Welcome To Living Well Clinical Nutrition Center

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The vision and goal of Living Well Clinical Nutrition Center

The vision and goal we offer is to guide and mentor each individual client to their optimal wellness. We believe all life starts and stops at the cellular level and nutrition is the fundamental back bone to optimize cellular repair. We are committed to creating incremental, safe and effective change to your health. Every client that comes in will be exposed to ideas that challenge the status quo in every area of standardized health taught by many medical professionals today. Because food is the primary component to our health and well-being, it is what makes our work so special, so unique, and so important. All food, no matter how basic, plays a part in the expressive nature of your genes. We set out to find the underlying cause of every disease process that people may be experiencing. Getting sick people well is our top priority. We believe that if you stick to our program recommendations closely and long enough nothing will help you as much.

About Dr. Aaron Chapa D.C., A.C.N.

Dr. Aaron Chapa is an Applied Clinical Nutritionist and Clinical Kinesiologist (a wellness doctor), specializing in Applied Clinical Nutrition, Applied Kinesiology, Neuro-Emotional Technique, diet, weight loss, detoxification therapy, cold laser therapy, family pediatric wellness, and Quantum Neurology. It is his belief that nutrition, energy, and a properly functioning nervous system are the building blocks of life, and when these foundational aspects are balanced, it allows the body the greatest opportunity to use its own naturally occurring restorative capabilities. Dr. Chapa strides to learn the top-tier cutting edge techniques in the field of alternative wellness. He is in constant pursuit of how to rapidly bring the body back to ideal health. Nutrition applied incrementally, sequentially, and safely over time is the core philosophy of this work.

About Jennifer Withey

Jennifer Withey is a geologist, a wellness practitioner, specializing in Applied Clinical Nutrition, diet, weight loss, detoxification therapy, cold laser therapy, and family wellness alternatives. Helping people and serving people is her passion. She has a personal story to share with the world about how the nutritional insights shared using Dr. Aaron Chapa's 5 Steps to Health impacted her and her family. Her desire now is to expand the vision with Dr. Chapa in getting more sick people well. She shares the vision that the right nutrition, energy, and a properly functioning nervous system are the building blocks of life and when these foundational aspects are balanced, it allows the body the greatest opportunity to use its own naturally occurring restorative capabilities.

Living Well Clinical Nutrition Center

Today's Date: _____ Referred By: _____

Name: _____ Gender: M or F Birthday: ___/____/____ Age: _____

Mailing Address: _____ E-mail Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Height: _____ Weight: _____ Blood Type: A AB B O - + Marital Status: M D S W # of Children: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact (Name): _____ Phone Number: _____

Initial Evaluation

1. PURPOSE OF THIS APPOINTMENT: Please tell us the main reason for coming to see our office.

   _____

   _____

2. HEALTH CONDITIONS & COMPLAINTS: Please list in order of severity.

   _____

   _____

3. MEDICATIONS (List meds by name, mg's, what for, how long. Don't forget birth control, aspirin, pain meds.)

   _____

   _____

4. SURGERIES (List surgeries, operations, plastic surgery, and trauma. Please date when they occurred.)

   _____

   _____

5. ALLERGIES (Please list food, environmental, chemical, and drug allergies.)

   _____

   _____

6. SUPPLEMENTS & HERBS: (List name and why you are taking them.)

   _____

   _____

7. OTHER INFORMATION: (Please list anything else about your health that may be important.)

   _____

   _____

My signature Below confirms that this information is true.

_____ Date:_____

Health Overview

SMOKING: Do you smoke? Y N If yes, how much? _____ How long have you smoked? _____

DRUG USE: (CONFIDENTIAL) Do you use any recreational drugs?_____(If yes, *CIRCLE*: marijuana cocaine heroin uppers downers) Others:_____
How Often? _____

STRESS: Please rate your current stress level on a scale 1 to 10; 10 being the highest.
What are the main reasons for your stress?_____
How do you reduce stress? _____

SLEEP: How is your sleep? (*CIRCLE*: restful restless hard to fall asleep wake-up often bad dreams.)_____
What time do you go to sleep? _____ Number of hours of sleep per night? _____

DIGESTION: (*CIRCLE*: good adequate poor acid reflux burping bloating burning pain cramping.)
Other complaints: _____

URINATION: (*CIRCLE:* every 2-3 hours too frequent sense of urgency burning dribbling urinate at night)
Other Complaints: _____

BOWELS: How many bowel movements per day? _____ per week? _____
Consistency: (*CIRCLE*: normal hard soft diarrhea) Color: (*CIRCLE*: tan brown black green)
Other: (*CIRCLE* : gas mucous smell) Amount: (normal, too big, too small)
Other complaints: _____

EXERCISE: Do you exercise? _____What kind of exercise?
_____
How often? _____ For how long a time? _____

SUNLIGHT: How many hours of sunlight do you get daily? _____ weekly? _____
How many hours daily do you spend under fluorescent lights? _____

ELECTROMAGNETIC POLLUTION: **How many hours do you spend daily?** Watching TV?_____ Working on a computer?_____ Talking on a phone or cell phone?_____ Wearing a watch?_____
Wearing a hearing aid?_____ Riding in a car?_____ Do you live next to power lines?_____
DIET: How many times a day do you eat?_____How often do you eat out?_____

DRINKING: What kind of water do you drink?_____
(*CIRCLE*: Tap Filtered Spring Reverse Osmosis Distilled Well water)
(*CIRCLE*: beverages you drink and how many times per day **(D)** or per week **(W)** you drink them:
Milk_____ Coffee_____ Tea_____ Herbal Tea_____ Regular Tea_____
Soda_____ Beer_____ Wine_____ Liquor_____)
(*CIRCLE*: foods you eat and how many times per day **(D)** or per week **(W)** you eat them:
Corn_____ Bread_____ Rice_____ Cereal_____ Pasta_____
Cheese_____ Potatoes_____ Cookies_____ Candies_____ Cakes_____
Ice cream_____ Pork_____ Red Meat_____ Chicken_____ Chocolate_____

***WOMEN ONLY:** Are you pregnant?_____ Are you breastfeeding?_____Do you have monthly periods?_____
Last period date_____ Are you going through menopause? Y N Have your periods stopped?_____

MENSTRUAL CYCLE: Number of days of flow:_____ (*CIRCLE*: heavy light spotting normal)
(*CIRCLE*: cramping bloating weakness mood swings cravings pain bright blood dark blood blood clots)
Other menstrual complaints:_____

My signature confirms that this information is true._____Date:_____

Toxicity Questionnaire

Please rate each of the following based on your health profile based on the last 90 days

0 = Rarely or never experience the symptom
1= Occasionally experience but effective is not severe
2 = Occasionally experience but effect is severe
3 = Frequently experience and effect is not severe
4 = Frequently experience and effect is severe

Digestive:	
Nausea	0 1 2 3 4
Diarrhea or Vomiting	0 1 2 3 4
Heartburn, Reflux	0 1 2 3 4
Straining on bowel Mvmt	0 1 2 3 4
Day without bowel mvmt	0 1 2 3 4
Gas, Belch, Bloating	0 1 2 3 4
Hemorrhoids	0 1 2 3 4
Total for section:	_____
Heart:	
Shortness of Breath	0 1 2 3 4
Skipped, Rapid Heartbeat	0 1 2 3 4
High/Low Blood Pressure	0 1 2 3 4
Chest Pain	0 1 2 3 4
Tightness in chest	0 1 2 3 4
Total for section:	_____
Emotions:	
Mood Swings	0 1 2 3 4
Anxiety / Fear / Nervous	0 1 2 3 4
Anger / Irritability	0 1 2 3 4
Panic Attacks	0 1 2 3 4
Depression	0 1 2 3 4
Sense of Despair	0 1 2 3 4
Total for section:	_____
Energy:	
Fatigue / Tired	0 1 2 3 4
Sluggishness	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Restlessness	0 1 2 3 4
Brain Fog	0 1 2 3 4
Irritable if miss meals	0 1 2 3 4
Swelling hands and feet	0 1 2 3 4
Total for section:	_____
Skin, Hair, Nails:	
Flushing	0 1 2 3 4
Cold hands & feet	0 1 2 3 4
Acne	0 1 2 3 4
Dry skin /Oily skin	0 1 2 3 4
Hives, rashes	0 1 2 3 4
Eczema, Psoriasis	0 1 2 3 4
Hair loss	0 1 2 3 4
Cracked heels on feet	0 1 2 3 4
Bruising	0 1 2 3 4
Brittle nails	0 1 2 3 4
Total for section:	_____

Hormones:	
Oily Skin, Acne	0 1 2 3 4
Pain during period	0 1 2 3 4
Breast tenderness	0 1 2 3 4
Irregular cycle	0 1 2 3 4
Weight gain	0 1 2 3 4
Cry easily	0 1 2 3 4
Vaginal dryness	0 1 2 3 4
Hot flashes	0 1 2 3 4
Loss of sex drive	0 1 2 3 4
Erectile dysfunction	0 1 2 3 4
Balding	0 1 2 3 4
Anger easily	0 1 2 3 4
Total for section:	_____
Head, Eyes:	
Blurred Vision	0 1 2 3 4
Pressure	0 1 2 3 4
Faintness	0 1 2 3 4
Dizziness	0 1 2 3 4
Headaches	0 1 2 3 4
Total for section:	_____
Allergies:	
Watery, Itchy Eyes	0 1 2 3 4
Runny Nose	0 1 2 3 4
Sneezing	0 1 2 3 4
Itchy throat	0 1 2 3 4
Itchy skin	0 1 2 3 4
Post nasal drip	0 1 2 3 4
Total for section:	_____
Immune:	
Frequent illness	0 1 2 3 4
Sore throat	0 1 2 3 4
Fever	0 1 2 3 4
Genital itch, Discharge	0 1 2 3 4
Yellow nail fungus	0 1 2 3 4
Total for section:	_____
Urinary Tract:	
Frequent urination	0 1 2 3 4
Burning on urination	0 1 2 3 4
Dribbling urine	0 1 2 3 4
Leaky bladder	0 1 2 3 4
Blood in urine	0 1 2 3 4
Kidney stones	0 1 2 3 4
Total for section:	_____

Ears, Sinus, Nose:	
Popping ears	0 1 2 3 4
Fluid in ears	0 1 2 3 4
Ringing ear	0 1 2 3 4
Hearing loss	0 1 2 3 4
Ear Infections	0 1 2 3 4
Excessive mucous	0 1 2 3 4
Stuffy nose	0 1 2 3 4
Sinus headache	0 1 2 3 4
Nose bleeds	0 1 2 3 4
Total for section:	_____
Mouth, Throat, Teeth:	
Dry Mouth	0 1 2 3 4
Canker sores	0 1 2 3 4
Cold sores	0 1 2 3 4
Tooth pain	0 1 2 3 4
Bleeding gums	0 1 2 3 4
Gagging, clearing throat	0 1 2 3 4
Total for section:	_____
Lungs:	
Difficulty breathing	0 1 2 3 4
Chest congestion	0 1 2 3 4
Coughing	0 1 2 3 4
Asthma	0 1 2 3 4
Total for section:	_____
Joints, Muscles, Bones:	
Twitching	0 1 2 3 4
Cramping	0 1 2 3 4
Stiff & achy joints	0 1 2 3 4
Pain in joints	0 1 2 3 4
Swelling in Joints	0 1 2 3 4
Muscle aches	0 1 2 3 4
Muscle pains	0 1 2 3 4
Osteoporosis	0 1 2 3 4
Numbness, Burning	0 1 2 3 4
Flat feet, Fallen arch	0 1 2 3 4
Total for section:	_____
Sleep:	
Can't fall asleep	0 1 2 3 4
Wake up often	0 1 2 3 4
Nighttime Urination	0 1 2 3 4
Wake up tired	0 1 2 3 4
Bad dreams/Nightmare	0 1 2 3 4
Night sweats	0 1 2 3 4
Total for section:	_____

Signature:_____ Date:_____Total For All Sections:_____

LWCNC Athlete Form

(Only Fill Out If Patient is participating in any exercise or athletic routine)

Are you a professional Athlete (Paid to Play or have a Sponsor): Yes/No

Your sport is:_____ Your Team name is:_____

Are you an Amateur athlete? Yes/No

Your sport is:_____ Your Team name is:_____

Your purpose for your routine is (examples: career, lose/gain weight, be faster/stronger, de-Stress)

_____

_____

Please describe your routine:

Day	Duration	Type of Training
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____
Sunday	_____	_____

Greatest Strengths:_____

Greatest Weakness:_____

Signature confirms this information is true:

Signature:_____ Date:_____

Name of minor: _____ Date: _____

Your Name: _____

Pediatric Form

Living Well Clinical Nutrition Center

(only fill out if 5 years old or under)

Prenatal History:

Were you taking prenatal vitamins while pregnant? _____ When did you begin taking them? _____

Did you take any medications while pregnant? _____ Why? _____

How stressful would you rate your pregnancy on a scale of 1-10 (10 being the most stressful?) _____

Birthing History:

How long were you pregnant? _____weeks.

Who delivered your baby? Circle: Obstetrician, Midwife, Other:_____

How was your baby delivered? ***Circle:*** vaginal, C-section, forceps, vacuum, other:_____

Did you receive any medications during labor? ***Circle***: induction (pitocin), pain meds (epidural), other: _____

What was your baby's APGAR score? 1 2 3 4 5 6 7 8 9 10

Infant or Toddler:

What is the number one complaint today?_____

How long has it been going on? _____

What makes the situation worse? _____

What makes the situation better? _____

******Please circle all that your infant or toddler is having trouble with:***

eyes ears nose throat heart lungs breathing gassy

diarrhea constipation vomiting seizures skin learning disorders

emotional disorders behavioral disorders genetic disorders

What does your baby's diet consist of? _____

Is there anything else that may be important? _____

Mothers Information:

How many past pregnancies? _____How many were delivered?

_____

Do you take vitamins? _____ What kind? _____

Do you smoke? _____ How many packs per day? _____ How long have you smoked? _____

******If you are breastfeeding continue:***

Do you drink alcohol? _____ How much? _____ How often? _____

Do you drink soft drinks? _____ How many per day? _____

Do you drink coffee? _____ How many cups per day? _____

Do you consume dairy products? _____ How much per day? _____

My signature confirms that the above information is true.

Legal Guardian Signature: _____ **Date:** _____

Practitioner~Client INFORMED CONSENT

HEALTH AND WELLNESS

We want you to be informed about our goals, philosophies, and expectations at Living Well Clinical Nutrition Center in regards to how we work to achieve health and wellness for you and your family. It is our premise that nutrition, energy, and a properly functioning nervous system are the building blocks of life. When these foundational aspects are balanced, it allows the body the opportunity to optimize its own naturally occurring recuperative abilities. With this in mind, we seek to restore health through natural means without the use of drugs or surgery. (If medication or surgery is warranted, we advise the individual with the building blocks of life, we give their body the maximum opportunity to utilize its inherent recuperative powers. We do not claim to treat or cure any specific disease or condition. The staff at Living Well Clinical Nutrition Center provide a specialized, unique, non-duplicating health service and are certified in their special areas of practice.

ANALYSIS AND APPROACH

At your appointment, we will conduct an analysis for the express purpose of determining the nutritional, neurologic, and/or energetic deficiencies or any interference that hinders you from achieving optimal wellness. Specialties of our practitioners include Applied Clinical Nutrition, Applied Kinesiology, Quantum Neurology, joint mobilization, Neuro-Emotional Technique, diet and weight loss support, detoxification, cold-laser therapy, family and pediatric wellness. They will utilize the aforementioned, safe and non-invasive techniques to achieve your optimal wellness.

RESULTS

The purpose of office visits is to promote natural health through the stabilization of the nutritional, neurological, and energetic systems of your body. Due to the individuality of every person, it is difficult to predict the healing time. Most often the response is incredible as to how the body begins to heal quickly, however, in some cases, there is a more gradual healing process. Two or more similar conditions may respond differently to the same type of care and actual response time is unpredictable. Many conditions, for which the medical field has not found much improvement, have found significant benefit through the approach we use at Living Well Clinical Nutrition Center. Our practitioners work with you to help you make an informed decision prior to being accepted as a new client.

DIAGNOSIS

Although the staff at Living Well Clinical Nutrition Center are experts in the analysis of the nutritional, neurological, and energetic aspects of the human body, they will not make a diagnosis outside of their scope of practice. Individuals that require additional testing (MRI, X-Ray, Blood, etc...) will be informed and have access to those reports at any time.

INFORMED CONSENT

By signing this page you give Living Well Clinical Nutrition Center permission and authority to use any or all of the aforementioned analyses and techniques. You are giving permission to utilize the gathered data, according to HIPAA guidelines (no use of names/complete anonymity, etc...), for research, research presentations, and other office applications should the practitioners deem the case appropriate. It is the responsibility of the client to make any diagnosed or observed deformities, injuries, illnesses, or other pathological conditions known in order to receive the most optimal care. If you have any further questions concerning our office please feel free to ask.

Signature: _____ **Date:** _____

Living Well Clinical Nutrition Center Fees and Policies

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At your appointment:

We appreciate the fact that people have schedules to follow and for that **we do our very best to run on time**. This insures that you know when your appointment begins and ends and can make plans accordingly. This also insures that you get the full allotted time for your visit.

Cancellation Policy:

If for some reason you have to reschedule or cancel your existing patient appointment we do ask that you give us **24 hours notice.** If we do not answer the phone, please leave a message because the machine will identify the date and time that you called. By giving us 24 hours notice, it allows us to fill the spot with another patient on our waiting list. If we do not receive 24 hours notice we will charge you in the amount of the appointment that you missed. ($45 for existing patients, $150 for new patients.) **Note:** The new patients reschedule or cancellation policy is at least 7 days notice.

Office Fees:

Our fees are based on the time that you spend in the office. A new office visit or initial phone consultation is 45 minutes and existing office visits or phone consultations are 15 minutes. If you do not visit our office within 1 year you will be required to have another new visit due to the need for a complete re-evaluation.

New Client: 45 minute office visit or phone consultation:	$ 150.00
Existing Client: 15 minute office visit or phone consultation:	$ 45.00
Foot Bath (Iontophoresis or Detoxification excluding botanicals/minerals):	$ 30.00
Botanicals for Iontophoresis and Detoxification:	$ 5.00
Laser Therapy:	$ 15.00
Interpretation Fee (Time to review any and all diagnostics test):	$ 35.00

*Supplements and laboratory work are NOT included in the price of the visits. This amount will vary based on your evaluation. (NOTE: All supplements are permanently discounted 10-35% as a courtesy of being a patron of our office. Blood work is discounted down over 75% as a client of Living Well Clinical Nutrition Center.
*We are happy to mail supplements for a shipping fee of $5.00. Outside of U.S., shipping is $50. **Overnight shipping excluded.** Orders over $100 is free shipping.

Payment:

Payment is due at the time of services rendered. We accept cash, check, and credit cards. We provide you with information so that you may file with your insurance.

I have read and understand the above information and I accept the policies of Living Well Clinical Nutrition Center.

Signature: _____ Date: _____