

# Welcome To: Stanton Wellness Solutions (SWS)

9950 Cypresswood #350 Houston, TX 77070

Phone: 281-970-4459 Fax: 281-970-4724

## About Dr. Brian Stanton BS, DC, ACN:

Dr. Stanton is a Clinical Kinesiologist (wellness doctor). He specializes in Applied Clinical Nutrition, Applied Kinesiology, chiropractic/joint mobilization, diet and weight loss, detoxification, cold laser therapy, family and pediatric wellness, and providing quality therapy for athletes. These techniques create a holistic practice focusing on the individual patient. His vision is to guide and mentor patients to a *natural health restoration*.

## At your appointment:

We know that our patients have schedules to maintain, so we do run on time. We will let you know when your appointment begins and ends so that you can make plans accordingly. This insures that you get the full time with the doctor.

## 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. (\$50 for existing patient, \$150 for new patient) Note: The new patients reschedule or cancellation policy is at least 1 weeks notice.

## Office Fees:

Our fees are based on the time that you spend with the doctor. A new patient office visit or phone consult is 45 minutes with the doctor and existing patient office visits or phone consults are 15 minutes. If you do not visit the doctor within 1 year you will be required to have another new patient visit due to the need for a re-evaluation.

<b>New patient visit</b> (45 min. office visit or phone consultation):	\$150.00
<b>Existing patient visit</b> (15 min. office visit or phone consultation):	\$ 50.00
<b>Energy Balance Footbath:</b>	\$ 30.00
<b>Cold Laser Therapy:</b>	\$ 15.00

\*Supplements and laboratory work are NOT included in the price of the visit. This amount will vary based on your evaluation.

\*We are happy to mail supplements for a shipping fee of \$5. An order over \$100 is free shipping. Overnight shipping excluded. Outside of U.S. shipping is \$50.

## 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 NHRC

Signature \_\_\_\_\_ Date \_\_\_\_\_

# SWS New Patient Evaluation

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Referral: \_\_\_\_\_ Gender: M / F Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mailing Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: A AB B O - + Marital Status: M S D W # of Children \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**1. PURPOSE OF THIS APPOINTMENT:** (Why are you coming to this office?)

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**2. HEALTH CONDITIONS AND COMPLAINTS:** (Number & list in the order of severity)

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**3. MEDICATIONS:** (List by name, dose, what for, how long include birth control & aspirin etc..)

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**4. SURGERIES:** (List surgeries/operations, plastic surgery & trauma. Date when they occurred)

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

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

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

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My signature confirms that this information is true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SWS Health Overview

(Please circle where answers are given and fill in where answers are not given)

**Smoking:** Do you smoke? Y N If yes, how much? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

**Drug Use:** (CONFIDENTIAL) Do you use any recreational drugs? Y N if yes, circle: marijuana, cocaine, heroin, uppers, downers Others: \_\_\_\_\_ How often? \_\_\_\_\_

**Stress:** Please rate your current stress level on a scale of 1 to 10, 10 being the highest stress: \_\_\_\_\_

What are the main reasons for you stress? \_\_\_\_\_

How do you reduce stress? \_\_\_\_\_

**Sleep:** How do you sleep? (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:** (good, adequate, poor, acid reflux, burping, bloating, burning, pain, cramping)

Other Complaints: \_\_\_\_\_

**Urination:**(every 2-3 hrs, too frequent, sense of urgency, burning, dribbling, urinate at night)

Other Complaints: \_\_\_\_\_

**Bowels:** How many bowel movements per day \_\_\_\_\_, per week \_\_\_\_\_ Amount: normal, too big, too small

Consistency: normal, hard, soft, diarrhea Color: tan, brown, black, green

Other: gas, mucus, blood, smell

Other Complaints: \_\_\_\_\_

**Exercise:** Do you exercise? Y N What kind of exercise? \_\_\_\_\_

How often? \_\_\_\_\_ Duration of exercise regimen? \_\_\_\_\_

**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? \_\_\_\_\_ Wearing a watch? \_\_\_\_\_

Wearing a hearing aid? \_\_\_\_\_ Riding in a car? \_\_\_\_\_ Do you live by power lines? Y N

**Diet:** How many times a day do you eat? \_\_\_\_\_ How often do you eat out? \_\_\_\_\_

**Liquid Intake:** What kind of water do you drink? tap, filtered, spring, reverse osmosis, distilled

Mark what you drink and how many a day (d) or week (w) you drink them:

milk \_\_\_\_\_ coffee \_\_\_\_\_ tea \_\_\_\_\_ herbal tea \_\_\_\_\_

soda \_\_\_\_\_ beer \_\_\_\_\_ wine \_\_\_\_\_ liquor \_\_\_\_\_

**\*Woman Only:** Are you Pregnant? Y N Are you breastfeeding? Y N Do you have periods? Y N

Do you have monthly periods? Y N Last period date \_\_\_\_\_ Are you in menopause? Y N

\*Menstrual Cycle: Number of days of flow \_\_\_\_\_ heavy, light, spotting, normal

Circle if you experience: cramping, bloating, weakness, mood swings, cravings, pain, bright blood, dark clotting

Other menstrual complaints: \_\_\_\_\_

My signature confirms that this information is true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SWS Pediatric Form

(only fill out if patient is 5 years old or under)

## Prenatal History:

Did you take prenatal vitamins while pregnant? Y N When did you start them? \_\_\_\_\_

Did you take any medications while pregnant? Y N Why? \_\_\_\_\_

How stressful would you rate your pregnancy on a scale of 1-10(10=stressful)? \_\_\_\_\_

## Birth History:

How long were you pregnant? \_\_\_\_\_ weeks.

Who delivered your baby? Circle: obstetrician, midwife, Other: \_\_\_\_\_

How was your baby delivered? vaginal, c-section, forceps, vacuum, other:

Did you receive any medications during labor? Y N If yes, what? \_\_\_\_\_

What was your baby's APGAR score? \_\_\_\_\_

## 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 child 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 child's diet consist of?

\_\_\_\_\_

Is there anything else that may be important?

\_\_\_\_\_

## Mother's Information:

How many past pregnancies? \_\_\_\_\_ How many were delivered? \_\_\_\_\_

Do you take vitamins? Y N What kind? \_\_\_\_\_

Do you smoke? Y N How many packs/day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

\*\*\* If you are breastfeeding continue

Do you drink alcohol? Y N What kind? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink soft drinks? Y N What kind? Diet, regular How many per day? \_\_\_\_\_, per week? \_\_\_\_\_

Do you drink coffee? \_\_\_\_\_ How many per day? \_\_\_\_\_

Do you consume dairy products? \_\_\_\_\_ How much per day? \_\_\_\_\_

What food do you eat regularly? \_\_\_\_\_

\_\_\_\_\_

My signature confirms that this information is true.

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SWS Scar/Trauma Chart

**SCARS:** Please *draw a line* on the drawing where you have scars, even if they are very old.

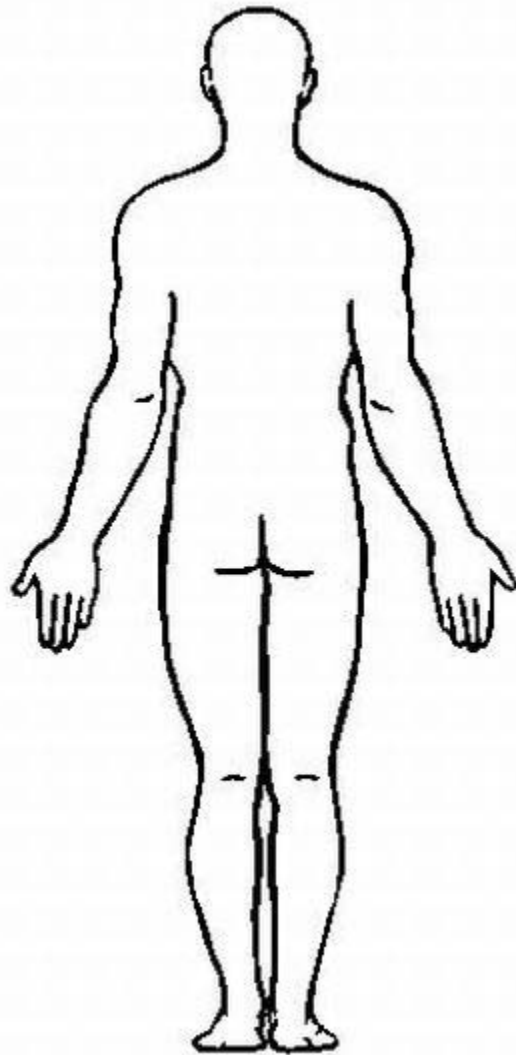
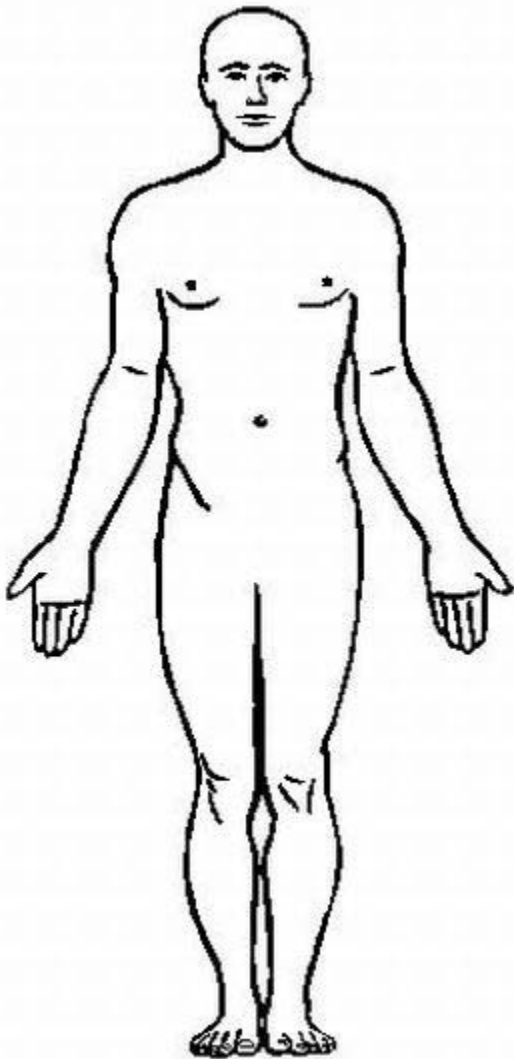
Don't forget c-sections, episiotomies, surgeries, vasectomies, vaccination scars, punctures, stitches, Cuts, etc...

**TRAUMA Areas:** Please *put an "X"* where you have had trauma even if it is very old.

Don't forget burns, falls, sprains, whiplash, radiation, etc...

**INTERNAL METAL:** Please *draw a circle* on the drawing if you have any type of internal metal objects such as surgical pins, metal plates, hip or knee replacement, surgical wire mesh, screws, spinal rods, etc...

**Please date and briefly describe each incident.** Ex: Car accident, 1988



My signature confirms that this information is true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SWS Toxicity Questionnaire

Please circle a number in each of the following categories based on your health in the last 90 days.

**0 = rarely/never experience the symptom**                      **3 = frequently experience and effect is not severe**

**1 = occasionally experience but effect is not severe**    **4 = frequently experience and effect is severe**

**2 = occasionally experience but effect is severe**

**Digestive:**

Nausea or Vomiting      0 1 2 3 4  
 Diarrhea                    0 1 2 3 4  
 Constipation              0 1 2 3 4  
 Gas, Belch, Bloating    0 1 2 3 4  
 Heartburn/Reflux        0 1 2 3 4  
 Hemorrhoids              0 1 2 3 4  
**Total: \_\_\_\_\_**

**Sleep:**

Can't fall asleep            0 1 2 3 4  
 Wake up often             0 1 2 3 4  
 Wake up to urinate        0 1 2 3 4  
 Wake up tired             0 1 2 3 4  
 Bad dreams                0 1 2 3 4  
**Total: \_\_\_\_\_**

**Ears:**

Itchy ears                    0 1 2 3 4  
 Earaches / infections     0 1 2 3 4  
 Fluid in ears                0 1 2 3 4  
 Ringing in ears            0 1 2 3 4  
 Hearing loss                0 1 2 3 4  
**Total: \_\_\_\_\_**

**Heart:**

Shortness of Breath        0 1 2 3 4  
 Skipped Heartbeats        0 1 2 3 4  
 Rapid Heartbeats          0 1 2 3 4  
 High/Low Blood Pressure 0 1 2 3 4  
 Chest Pain/Tightness      0 1 2 3 4  
**Total: \_\_\_\_\_**

**Skin:**

Flushing                    0 1 2 3 4  
 Acne                        0 1 2 3 4  
 Dry skin                    0 1 2 3 4  
 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  
**Total: \_\_\_\_\_**

**Sinus / Nose:**

Stuffy Nose                0 1 2 3 4  
 Sinus Headache            0 1 2 3 4  
 Excessive Mucous         0 1 2 3 4  
 Sinus Infections          0 1 2 3 4  
 Nose Bleeds                0 1 2 3 4  
**Total: \_\_\_\_\_**

**Emotions:**

Mood Swings                0 1 2 3 4  
 Anxiety / Fear / Nervous 0 1 2 3 4  
 Anger / Irritability        0 1 2 3 4  
 Depression                 0 1 2 3 4  
 Sense of Despair          0 1 2 3 4  
**Total: \_\_\_\_\_**

**Head / Eyes:**

Headaches                 0 1 2 3 4  
 Faintness                  0 1 2 3 4  
 Dizziness                  0 1 2 3 4  
 Pressure                    0 1 2 3 4  
 Blurred Vision             0 1 2 3 4  
**Total: \_\_\_\_\_**

**Mouth / Throat:**

Dry Mouth / Thirsty        0 1 2 3 4  
 Post Nasal Drip            0 1 2 3 4  
 Swollen tongue, gums, lip 0 1 2 3 4  
 Canker Sores              0 1 2 3 4  
 Cold Sores                 0 1 2 3 4  
 Gagging / Clearing throat 0 1 2 3 4  
 Tooth Pain                 0 1 2 3 4  
**Total: \_\_\_\_\_**

**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  
**Total: \_\_\_\_\_**

**Allergies:**

Watery / Itchy Eyes        0 1 2 3 4  
 Runny Nose / Drainage    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  
**Total: \_\_\_\_\_**

**Lungs:**

Chest Congestion          0 1 2 3 4  
 Asthma                     0 1 2 3 4  
 Coughing                  0 1 2 3 4  
 Difficulty Breathing      0 1 2 3 4  
**Total: \_\_\_\_\_**

**Weight:**

Cravings                    0 1 2 3 4  
 Over Weight                0 1 2 3 4  
 Compulsive Eating        0 1 2 3 4  
 Water Retention          0 1 2 3 4  
 Under Weight              0 1 2 3 4  
**Total: \_\_\_\_\_**

**Immune:**

Frequent Illness            0 1 2 3 4  
 Fever                        0 1 2 3 4  
 Sore Throat                0 1 2 3 4  
 Leaky Bladder             0 1 2 3 4  
 Genital Itch / Discharge 0 1 2 3 4  
**Total: \_\_\_\_\_**

**Joints / Muscles / Bone:**

Arthritis                    0 1 2 3 4  
 Osteopenia/Osteoporosis 0 1 2 3 4  
 Stiffness/Limited moving 0 1 2 3 4  
 Pain / Aches in muscles 0 1 2 3 4  
 Pain / Aches in joints    0 1 2 3 4  
 Cramping                  0 1 2 3 4  
**Total: \_\_\_\_\_**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **TOTAL FOR PAGE =** \_\_\_\_\_

# Stanton Wellness Solutions

## Doctor-Patient Informed Consent

### HEALTH AND WELLNESS

We want our patients to be informed about our goals, philosophies, and expectations at Stanton Wellness Solutions 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 patient accordingly). We do this by balancing nutritional needs and restoring optimal neurologic and electrical communication with a myriad of techniques. We believe by supplying our patients 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 doctors at Stanton Wellness Solutions provide a specialized, unique, non-duplicating health service and are licensed in their special areas of practice.

### ANALYSIS AND APPROACH

Your doctor will conduct a clinical analysis for the express purpose of determining the nutritional, neurologic, and/or energetic deficiencies or any interference that hinders you from achieving optimal wellness. Your doctor specializes in Applied Clinical Nutrition, Applied Kinesiology, chiropractic/joint mobilization, EFT, diet and weight loss, detoxification, cold laser therapy, family and pediatric wellness, and providing quality therapy for athletes. They will utilize the aforementioned safe and non-invasive techniques to achieve a natural health restoration.

### 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 each patient, it is difficult to predict the healing time. Most often the response is incredible as to how quickly the body begins to heal, however, in some cases there is a 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 that the medical field has not found much improvement, have found significant benefit through the approach we use at Stanton Wellness Solutions. Our doctors work with you to help you make an informed decision prior to being accepted as a patient.

### DIAGNOSIS

Although the doctors at Stanton Wellness Solutions 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. Patients that require additional testing (MRI, XRAY, Blood, etc...) will be informed and have access to those reports at any time.

### INFORMED CONSENT

By signing this page the patient gives the doctor permission and authority to use any or all of the aforementioned analyses and techniques. The patient gives permission to utilize the patient information, according to HIPAA guidelines (no use of names/complete anonymity etc...), for research, research presentations, and other office applications should the doctor deem the case appropriate. It is the responsibility of the patient to make any diagnosed or observed deformities, injuries, illnesses, or other pathological conditions known to the doctor in order to receive the most optimal care. If you have any further questions concerning our office please feel free to ask!

Signature: \_\_\_\_\_ Date: \_\_\_\_\_