COSTA

LIFESTYLE MEDICINE

FUNCTIONAL BLOOD CHEMISTRY ANALYSIS

Hello,
Thank you for your inquiry in Dr. Cynthia Costa D.C.'s Functional Blood Chemistry Analysis. The objective of
this letter is to answer some of your questions before we get started.

Dr. Costa is a Chiropractor that specializes in Functional Blood Chemistry Analysis. She has been in practice
for over ten years and has worked in the Chiropractic industry for over 21 years.
Due to her busy private practice Dr. Costa will only take on a limited number of Biochemical patients per month. In order to assess whether you are an ideal candidate who will benefit from her service, the first step is for her to conduct a case review.

Each case review is formulated by a series of questionnaires that we will email to you. Every patient's individual case has to be assessed in great detail so that she may outline an appropriate treatment plan and then a course of management. Please fill out all the questionnaires entirely and include any recent lab tests that you may have (from the last 2 years). You will also need to send a brief detailed medical case history and any older lab information or history of medical events summarized in a flow chart. When they are received, Dr. Costa will review all the information. Then she will call to schedule an appointment for her to discuss her professional opinion of the results with you. This half hour appointment will be done over the phone.

The case review serves several purposes. Dr. Costa will be giving you her second opinion, allowing her to give you her interpretation of your pre-existing lab tests. It also serves an opportunity to speak with her and have your questions answered in order to determine if she is your best choice in being your managing physician.

Dr. Costa wants you to understand that she only takes patients that are willing to play an active role in the process of improving their health. It is the patient's responsibility to comply with the recommended treatment plan once given in order to assess progress.

The case review is a stand alone visit and nothing more is required. The fee for the case review is $200 (U.S. dollars) and we accept payment via credit card only. We are unable to accept any form of insurance as payment and we do not accept cash or checks.

Case Review cost will cover the following:
1) Review summary of all preexisting labs
2) Additional labs recommended /ordering prep cost and financial prioritization
3) Limited nutrition/dietary recommendations
4) Outline of biochemical priorities
5) Brief medical exam checking basic vitals

Dr. Cynthia Costa D.C.FICPA
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If new labs are ordered after the case review appointment, a follow up visit to review the new lab results will be required.

Please be advised that the lab tests clinical recommended by Dr. Costa could range anywhere between $100 to $2,000 dollars over the course of the first year, depending on your specific metabolic needs. This may include repeat tests to analyze whether a lab value has improved. Please note that Dr. Costa has NO affiliation with these labs and receives NO financial compensation for recommending and using these lab companies.

New Lab Review calls that are 30 minutes in length cost $100 to $200. This does not include the supplement/detox supplies that are given in the treatment plan recommendation which can range from $ 1to $400 on the initial visit.

New Lab Review Cost Includes:
1) Review of new labs
2) More comprehensive nutritional/dietary cleanse recommendations
3) Outline of new biochemical priorities
4) Supportive literature lifestyle management

Dr. Costa uses high quality pharmaceutical grade herbal supplements to help manage her patient cases. The supplement costs could run anywhere between $100 to upward of $1,500 dollars over the course of the first year.

Once treatment has been underway, a scheduled Follow up visit every 6 to 8 weeks and weekly emails to Dr. Costa with symptom updates are important to monitor patient progress. Subsequent follow up visits are $75 dollars for 15 to 20 minutes.

Please note that Dr. Costa may need you to retake lab tests to measure the progress and to compare the results with the first tests to see the improvement with the biochemical markers.

The overall costs for the first year of her care typically will run from $1,000 - $3,000. The next year is usually maintenance care and is much less expensive. This includes annual lab work recheck and maintenance supplement costs. It is different for each person seeing that everyone's health and needs are unique. There is no one treatment plan that is the same for everyone.

I hope this answered most of your questions. If you have any more please do not hesitate to email them to me or leave a message on the voicemail.

Thank you,

Dr. Cynthia Costa D.C.

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Terms of Case Management:

Item l: I understand if I become a patient of Dr. Cynthia Costa, D. C. (Doctor of Chiropractic) that her care is not a substitute for conventional medical care with my medical physician and that her involvement with my case is to provide dietary, nutritional, and lifestyle suggestions as an attempt to improve quality of life.

Item 2: I understand as a Doctor of Chiropractic, that Dr. Costa cannot recommend or prescribe medications nor perform surgeries within her scope of practice as her scope is limited to clinical evaluation related to diet, nutrition, and lifestyle.

Item 3: I understand that Dr. Costa is a consultant to the healthcare industry and her recommendations for my care may involve affiliations that she has with industry products such as nutritional supplements, diagnostic tests, books, educational material, etc.

Item 4: I understand that the suggestions provided by Dr. Costa are not a treatment or a curative procedure for any disease process and she will only be providing a theoretical model of nutritional supplementation, diet, and lifestyle to provide adjunctive support to my overall health.

Item 5: I understand that Dr. Costa does not guarantee any positive outcomes for cases and there is a risk of spending money, time, and energy without any guarantee of results.

I, _____ hereby understand items 1-5.

(Print name)

_____ Date_____

(Signature)

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CASE REVIEW TERMS

1. I understand that the case review process is used to determine if I am a candidate for care.
2. I understand that case review process does not establish me as a patient under Dr. Costa's care and there is no doctor-patient relationship or obligation.
3. I am aware that after the case review, I may not be accepted as a patient.
4. I understand that the case review fee is $200 U.S. dollars and is not refundable, even if I am not accepted as a patient.
5. I understand the case review process is a one-time service to review my case history and laboratory tests. No further service is provided with the case review.
6. I understand that all lab tests and history must be provided, at one-time, for the case review process. Review of additional lab tests, after the one-time case review process, is not permitted.
7. I understand that if I am not a candidate for care that Dr. Costa D.C. will send me a letter or email with an explanation of why I am not a candidate for care.

I have read, understand and accept the terms of items 1-7 as listed above,

Patient _____ Date _____

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Biochemistry Comprehensive Intake Form

PLEASE KEEP A COPY FOR YOUR RECORDS

Confidential Patient Health Record

Please complete the following questionnaire as thoroughly as possible to aid us in your diagnosis and treatment. This will become a part of your confidential medical record and will not be released unless you have authorized us to do so.

Name: _____ Date: _____

Address: _____ Unit: _____

City: _____ State: _____ Zip Code: _____

DOB: _____ Age: _____ Sex: **M F Other:** _____

Email: _____

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

Referred By/How did you hear about us? _____

Emergency Contact Name and Phone: _____

Circle One: **Single / Married / Divorced** Partner's Name/Occupation: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Specialist's Name: _____ Specialist's Phone Number: _____

Overall Health (circle one): **Excellent/ Good / Fair / Poor Other:** _____

Occupation: _____

Occupational Stresses (chemical, physical, psychological, etc.) _____

_____

Hobbies/Past-time: _____

Place of Birth: _____

Denomination/Religious/Spiritual Beliefs (OPTIONAL): _____

What level of change to your lifestyle/habits are you willing to make to improve your health? (circle one):

Whatever it takes **Significant change** **Some change** **No change**

ꕥ Chief Complaint Intake Form ꕥ

ꕥ What are your chief complaints?

ꕥ When did the symptoms begin?

ꕥ What precipitated or started the condition?

ꕥ Does anything make it better or worse?

ꕥ Can you think of any other complaints or problems, even if you think they may be insignificant or unrelated to your main complaint?

ꕥ Please describe your long and short term goals here:

Patient Name:_____ Date:_____

∞ Medical Health History Form ∞

Please check the appropriate box that correlates with the statement
Y = Yes (currently), N = No, P = Past

General:	Y	N	P
Do you have any tattoos?			
Have you ever served in the armed forces?			
Have you ever had a blood transfusion? if so, approximate date of transfusion:_____			
Have you ever been exposed to chemicals, pesticides, etc? Specify:_____			
History of concussion or of hitting your head?			

Cardiovascular: (Circle all that apply)

Shortness of Breath High Blood Pressure Low Blood PressureFainting

Phlebitis Hand/Feet Swelling Blood Clots(DVT, PE, Stroke)

Dizziness Irregular Heartbeat

Pain or abnormal sensation in chest (Palpitations, tightness, etc.)

Personal history of heart attack stents, cardiac surgery?_____
Other:_____

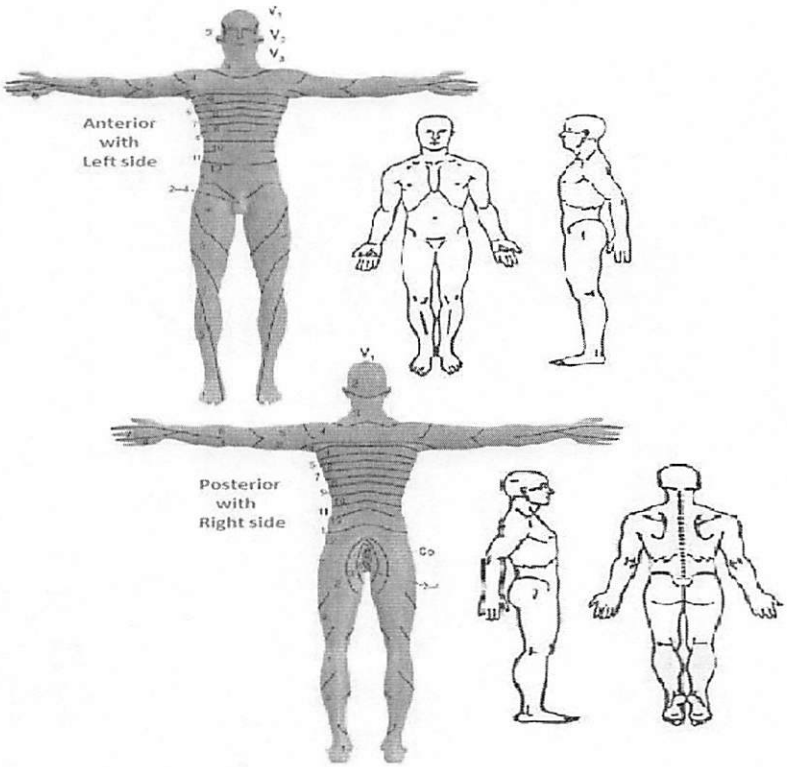
Respiratory: (Circle all that apply)

Persistent Coughing Shortness of Breath Asthma COPD

Bronchitis Coughing Blood Pneumonia Production of Phlegm
Difficulty breathing while lying down

Other:_____

Musculoskeletal/Pain:	Y	N	P
Joint Pain?			
Aches or pain in the neck, middle back, or low back?			
Muscle Pain?			
Pain, numbness, or tingling in the arms of legs?			
Joint/ Muscle pain in the night?			
Hypermobile Joints? (fingers, elbows, knees, shoulders)			
Tendon/ligament injuries?			
Jaw pain/clicking jaw/grind teeth?			
History of injury or car accidents? Briefly what happened? _____ _____			
Other:_____			



Please mark/circle where you have pain symptoms.

Describe the pain in a word or two (stabbing, dull, throbbing, constant, migrating) AND list pain level (10= worst, 1 =barely feel):

Severity: 0 1 2 3 4 5 6 7 8 9 10

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name:_____ Date:_____

Gastrointestinal: (Circle all that apply, then answer 1-4)

Heartburn/Reflux Nausea/Vomiting Diarrhea/Loose Stools Fecal Incontinence

Rectal Pain Hemorrhoids Bad Breath Constipation

Distress in upper abdomen or stomach Problems with gas or belching

1. How many times per day/week do you have a bowel movement?_____
2. How often are you constipated?_____
3. Bloody stools?_____Red blood?_____ Black or tarry looking?_____
4. Other:_____

Genito-Urinary: (Circle all that apply)

Pain with Urination Frequent Urination Urgent Urination

History of Kidney Stones Genital Odor/ Discharge. Genital Sores/Pain

Sexual Function Issues Blood in Urine

Loss of Bladder Function/Urinary Incontinence

History of Sexually Transmitted disease(eg. HPV, Gonorrhea,Herpes)

Recurrent Urinary Tract Infections: How frequent?_____

Other:_____

MALES ONLY:

Prostate Problems Burning/ Pain with Ejaculation

Gynecology and Pregnancy: (Circle all that apply, then answer 1-6)

Premenstrual Symptoms Irregular Periods Body Changes

Miscarriages Gynecology Surgeries Breast Lumps

1. Age of first Menses?_____
2. Flow? Describe_____
3. Length of period?_____
4. Last Menses?_____
5. Number of Pregnancies?_____Live births_____Premature births_____
6. Birth Control? Type:_____
7. Menopause Age:_____
8. Do you take Female Hormones?_____

Head, Eyes, Ears, Nose and Throat: (Circle all that apply)

Headaches	Migraines	Dizziness	Poor Hearing	Sinus Problems
Near/Far Sighted	Blurry Vision	Night Blindness	Color Blindness	Ear Pain
Spots on eyes	Pterygium	Cataracts	Glaucoma	Ear Wax
Tinnitus	Ear Discharge	Nose Bleeds	Mouth/Tongue Sores	
Chronic Sore Throat		Auras, Sounds, Smells		

Other:_____

Dental: (Circle all that apply)

Teeth Problems	Cavities	Fillings	Braces
Crowns gold/ Porcelain	Tooth Pain	Extractions	Facial Pain
Grinding Teeth	Root Canals	History of Tooth Abscess	
Jaw Pain	Amalgams	Swollen/Bleeding Gums	

Surgeries? Describe: _____
Other:_____

Neurological: (Circle all that apply)

Seizures	Vertigo	Nausea/Vomiting
Loss of Consciousness	Weakness in limb/body	Stumbling/Tripping
Loss of Coordination	Balance Problems	Loss of Grip Strength
Loss of Fine Motor Skills	Numbness/ Tingling	

History of Concussion? Describe:_____

Other:_____

Diagram of Tooth Numbering

Adult Dentition: Permanent Teeth 1 - 32

Child Dentition: Primary Teeth A -T

Please mark teeth that have current dental issues or teeth that have had previous dental interventions.

Use the key below to mark specific issues and give a brief explanation:

KEY:

R = Root canal CR = Crown

P = Pulled B = Bridge

I = Implant CA = Cavities

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

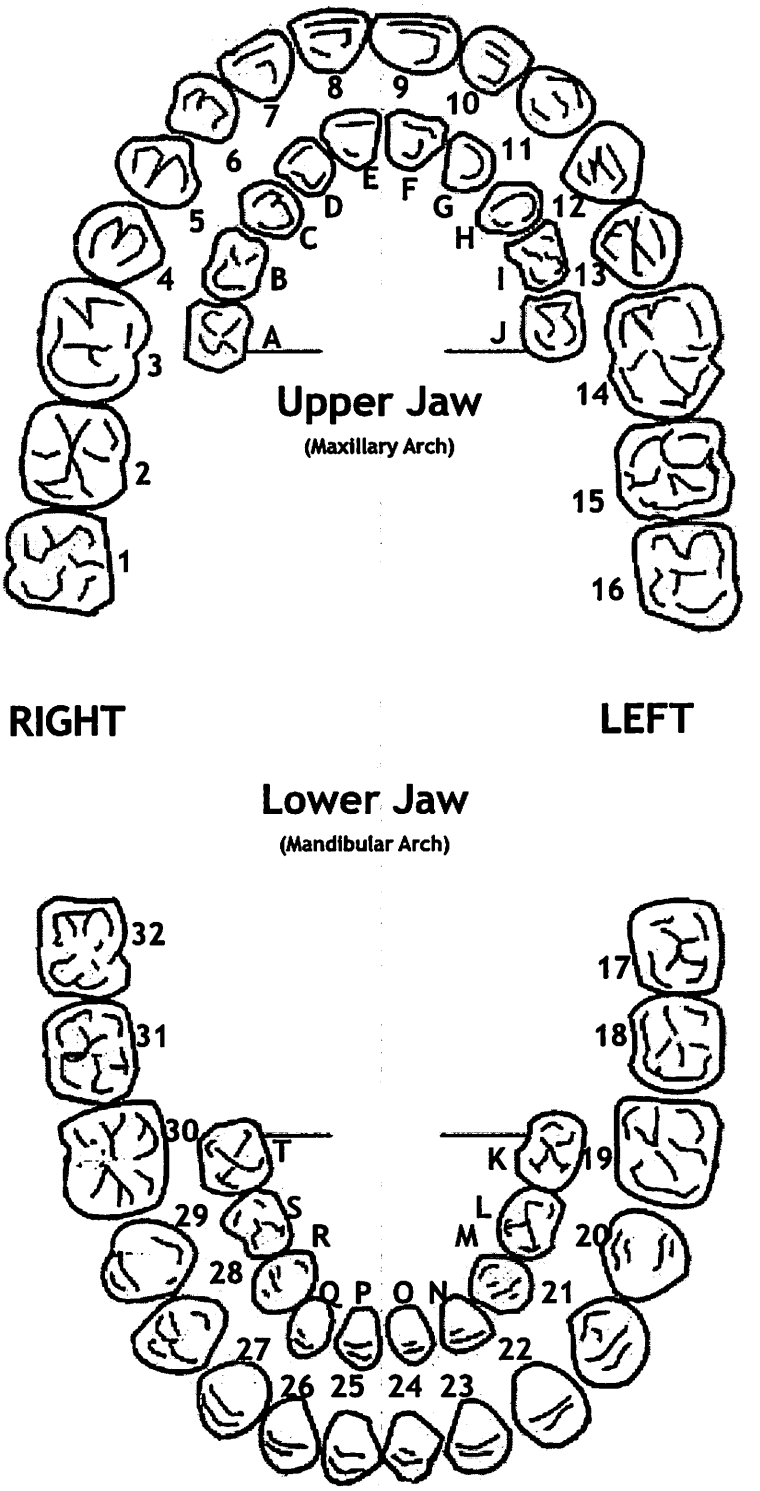
Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____



Patient Name:_____ Date:_____

Neuropsychological: (Circle all that apply then answer 1-3)

Depression Anxiety Poor Memory Foggy Thinking

Anger Issues Suicidal Ideation Suicide Attempts

1. Do you cry? _____Do you prefer to be alone?_____ or do you prefer comfort?_____
2. Treated for other emotional issues? _____
3. Have you ever been hospitalized for psychological issues?_____

Stress Screening:	Y	N	P
Trouble dealing with Stress?			
Does stress lead to digestive problems?			
Can you relax when you want?			
Does stress affect your sleep?			
Do you bite your nails?			
Do you abuse food/alcohol/ tobacco to deal with unpleasant feelings?			
Do you feel your health is out of your hands?			
Do you avoid conflicts at your expense?			
Other:_____			

Living Environment:

1. What type of building do you live in? House__Apartment___Mobile home___Other:_____
2. How long have you lived there?_____
3. How old is the building you live in?_____
4. Do you have house plants? How many?_____
5. Do you sleep on a waterbed?_____
6. Do you use an electric blanket?_____
7. Do you drink tap or well water?_____
8. Do you have pets? Dogs_____ Cats_____ Indoor_____Outdoor_____
9. If you do have pets, what are their names?_____
10. Other:_____
11. Have you ever lived/ worked in a water damaged building (Flood/leaks)? Provide brief detail.

_____

_____

_____

12. Any signs of water staining, including cracked/peeled paint? Home Office

13. Has there ever been a water leak in your home? *(check all that apply)*

- □Roof Leak
- □Basement Flood
- □Water Heater Leak
- □Supply Line to refrigerator/Toilet
- □Burst Pipe
- □Broken Sprinkler Line
- □Toilet/Bathtub Overflow
- □Sewer Backup
- □Gutter Backup
- □Air-conditioning Leak
- □Draw Pipe Leak Under Kitchen/Bathroom Sink
- □Wash Machine Overflow
- □Water Stain from Plants
- □Other:_____

14. Do you have a swamp cooler?_____
15. What does your house use to Heat/Cool?

□Forced air □Radiant floor heat □Piped Hot Water □Other:_____

16. Has there ever been a water leak in your place of employment?_____
17. Do you walk/recreate/live near or swim in any bodies of water (lakes, backyard ponds etc.)? Have you ever seen any algae blooms or scum in the water? Provide brief detail.

_____

_____

18. Do you go fishing often? _____
19. Do you eat seafood? List fish you eat (sea bass, etc.)

_____

20. Do you have any history of a tick bite or spider bite? Please describe. _____

_____

Social History:	Y	N	P
Do you exercise regularly?			
Exercise type:_____ Quantity:_____			
Do you participate in community events?			
Do you wear seatbelt when driving?			
Caffeine/pills/coffee/tea/energy drinks? Amount:_____ Frequency:_____			
Consume Alcohol? Amount:_____ Frequency:_____			
Do you smoke/chew tobacco? Amount:_____ Frequency:_____			
Marijuana use? Frequency:_____			
Do you use other recreational drugs?			
Do you engage in risky behaviors?			
Road Rage?			
Do you engage in high risk sexual behavior?			
Have you ever been abused physically, emotionally, or sexually?			
Eating disorder (bulimia, anorexia, or compulsive eating)?			
Other:_____			

Family History

Where you adopted? Yes ☐ No ☐

Please list any health issues, which have affected your relatives; include their age or age at death

Mother: _____

Father:_____

Brothers: _____

Sisters: _____

Maternal Grandmother:_____

Maternal Grandfather:_____

Mothers siblings:_____

Paternal Grandmother:_____

Paternal Grandfather:_____

Fathers siblings:_____

List your children's names:

	Ages	Health
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sleep

□Witnessed apnea events during sleep greater than 10 seconds in duration
□Disruptive Snoring
□Awaken with headache or dry mouth
□History of Heart Disease
□History of Stroke or family history
□Upper Airway soft tissue abnormalities
□Diabetes
□Excessive Daytime Sleepiness
□Gasping/Choking
□Mood Disorder,Fatigue, inability to concentrate
□Hypertension/High Blood Pressure
□Craniofacial abnormalities
□Disturbed or restless sleep
□Non-restorative sleep

Sleepiness Scale *(Choose the most appropriate response for each situation)*	Never would doze off	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
1.Siting and Reading	☐ 0	☐ 1	☐ 2	☐ 3
2.Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
3.Sitting inactive in a public place	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passanger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5. Laying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking with someone	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3

Score of All Questions (sum total of all eight responses):_____

1. How many hours per night do you sleep? _____ Do you take naps?_____
2. What Position do you sleep? *(circle one)* Back Side Stomach
3. Do you often feel tired, fatigued, or sleepy during the daytime? _____
4. Do you wake rested, refreshed, ready to go?_____
5. Do you need an alarm clock to wake? _____
6. Has anyone observed you stop breathing during your sleep?_____
7. Do you grind your teeth in your sleep?_____
8. Other:_____

Eating Habits	Yes	No

1. Do you eat dairy products? (milk, yogurt, cheese, etc.) ..... ☐ ☐
2. Do you eat red meat? *Please circle*..... ☐ ☐
   Beef Venison Lamb Pork
3. Do you eat fish or fowl? *Please circle.* ..... ☐ ☐
   Tuna Chicken Turkey
4. Eggs? *Please Circle*..... ☐ ☐
   Free ranged or Caged
5. Commercially canned food..... ☐ ☐
6. Fruit or vegetable juice..... ☐ ☐
7. Refined cereals or products made with flour(pasta, bread)..... ☐ ☐
8. Vegetables and/or legumes..... ☐ ☐
9. Fruit? How many pieces per day?_____ ..... ☐ ☐
10. Whole grains (brown rice, millet, oats)..... ☐ ☐
11. Soy products (tofu, soy milk, tempeh)..... ☐ ☐
12. Alternative milk products (coconut, almond, hemp)..... ☐ ☐

Please note how often you consume the following items:

Spoons of sugar _____ Cookies/Cake _____
Pop/Soft drinks _____ Ice Cream _____
Pastries _____ Coffee _____

Please List EVERYTHING you Eat and Drink for Three Full Days

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Snacks			
Dinner			

Patient Name:_____ Date:_____

Patient History – Timeline

In the space below, please provide a brief timeline in outline form of your own history. Begin with birth and childhood; please include any major illnesses, injuries, or hospitalizations up to the present time. Be sure to list any significant turning points or major events in your line; include any periods of heavy usage of alcohol, cigarettes, coffee, and pharmaceutical or recreational drugs. **WOMEN ONLY:** please include events related to your reproductive system such as first period, pregnancies, abortions, birth control, menopause, etc. If you are filling this out for your child, please include notable information about the pregnancy and nursing.

∞ Allergies ∞

Allergies: (drugs, food, environmental)	**Symptoms / Severity of Reaction:** (please state if any reactions have been life-threatening)

Medication and Supplement Intake Form

Prescription Medications:	Dose (Frequency and Route)	Length of Use	Reason for drug & Any Reactions?	Date Stopped	Do you take Consistently (Y/N)

Patient Name:____Date:________________

Vitamins/Herbs/ Supplements with brand (currently taking)	Dose (Include route)	Frequency	Start Date	Reason for taking, any reactions, compliance	Date Stopped	Do you take Consistently (Y/N)

Imaging and Screening History

To be filled out by your provider, unless you are aware of the following results/genes

EBT Heart Scan:

Date	Results	Date	Results	Date	Results

Pulmonary Nodules:

Date	Results	Date	Results	Date	Results

Carotid U/S:

Date	Results	Date	Results	Date	Results

Colonoscopy:

Date	Results	Date	Results	Date	Results

Mammogram:

Date	Results	Date	Results	Date	Results

Pap (F):

Date	Results	Date	Results	Date	Results

PSA/DRE (M):

Date	Results	Date	Results	Date	Results

Thyroid:

Date	Results	Date	Results	Date	Results

Other: Date/Results Date/Results

Endoscopy: _____ _____ **Bone Density:** _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Abdominal Imaging: _____ _____
_____ _____
_____ _____

Genetics:

Gene's	Date	Results	Related Performance Markers
HLA (Biotoxin)			
HLA (Celiac)			
HLA B27			
MTHFR (C677T)			
MTHFR (A12986)			
Factor V Leidien			
Prothrombin			
Von Wiillerbands			
Other:			