OPTIMAL WELLNESS OF LONG ISLAND
516-801-4971
Optimal-wellness.com

FIRST TIME EVALUATION – Quantum Reflex Analysis

Please complete the following questions carefully. This information will help us to build a specialized Nutritional Program, personally designed for you.

Today's Date:________________________________ Referred by: ____

Name: ____ M [ ] F [ ] Birth date ____/____/____ Age __________

Mailing Address: ____E-Mail____________________________________

City: ____ State ______ Zip: ______ Occupation: ________________________

Height: __________ Weight: __________ Marital Status: S [ ] M [ ] D [ ] W [ ] # children ___________________

Day # ( ) Evening # ( ) Cell # ( )

***** DO NOT TAKE ANY SUPPLEMENTS THE DAY OF THE EVALUATION*****

1. Complaints: Please rank your current complaints and rate their severity (on a scale of 1 to 5, 1 being the most severe):

____

____

____

2. Other Information: Please tell us any additional information or concerns about your health: ____________________________

____

3. Medications: Please list any medications you are currently taking and how long you have taken them (including birth control pills, aspirin, pain medications, etc.):

____

____

4. Smoking: Do you currently smoke? _____ If yes, how much? _____ How long have you smoked? ________

5. Surgeries: What surgeries, operations, traumas, car accidents, etc., have you had? __________________________________

____

____

a.) Have you ever had full-body anesthesia? ______________________________
b.) Do you have breast implants? ______ Other surgical implants or prostheses? ___________________________
c.) Have you had elective surgery (tummy tuck, face-lift burned off moles, etc.)?____________________________
d.) Do you have any metal or plastic inside your body (such as pins, clamps, plates, etc.)?____________________
e.) Do you have pierced ears or other body piercing? ________________________ Tattoos? __________________

6. Scars: Describe any scars on your body (major and minor ones): ____

____

7. Stress: Please rate your current stress level (on a scale of 1 to 10, 10 being the highest stress): ___________________________

What is the main reason for your stress? ____

If over level 5, what step(s) are you taking to reduce your stress level? ____

8. Energy: Please rate your energy on a scale from 1 -10 (10 = "optimal energy" – 1 = "can't get out of bed") ___________________

9. Dental Work: Indicate how many of the following you have:

Silver fillings ______	Gold crowns or inlays ______	Root canals _____	Braces ____
Composites ______	Stainless steel crowns or inlays ____	Root canals with BioCalex ____	Bleeding Gums ____
Extractions ______	Porcelain crowns or inlays ______	Posts ____	Sensitive teeth ____
Bridgework ______	DeGussa Porcelain crowns or inlays _____	Implants ____	Bad bite ____
Partial /full dentures _____	Veneers ______	Temporaries ____	New cavities ____

Have you had any teeth extracted (wisdom teeth, four bicuspid extraction, etc.?) _____________________________________

Have you had dental surgery (gum surgery, jaw surgery, etc.)? ____

Do you need further dental work? If so, what? ____

10. Sleep: How is your sleep? [Circle: restful, restless, hard to get to sleep, wake up often, get up during the night, bad dreams]

Other complaints? ____

What time do you usually go to sleep? ______________________ Number of hours of sleep per night? ___________________

11. Digestion: How is your digestion? [Circle: adequate, poor, acid reflux, bloating, burning/pain in stomach.]

Other complaints:____

12. Urination: How are your daily urinations? *[Circle: every 2 to 3 hours, too frequent, sense of urgency, too small amount, too large amount, burning, dribbling, up at night several times.]*

Other complaints:____

13. Bowels: How are your bowel eliminations? *[*How often? *3 times daily, once per day, skip days* Amount*: normal, too little, too large,* Consistency*: normal, too hard, very soft, diarrhea* Color: *brown, black whitish,* Other*: lots of mucus, lots of gas, foul smell]*

Other complaints: ____

14. WOMEN ONLY: Are you pregnant? _____ Are you breastfeeding? _____ Do you have monthly periods? _______
Date of last menstrual period? _______ Are you going through menopause? ______Have your periods stopped? _____
Had a hysterectomy? _________ If so, when? _______________________________
Menstrual Cycle. Are your monthly periods regular (28 day cycles?) ______ # of days of your menstrual flow? ______
Circle any of the following symptoms you experience with your period: *cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood*. Other menstrual complaints? ___________________________

____

15. Exercise: What kind of exercise do you do? ____

How often? _________________________ For how long at a time? ____

16. Sunlight: Amount of natural sunlight you receive daily outside? ________ Amount of sunlight daily through windows? _______ Hours spent daily under fluorescent lights? ________ Do you use Chromalux light bulbs at home? ______ At work? ____________

17. Eyewear: Do you wear contact lenses? ___________ Glasses? _________ If so, how man hours per day? _________

18. Electromagnetic Exposure: *How many hours do you spend daily:* Watching TV? _______Working on a computer? ______ Talking on a phone? _______ Talking on a cellular phone? _______ Wearing a pager? _______ Wearing a headset? ________ Wearing a wrist watch (with battery)? ________ Riding in a car/truck/vehicle? ________ Near electrical equipment for long periods of time (such as copy machines, high power lines, computers, etc.)? ________ When you sleep, is your head within 10 feet of a plug-in clock (such as on a nite stand)? _________

19. Appliances: Circle which of the following you use: gas stove, electric stove, electric heater, electric blanket , water bed, turbo blend, microwave oven, air purifier (Brand:_____________________________) water purifier (Brand: ____________________)

20. Cookware: What type of cookware do you use? [Circle: stainless steel, aluminum, iron, Teflon-coated, glass, Ultrex]

Other types: ____

21. Shower Filter: Do you use a shower filter (for chlorine protection)? ________When your filter was last changed? ____________

FOOD CHOICES: *Circle each type of food you eat often*

1. **Pre-made foods:** a) canned food B) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food
2. **Red meat:** (beef, pork, lamb) a) commercially grown b) naturally raised (Brand: ________________________)
3. **Chicken:** a) commercially grown b) naturally raised (Brand: ________________________________)
4. **Turkey** a) commercially grown b) naturally raised (Brand: ________________________________)
5. **Fish:** a) canned tuna b) fresh fish c) frozen fish d) restaurants e) farm raised salmon (Other: ________________________)
6. **Fresh vegetables:** a) commercially grown (store-bought) b) organically grown (store bought) c) organically grown (direct from Farmers) d) from natural growers at a farmer's market.
7. **Fresh fruit**: a) commercially grown (store bought) b) organic (store bought) c) organic (direct from farmer)
8. **Whole grains:** a) commercially grown (store bought) b) organic (store bought) c) organic (direct from farmer)
9. **Whole beans:** a) commercially grown (store bought) b) organic (store bought) c) organic (direct from farmer)
10. **Eggs/ butter:** a) commercial eggs (store bought) b) organic eggs c) commercial butter d) organic butter
11. **Milk:** a) commercial milk b) organic milk c) goat's milk d) raw milk e) soy milk f) rice milk g) other: ____________________
12. **Cheese:** a) commercial cheese b) organic cheese (store bought)
13. **Fermented Foods**: a) mustard b) vinegar c) sauerkraut d) kefir e) kim-chi

FOOD STRESSERS: *Circle which of the following you have every week. In the column, indicate how many times per week you have each item:*

Stimulants		**Toxic Oils**		**Commercial Dairy**		**Highly-Heated Foods**	
Coffee (including decaf)		Fried food		Cow's milk		Bread (store bought)	
Black tea, caffeine drinks		Fast food		Yogurt		Crackers (store bought)	
Soft drinks (colas, etc.)		Potato or corn chips		Ice cream		Bagels (store bought)	
Drinks with Nutra Sweet		Roasted nuts		Cottage cheese		Buns (store bought)	
Alcohol (wine, beer, etc.)		Mayonnaise		Sour cream		Pasta (store bought)	
Chocolate		Margarine		Cheese (commercial)		Muffins (store bought)	
Candy, pastries, sweets		Peanut butter (commercial)				Cookies (store bought)	

IF YOU ARE A FEDERAL, STATE OR LOCAL AGENT UPON ENTERING THESE PREMISES, YOU MUST DECLARE SAME OR UNDER THE BIVENS ACT – ARTICLE 42 BE HELD PERSONALLY AND INDIVUALLY RESPONSIBLE.

Signature ____

Date: ______________________

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516-942-0777
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Quantum Reflex Analysis

FINANCIAL & CANCELLATION POLICY

Initial QRA Consultation & Treatment (initial session is approximately 2 or more hours)		$110.00 / hour plus the cost of supplements
Follow up QRA Sessions (sessions take approximately 1-2 hours)		$110.00 / hour plus the cost of supplements
Missed QRA Appointments	- Intake Session	$150.00 charge
	- Follow up Session	$110.00 charge

Due to our waiting list of clients we must charge for any missed appointments.

Unless 48 hours notice is given to change or cancel an appointment, you will be charged for the missed appointment.

Your time is valuable and we appreciate your understanding that our time is valuable as well. Your willingness to cover the cost of a missed appointment when you cannot give 48 hours notice clearly demonstrates your consideration of our time and efforts. We appreciate it.

Thank you for your understanding and cooperation of these financial guidelines.

Dan Goldberg and Staff

I understand the above Financial Policy and Cancellation Policy and will abide by these charges:

____ _______________
Signature of Client Date

Informed Consent
For Quantum Reflex Analysis
Dan Goldberg CN, CT.

Advanced Nutritional Programs

I acknowledge that Dan Goldberg CN, CT. and staff members of Optimal Wellness of Long Island, Inc. are not medical doctors. I understand that Dan Goldberg and staff members of Optimal Wellness of Long Island, Inc. provide nutritional and other health-related information to me attain and maintain my best health. Dan Goldberg will help determine which nutrients my body needs bolstered. All recommendations are designed to help me move towards my best state of health through personalized recommendations in lifestyle, exercise, health habits and advanced nutrition. I understand that Dan Goldberg and staff members of Optimal Wellness on Long Island, Inc. do NOT diagnose, treat or claim to cure cancer or any other disease.

I have read this informed consent and understand it. I am not a minor (under the age of 18). Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation.

Date:_______________________________________

Signature:___________________________________

Printed Name:________________________________