FAMILY HEALTH INFORMATION: (Many health problems are hereditary; thus information about your family members will give us a better picture of your total health picture)

Relation	Name	Age	Present Symptoms	Previous Serious Illnesses
Mother				
Father				
Sisters				
Brothers				
Children				
Spouse				

HAVE YOU EVER:

	YES	NO	DESCRIBE BRIEFLY
Used a cane, crutch or other support?	___	___	_____
Been treated for a spine or nerve disorder?	___	___	_____
Had a fractured bone?	___	___	_____
Been hospitalized for other than surgery?	___	___	_____
Been diagnosed as having Hepatitis?	___	___	_____
Been diagnosed as having HIV or AIDS?	___	___	_____
Been diagnosed as having Mumps?	___	___	_____
Been diagnosed as having Measles?	___	___	_____
Been diagnosed as having Chicken Pox?	___	___	_____

DO YOU:

	YES	NO	
Currently take any vitamins or supplements?	___	___	_____
Think you may need vitamins or supplements?	___	___	_____
Have an allergy to any drug?	___	___	_____

HABITS:

	HEAVY	MODERATE	LIGHT	NONE	LIST ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE LAST TEN YEARS:
Alcohol	_____	_____	_____	_____	
Coffee	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Drugs	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____
Sleep	_____	_____	_____	_____	_____
Appetite	_____	_____	_____	_____	_____

 Signature of patient

Dysbiosis Questionnaire and score sheet

This questionnaire is designed for adults and the scoring system is not as appropriate for children. It lists factors in your medical history which are known to contribute to the disruption of normal healthy gastrointestinal bacteria, directly or indirectly promoting the overgrowth of yeast, fungi and other pathogens, (Section A), and symptoms commonly found in individuals with dysbiosis related illness (Section B and C).

By filling out and scoring this questionnaire you and your physician can evaluate if dysbiosis may be contributing to your health problems. Yet it will not provide an automatic “Yes” or “No” answer.

Note: *Dysbiosis refers to the condition where the normal healthy population of beneficial bacteria in the intestines has been disrupted, leaving it open to the overgrowth of yeast, fungi, parasites and potentially harmful strains of bacteria. This intestinal imbalance in turn adversely affects other important systems via toxic stress and interfering with nutrient absorption and utilization.*

SECTION A: HISTORY

For each “yes” answer in Section A, circle the point score for that question. Total your score and record it in the box at the end of the section. Then move to sections B and C and score them as directed.

1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, etc.) or other antibiotics for skin acne or anything else for one month (or longer)? Yes= 25

2. Have you **at any time in your life**, taken other antibiotics for respiratory, urinary or other infections in shorter courses four or more times in a one year period? Yes = 20

3. Have you taken an antibiotic drug – even a single course? Yes = 6

4. Have you, at any time in your life, been bothered by recurrent or persistent prostatitis, vaginitis or other problems affecting your reproductive organs? Yes = 25

5. Have you taken birth control pills..... for more than 5 years? Yes = 25
for more than 2 years? Yes = 15
for 6 months to 2 years? Yes = 8

6. Have you been pregnant.....

two or more times? Yes = 5
one time? Yes = 3

7. Have you taken prednisone, Decadron or other cortisone type drugs.....

For more than 6 months? Yes = 25
For more than 2 weeks? Yes = 15
For 2 weeks or less? Yes = 6

8. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke...

Moderate to severe symptoms? Yes = 20
Mild symptoms? Yes = 5

9. Are your symptoms worse on damp, muggy days or in moldy places? Yes = 20

10. Have you had athlete’s foot, ring worm, “jock itch” or other chronic fungous infections of the skin or nails? (Y/N)
Have such infections been.....

Severe or persistent? Yes = 20
Mild to moderate? Yes = 10

11. Do you crave sugar? Yes = 10

- | | |
|---|----------|
| 12. Do you crave breads? | Yes = 10 |
| 13. Do you crave alcoholic beverages? | Yes = 10 |
| 14. Does tobacco smoke really bother you? | Yes = 10 |
| 15. Have you ever had a parasitic infection, dysentery, or unexplained episode of prolonged diarrhea and intestinal distress? | Yes = 15 |
| 16. Have you ever consumed chlorinated (tap) drinking water for more than 3 months? | Yes = 15 |
| 17. Do you consume non-organic meat on a regular basis? | Yes = 15 |
| 18. Do you eat processed/packaged food regularly? | Yes = 20 |
| 19. Do you drink alcohol or coffee daily? | Yes = 20 |
| 20. Do you have or have you ever had an ulcer, colitis, crohn's disease or diverticulitis? | Yes = 35 |

Total Score, Section A: _____

SECTION B: MAJOR SYMPTOMS

For each of your symptoms, enter the appropriate figure on the line following the question:

If a symptom is occasional or mild = 3 points	If a symptom is frequent &/or moderate = 6 points
If a symptom is severe or disabling = 9 points	Add total score and record it in the box at the end of the section.

- | | |
|---|-------|
| 1. Fatigue or lethargy | _____ |
| 2. Feeling of being drained | _____ |
| 3. Poor memory | _____ |
| 4. Feeling "spacey" or "unreal" | _____ |
| 5. Depression | _____ |
| 6. Numbness, burning or tingling | _____ |
| 7. Muscle aches | _____ |
| 8. Muscle weakness or paralysis | _____ |
| 9. Pain &/or swelling in joints | _____ |
| 10. Abdominal pain | _____ |
| 11. Constipation | _____ |
| 12. Diarrhea | _____ |
| 13. Bloating | _____ |
| 14. Troublesome vaginal discharge | _____ |
| 15. Persistent vaginal burning or itching | _____ |
| 16. Prostatitis | _____ |
| 17. Impotence | _____ |
| 18. Loss of sexual desire | _____ |
| 19. Endometriosis | _____ |
| 20. Cramps and /or other menstrual irregularities | _____ |
| 21. Premenstrual tension | _____ |
| 22. Spots in front of eyes | _____ |
| 23. Erratic vision | _____ |
| 24. Eczema, dermatitis, psoriasis | _____ |

Total Score, Section B _____

SECTION C: OTHER SYMPTOMS

For each of your symptoms, enter the appropriate figure on the line following that question.
If the symptom is occasional or mild = 1pt If the symptom is frequent &/or
moderately severe = 2pt If the symptom is sever &/or disabling = 3pt

-
1. Drowsiness _____
 2. Irritability _____
 3. Poor coordination _____
 4. Inability to concentrate _____
 5. Frequent mood swings _____
 6. Headache _____
 7. Dizziness/loss of balance _____
 8. Pressure above ears,
feeling of head swelling and tingling _____
 9. Itching _____
 10. Other rashes _____
 11. Heartburn _____
 12. Indigestion _____
 13. Belching & intestinal gas _____
 14. Mucus in stools _____
 15. Hemorrhoids _____
 16. Dry mouth _____
 17. Rash or blisters in mouth _____
 18. Bad Breath _____
 19. Nasal congestion or discharge _____
 20. Joint swelling or arthritis _____
 21. Postnasal drip _____
 22. Nasal itching _____
 23. Sore or dry throat _____
 24. Cough _____
 25. Pain or tightness in chest _____
 26. Wheezing or shortness of breath _____
 27. Urgency or urinary frequency _____
 28. Burning on urination _____
 29. Failing vision _____
 30. Burning or tearing of eyes _____
 31. Recurrent infection or fluid in ears _____
 32. Ear pain or hearing loss _____

Total Score Section C: _____

Total Score Section A: _____

Total Score Section B: _____

Grand Total Score

The grand total score will help you and your physician decide if your health problems are dysbiosis related. Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

Dysbiosis related health problems are almost certainly present in women with scores over 180, and in men with scores over 140.

Dysbiosis related health problems are probably present in women with scores over 120 and in men with scores over 80.

With scores of less than 60 in women and 40 in men, dysbiosis is unlikely to be contributing to your health challenges.



Back To Life Natural Health Center

Holistic Natural Health Care

2960 Winnetka Ave. N. #110 Crystal, MN 55427

763-546-3736, Fax 763-546-3807

www.backtolifehealth.com

MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name _____ Date _____

*Rate each of the following symptoms based upon your typical health profile for the last 30 days.

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

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
- (doesn't include near or far sightedness)
- 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
 - ___ Soar 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

- ___ Irregular or skipped heartbeat
 - ___ Rapid or pounding heartbeat
 - ___ Chest pain
- Total _____

LUNGS	<input type="checkbox"/> Chest congestion	
	<input type="checkbox"/> Asthma, bronchitis	
	<input type="checkbox"/> Shortness of breath	
	<input type="checkbox"/> Difficulty breathing	Total _____
DIGESTIVE TRACT	<input type="checkbox"/> Nausea, vomiting	
	<input type="checkbox"/> Diarrhea	
	<input type="checkbox"/> Constipation	
	<input type="checkbox"/> Bloating feeling	
	<input type="checkbox"/> Belching, passing gas	
	<input type="checkbox"/> Heartburn	
	<input type="checkbox"/> Intestinal/stomach pain	Total _____
JOINTS/ MUSCLE	<input type="checkbox"/> Pain or aches in joints	
	<input type="checkbox"/> Arthritis	
	<input type="checkbox"/> Stiffness or limitation of movement	
	<input type="checkbox"/> Pain or aches in muscles	
	<input type="checkbox"/> Feeling of weakness or tiredness	Total _____
WEIGHT	<input type="checkbox"/> Binge eating/ drinking	
	<input type="checkbox"/> Craving certain foods	
	<input type="checkbox"/> Excessive weight	
	<input type="checkbox"/> Compulsive eating	
	<input type="checkbox"/> Water retention	
	<input type="checkbox"/> Underweight	Total _____
ENERGY/ ACTIVITY	<input type="checkbox"/> Fatigue, sluggishness	
	<input type="checkbox"/> Apathy, lethargy	
	<input type="checkbox"/> Hyperactivity	
	<input type="checkbox"/> Restlessness	Total _____
MIND	<input type="checkbox"/> Poor memory	
	<input type="checkbox"/> Confusion, poor comprehension	
	<input type="checkbox"/> Poor Concentration	
	<input type="checkbox"/> Poor physical coordination	
	<input type="checkbox"/> Difficulty in making decisions	
	<input type="checkbox"/> Stuttering or stammering	
	<input type="checkbox"/> Slurred speech	
	<input type="checkbox"/> Learning disabilities	Total _____
EMOTIONS	<input type="checkbox"/> Mood swings	
	<input type="checkbox"/> Anxiety, fear, nervousness	
	<input type="checkbox"/> Anger, irritability, aggressiveness	
	<input type="checkbox"/> Depression	Total _____
OTHER	<input type="checkbox"/> Frequent illness	
	<input type="checkbox"/> Frequent or urgent urination	
	<input type="checkbox"/> Genital itch or discharge	Total _____
GRAND TOTAL		TOTAL _____



Back To Life Natural Health Center

Holistic Natural Health Care

2960 Winnetka Ave. N. #110 Crystal, MN 55427

763-546-3736, Fax 763-546-3807

www.backtolifehealth.com

If you have scheduled a lab appointment as well as an exam, please follow these instructions, (if you're not sure please contact us).

Inhouse Diagnostic Lab Patient Information and Instructions

You have been scheduled for our inhouse diagnostic lab workup. This is a test that will provide valuable information about the underlying biochemistry of your body. In order to insure accurate results, it is **very important** for you to follow these instructions:

- Fast for 12-14 hours prior to your test. For instance, if you are scheduled for a 9am test, you need to not eat or drink anything after 9pm the night before. (This includes gum, candy or water.) If you are on any prescribed medications (example: blood pressure medicine or insulin), take your medications after the test if possible or if you must take them before the test, do so with only a small amount of water.
- Do not use any toothpaste, mouthwashes, or mouth rinses at bedtime or in the morning before the test. Also avoid use of any lipstick or makeup around your mouth and lips. Do not smoke. Such substances can change the chemistry of the mouth and your saliva.
- Do not exercise for 12 hours prior to the test.
- Do not take any supplements for 48 hours prior to your test.
- On the morning of the test, obtain a small sample of your first morning urine after 3:00 a.m. If you get up in the night to urinate before 3:00 a.m., do not collect the sample. Wait until the first time you urinate after 3. Try to obtain a mid-stream specimen (urinate a small amount in the toilet, then urinate a small amount in your specimen cup). If you do not have a specimen cup you may use any clean container with a tight lid. You can get a specimen cup at a drug store if you like.
- We will be pricking your finger for a blood sample.

Your fluids will be analyzed by specialized laboratory equipment right here in our office, you will have access to important data about how your body is actually functioning. You will get your results that day. This will help you gain a greater understanding into what is going on at a deeper level within your body.

(NORTH)

HWY 694/94

Rockford Rd

42nd Ave

HWY 169

HWY 100

36th Ave

Back To Life Natural Health
2960 Winnetka Ave N #110
(763) 546-3736

30th Ave



Medicine Lake Rd

Winnetka Ave N

HWY 55

HWY 394