Welcome To Living Well Clinical Nutrition Center

815 East Main St STE A, League City Tx 77573
281-554-8600 office
281-554-8669 fax
info@justlivewell.com

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 backbone to optimize cellular repair. We are committed to creating incremental, safe and effective change to your health. Because food is the primary component to our health and well being, ideas that challenge the status quo in every area of standardized health taught by many medical professionals today. 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. When these foundational aspects are balanced, it allows the body the greatest opportunity to use its own naturally occurring restorative capabilities. The vision and goal of Living Well Clinical Nutrition Center is to guide and mentor each individual to his or her optimal wellness. Dr. Chapa strives to master 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 its natural state of health. Nutrition, applied incrementally, sequentially, and safely over time, is the cornerstone of this work.

About Jennifer Withey
Jennifer Withey is a geologist and 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; how using Dr. Aaron Chapa’s 5 Steps to Health impacted her and her family. Her desire now is to expand that vision with Dr. Chapa and focus on helping more sick people find health. It is her belief that the right 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 greatest opportunity to use its own naturally occurring restorative capabilities.

About Dr Amber Sorcic D.C.
Dr. Amber Sorcic is a board-certified chiropractor with a passion for preventative family care. She is trained in a variety of adjustment techniques, which allows her to treat family members of all ages. She has postgraduate training on prenatal and postpartum care, and is continuing her education in women’s health. Dr. Amber believes that when we provide the proper framework (through structural, emotional, and nutritional care), the body is able to live up to its fullest potential of health. Most importantly, she is raising her family of 5 in a holistic manner, right alongside you. She is pleased to be serving our community by helping families reach their wellness goals.

Signature: ____________________________________________ Date: ____________________
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: _______________________

Living Well Clinical Nutrition Center
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: _______________________

Page 2 of 8
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? ____________________________


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)

<table>
<thead>
<tr>
<th>Digestive:</th>
<th>Hormones:</th>
<th>Ears, Sinus, Nose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Oily Skin, Acne</td>
<td>Popping ears</td>
</tr>
<tr>
<td>Diarrhea or Vomiting</td>
<td>Pain during period</td>
<td>Fluid in ears</td>
</tr>
<tr>
<td>Heartburn, Reflex</td>
<td>Breast tenderness</td>
<td>Ringing ear</td>
</tr>
<tr>
<td>Straining on bowel Mvmt</td>
<td>Irregular cycle</td>
<td>Hearing loss</td>
</tr>
<tr>
<td>Day without bowel mvmt</td>
<td>Weight gain</td>
<td>Ear Infections</td>
</tr>
<tr>
<td>Gas, Belch, Bloating</td>
<td>Cry easily</td>
<td>Excessive mucous</td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td>Vaginal dryness</td>
<td>Stuffy nose</td>
</tr>
<tr>
<td><strong>Total for section:</strong></td>
<td>Hot flashes</td>
<td>Sinus headache</td>
</tr>
<tr>
<td><strong>Heart:</strong></td>
<td>Loss of sex drive</td>
<td>Nose bleeds</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>Erectile dysfunction</td>
<td></td>
</tr>
<tr>
<td>Skipped, Rapid Heartbeat</td>
<td>Anger easily</td>
<td></td>
</tr>
<tr>
<td>High/Low Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest Pain</td>
<td><strong>Total for section:</strong></td>
<td></td>
</tr>
<tr>
<td>Tightness in chest</td>
<td><strong>Head, Eyes:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total for section:</strong></td>
<td>Blurred Vision</td>
<td>Dry Mouth</td>
</tr>
<tr>
<td><strong>Emotions:</strong></td>
<td>Pressure</td>
<td>Canker sores</td>
</tr>
<tr>
<td>Mood Swings</td>
<td>Faintness</td>
<td>Cold sores</td>
</tr>
<tr>
<td>Anxiety / Fear / Nervous</td>
<td>Dizziness</td>
<td>Tooth pain</td>
</tr>
<tr>
<td>Anger / Irritability</td>
<td>Headaches</td>
<td>Bleeding gums</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td><strong>Total for section:</strong></td>
<td>Gagging, clearing throat</td>
</tr>
<tr>
<td>Depression</td>
<td><strong>Allergies:</strong></td>
<td></td>
</tr>
<tr>
<td>Sense of Despair</td>
<td>Watery, Itchy Eyes</td>
<td></td>
</tr>
<tr>
<td><strong>Total for section:</strong></td>
<td>Runny Nose</td>
<td></td>
</tr>
<tr>
<td><strong>Energy:</strong></td>
<td>Sneezing</td>
<td></td>
</tr>
<tr>
<td>Fatigue / Tired</td>
<td>Itchy throat</td>
<td></td>
</tr>
<tr>
<td>Sluggishness</td>
<td>Itchy skin</td>
<td></td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>Post nasal drip</td>
<td></td>
</tr>
<tr>
<td>Restlessness</td>
<td><strong>Total for section:</strong></td>
<td></td>
</tr>
<tr>
<td>Brain Fog</td>
<td><strong>Immune:</strong></td>
<td></td>
</tr>
<tr>
<td>Irritable if miss meals</td>
<td>Frequent illness</td>
<td></td>
</tr>
<tr>
<td>Swelling hands and feet</td>
<td>Sore throat</td>
<td></td>
</tr>
<tr>
<td><strong>Total for section:</strong></td>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td><strong>Skin, Hair, Nails:</strong></td>
<td><strong>Urine Tract:</strong></td>
<td></td>
</tr>
<tr>
<td>Flushing</td>
<td>Genital itch, Discharge</td>
<td></td>
</tr>
<tr>
<td>Cold hands &amp; feet</td>
<td>Yellow nail fungus</td>
<td></td>
</tr>
<tr>
<td>Acne</td>
<td><strong>Total for section:</strong></td>
<td></td>
</tr>
<tr>
<td>Dry skin /Oily skin</td>
<td><strong>Urinary Tract:</strong></td>
<td></td>
</tr>
<tr>
<td>Hives, rashes</td>
<td>Frequent urination</td>
<td></td>
</tr>
<tr>
<td>Eczema, Psoriasis</td>
<td>Burning on urination</td>
<td></td>
</tr>
<tr>
<td>Hair loss</td>
<td>Dribbling urine</td>
<td></td>
</tr>
<tr>
<td>Cracked heels on feet</td>
<td>Leaky bladder</td>
<td></td>
</tr>
<tr>
<td>Bruising</td>
<td>Blood in urine</td>
<td></td>
</tr>
<tr>
<td>Brittle nails</td>
<td>Kidney stones</td>
<td></td>
</tr>
<tr>
<td><strong>Total for section:</strong></td>
<td><strong>Total for section:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Signature:</strong></td>
<td><strong>Total For All Sections:</strong></td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td><strong>Energy:</strong></td>
<td></td>
</tr>
</tbody>
</table>

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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:

<table>
<thead>
<tr>
<th>Day</th>
<th>Duration</th>
<th>Type of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
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<tr>
<td>Wednesday</td>
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<td>Thursday</td>
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<tr>
<td>Friday</td>
<td></td>
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<tr>
<td>Saturday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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? ________________________________
What food do you eat regularly? ________________________________________________________________

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

815 East Main St STE A, League City Tx 77573
281-554-8600 office 281-554-8669 fax info@justlivewell.com

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. 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. 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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Evaluation with Dr. Chapa</td>
<td>$220.00</td>
</tr>
<tr>
<td>Nutrition/Wellness Evaluation</td>
<td>$110.00</td>
</tr>
<tr>
<td>Chiropractic Evaluation</td>
<td>$110.00</td>
</tr>
<tr>
<td>Follow Up Chiropractic or Nutrition Appointments: in office or phone consultation</td>
<td>$ 55.00</td>
</tr>
<tr>
<td>Foot Bath (Iontophoresis or Detoxification excluding botanicals/minerals):</td>
<td>$ 25.00</td>
</tr>
<tr>
<td>Botanicals for Iontophoresis and Detoxification:</td>
<td>$ 5.00</td>
</tr>
<tr>
<td>Laser Therapy:</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>Interpretation Fee (Time to review any and all diagnostic tests):</td>
<td>$ 35.00</td>
</tr>
</tbody>
</table>

*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. Our shipping fees are listed below:
Orders under $100.00: $10.00
Orders between 100.00 and 199.99: $5.00
Orders $200 and over: Shipping is free

Overnight shipping excluded

Payment:
Payment is due at the time of services rendered. We accept cash, check, and credit cards. We do not accept insurance.

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

Signature: ___________________________________________ Date: ___________________