

# 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 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. 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 adjustive 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: \_\_\_\_\_

# 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)

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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?) \_\_\_\_\_

### **Birth 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](mailto: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. (\$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. 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
Shipping outside of the U.S.:	\$50.00

## Overnight shipping excluded

## 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: \_\_\_\_\_