MorningStar *Family Health Center*

Getting to Know You!

Age 18+

Last Name: _____ First Name: _____ MI: _____

Street: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Best Phone: _____ Mobile Home Work other Alt Phone: _____ Mobile Home Work other

DOB: _____ Gender: [ ]Male [ ]Female

Marital Status: [ ]Single [ ]Married [ ]Widowed [ ]Divorced

Email: _____

Pharmacy: _____

Mail-Order Pharmacy: _____

Occupation: _____

Present Medical Doctor: _____

How did you hear about us? _____

How would you like to be contacted to confirm appointments?

[ ]Text [ ]Email [ ]Phone

Emergency Contact

Name: _____ Relationship: _____

Best Phone: _____ Mobile Home Work other Alt Phone: _____ Mobile Home Work other

Steps for your appointment:

1. Please fill out all registration forms in their entirety.
2. If you have any recent lab reports (within the last twelve months), please bring them to your appointment.
3. If you are married or in a relationship, please bring your spouse or significant other with you to your appointment. (There will be much information covered concerning your unique condition as well as the fundamentals of our programs.)
4. Please arrive on time.
5. We ask for a 24-hour notice to change or cancel your appointment.

Please Note:
If these steps are not followed, it may compromise the full value of your consultation, and therefore, we will kindly reschedule your appointment.

Directions to MorningStar Family Health Center
54 Old Highway 22 • Unity Bank Concourse II
Clinton, NJ 08809
(908)735-9344

Some GPSs do not find this address easily. Google Maps has been successful!

From the South: Take Route 31 North, past Route 78. Take the next exit, for Annandale, follow the jug handle, stay right and go over the bridge (that goes over Rt 31). At the light, go straight. You will see Mavis Tires, Unity Bank, then our building on the left. You can park in the front or back. Our suite is on the ground floor at the front of the building.

From the East: Take Route 78 west to Exit 15. Make a right at the light, you will be going through the town of Clinton. You will pass one traffic light at Leigh Street. On the right, after the Bank of America is our building. You can park in the front or back. Our suite is on the ground floor at the front of the building.

From the West: Take route 78 east to Exit 15. At the end of the exit ramp (traffic light), make a right. Continue through two lights. On the right, after the Bank of America is our building. You can park in the front or back. Our suite is on the ground floor at the front of the building.

10 Objections to Creating a Healthy, Abundant Life.

1. I don't have the personal knowledge to make the correct lifestyle choices.

You have the power to choose to learn. If you are open to learning, our personal mentoring program will guide you along an easy-to-follow path. Our programs our structured in a manner that gives each and every Practice Member the information needed to bring independence to their life. You do have the choice to avoid the all too common dependency of a care-giver or assisted living environment.

2. I don't have the time to take appropriate care of myself.

We all live in a world that gives each of us 24 hours /day. What we do with that time is a personal decision based on values (real or perceived). If you do not take time to care for yourself, you will have to take time to try and repair yourself. Pro-activity and maintenance are required for optimized health. It takes no more time to eat correctly than poorly. Proper exercise requires no more than approximately 35 minutes 3-4 times / week. If you're honest with yourself, you recognize it really is based on what you judge as a valuable use of your time. Hum? TV, or a thriving, abundant life.

3. My family won't be on board with the changes I will need to make.

I recognize that this sounds like a silly thought, but also realize it is a real concern for some. You would certainly think that all family members would be on board, however, in infrequent situations a spouse or family member may be negative toward your new enthusiasm. This usually comes down to a lack of understanding of what your lifestyle program entails, as well as some distrust of whether this approach will really work.
It may help to steer these family members to our site, www.MorningStarFHC.com, and view some of the incredible testimonials from our Practice Members. Without taking the time to learn about our programs and proven success it is only human nature to be cautious. Once familiarizing themselves, you will not only get support, but an accountability partner to help ensure your success.

4. Eating right is too hard and expensive.

If you have not been eating right, you should already understand how expensive eating wrong can be. Health deteriorates and medical bills escalate with each year that these poor choices are made. Like any habits, there are good and bad. Once you develop a habit it can be a challenge to change or alter. Once the good or correct habit is developed it will be hard to break. I would challenge anyone to compare grocery bills of a cart full of healthy food compared to one full of junk. And speaking of expense, this is not just a financial term. Losing out on the joys and experience in life because you're not feeding your body nutritious foods is a terrible, unnecessary expense.

5. I can't afford a lifestyle program or hire a health coach.

Most people recognize the importance of an education, whether this is a high-school, college or even an online education. It's widely accepted that this is an investment that must be made in order to have the best insurance of meeting our financial needs. The return on this financial investment can materialize into a very secure and abundant life. Although there are situations in life where funding higher education can seem impossible, we witness people every day finding solutions to "get it done". These individuals simply think differently. They do not accept anything less than their God-given potential. I am suggesting that your health should be viewed as at least

as valuable as your financial situation. What value is wealth if you do not have the health and vitality to enjoy it. At MorningStar Family Health Center, we work with each individual to overcome any financial obstacles. We have solutions to allow those on fixed budgets or in retirement to easily move forward.

6. I'm afraid that proper lifestyle changes might isolate me from my friends and family.

It is true that not all of your friends will share your newly found optimism toward taking control of your health. Friends who do not place high priority on their health often play down healthy lifestyle choices. Although they may not mean any negative intent, this behavior is sabotaging. In one of my practice member videos I discuss this as being all too common and some tips to disarm this behavior in a non-confronting manner. The bottom line is those who truly care for you will support your decision to place your health as a priority.

7. My doctor may not approve.

I will always be open and willing to work with any doctor or health professional you currently have. They also, should be open and willing to do the same if the goal is to optimize health and improve lifestyle choices. This includes reducing and/or eliminating unnecessary medications. A doctor's main concern and intent should always be to aid in the optimization of health in his/her Practice Members. This begins with "Do No Harm". I am always cautious of a physician that dismisses any holistic and natural approach to health. In summary, you are ultimately responsible for your health and therefore, the final decision and direction you wish to pursue.

8. I don't have the self-discipline to make permanent changes.

Self-discipline is not a trait that we are born with, but one that is developed over time through life experience. Discipline coincides with positive experience. In other words, as your actions result in positive changes you will be inclined to continue these actions. One could look at this as positive habits or simply, discipline. Self-discipline is also strengthened thru accountability held by loved ones, a friend or a mentor.

9. What happens if I commit to a lifestyle program and then hate the experience and give up?

Life is a series of ups and downs. We do not always enjoy the duties required for the end result we are seeking. It's funny how these duties or actions can initially seem to be difficult or "no fun", but later take on an uplifting emotion. This is because we come to recognize the most meaningful successes we have in life came from such actions. Having a successful marriage; raising children; optimizing our health and becoming financially independent all require discipline and actions that sometimes have us want to "give up and quit". Those of us who continue to play the game are allowed the pleasures of earned rewards.

10. I don't have the personal confidence to take action.

Very few of us have a natural born instinct of confidence. This comes from continually taking action even when we are fearful. The actual definition for this is courage. As we continue to develop skills from taking these bold steps, we become less fearful or confident. We are here to mentor you and support you. We do not judge or chastise. We offer an environment that anyone at any level can feel comfortable and genuinely cared for. As you become a veteran in the art of wellness, you too will become very confident.

MorningStar's Wellness Evaluation

Initial Consultation

Name: _____ Date: _____

Main Complaints:

1)_____ 2) _____

3)_____ 4) _____

How long have you suffered with this problem? _____

Any other complaints: _____

_____

Would you like improvement with any of the following?

- ☐ Digestion: Reflux, Gas, Constipation
- ☐ Sleep: Falling asleep or staying asleep
- ☐ Sense of Well Being
- ☐ Energy

What have you tried doing to resolve this problem that DID NOT work?

_____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at it's worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

_____

What effect does this have on your body functions? _____

_____

Are you here visiting us to:

Resolve my immediate problem
Life style program for optimized living
Both
Other: _____

How have you taken care of your health in the past?

Medications	Holistic
Routine medical	Vitamins
Exercise	Chiropractic
Diet and Nutrition	Other: _____

How did the previous methods work for you? _____

_____

What are you afraid this might be or will be affecting without change? Please circle

Job	Freedom
Kids	Future abilities
Marriage	Finances
Sleep	Time

Are there any health conditions you are afraid this might turn into?

Diminished Future abilities	Surgery
Stress	Arthritis
Weight gain	Cancer
Heart disease	Diabetes
Depression	Other: _____

If these problems are NOT addressed, where do you picture yourself being in the next 3-5 years? Please be specific _____

_____

_____

What would be different or better without this problem? Please circle:

Diminished stress	Sleep
More energy	Work
Self esteem	Outlook
Confidence	Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!

Last Name First Name M.I. Prefix/Suffix Date of Birth

MEDICAL CONDITIONS: Please circle or list any medical conditions you have: (i.e.: Diabetes, High Blood Pressure, Heart Disease, Migraines, Kidney Problems, Cancer, Arthritis, etc) Please provide dates began, if known, and any comments about the condition. If you see a specialist for it, please list name

MEDICAL CONDITION	DATE DIAGNOSED	COMMENTS (and specialist name if applicable)

SURGICAL HISTORY: Please list all surgeries/operations you have had: (i.e.; appendectomy, tonsillectomy, gall bladder removal, hysterectomy, knee replacements, etc.) Include dates, hospital, and surgeon if known.

DATE	SURGERY	HOSPITAL	SURGEON

OTHER HOSPITALIZATIONS: Please list any other overnight hospital stays you have had: (i.e.: childbirth, pneumonia, psychiatric hospitalizations, etc.) Include reason for admission, dates, and hospital, if known.

DATE	REASON FOR ADMISSION	HOSPITAL

MEDICATIONS: Please list all medications that you take. Please include prescription drugs, OTC medications, vitamins, and supplements. Also include medication dose, number of pills taken, and how often:

MEDICATION	STRENGTH	NUMBER OF PILLS	HOW OFTEN

ALLERGIES: Please list allergies to medications, foods, and other substances. Please indicate what your reaction was. (i.e.; Penicillin →Hives, Cats→Wheezing)

MEDICATION/SUBSTANCE	REACTION

DIET: Please describe your usual dietary intake:

Starchy Foods (pasta, breads, potatoes)	___ high	___ medium	___ low	___ none
Sweets (candy, pastries, doughnuts)	___ high	___ medium	___ low	___ none
Fatty Foods (bacon, sausage, fried foods)	___ high	___ medium	___ low	___ none
Fruits	___ high	___ medium	___ low	___ none
Vegetables	___ high	___ medium	___ low	___ none
Dairy (milk, cheese, yogurt)	___ high	___ medium	___ low	___ none
Lean Meats (fish, chicken)	___ high	___ medium	___ low	___ none

Are there any foods you do not tolerate, or try to avoid? (i.e.: gluten, lactose, etc.)

_____

Are you currently trying to lose weight, or are you considering it? ___ no __ yes (currently)
__ yes (considering)

EXERCISE:

Do you exercise regularly? __ Yes __ No

If so, what type and how often? _____

WORK:

Are you currently working/going to school? Please circle:

Yes, Full Time ♦ Yes, Part Time ♦ No, Retired ♦ No, Unemployed ♦ No, Disabled ♦ No, other:

Please describe current occupation/vocation: (Where and what you do)

Are you now, or have you in the past been exposed to hazards? (i.e.: asbestos, toxic chemicals, fumes, radiation, etc.)

__ No __Yes (past) __Yes (currently) If Yes, Please describe what and when:

MILITARY SERVICE:

Have you ever served in the military? __ No __ Yes, in past __ Yes, currently

If so, THANK YOU FOR YOUR SERVICE. Please describe service (branch, time in service, foreign posts, combat or other injuries and disabilities):

SOCIAL HISTORY:

TOBACCO:

Cigarettes: ___never smoked
___quit (please list packs per day, how many years, and date you quit) _____
___currently smoking (please list packs per day and when you started) _____

Cigars: ___never smoked
___quit (please list cigars per day or week, how many years, and date you quit) _____
___currently smoking (please list cigars per day or week and when you started) _____

Pipe: ___never smoked
___quit (please list how many years, and date you quit) _____
___currently smoking (please list times per day and when you started) _____

Chew: ___never used
___quit (please list cans per day, how many years, and date you quit) _____
___currently chewing (please list cans per day and when you started) _____

ALCOHOL: Please describe your alcohol use: (one drink= 12 oz. beer, 4 oz. wine, or 1 shot liquor)

___never drank
___quit drinking alcohol (please list drinks per day and date you quit) _____
___currently drink alcohol

very rarely	occasionally	socially		regularly			(circle)
Number of drinks_____		per	day	week	month	year	(circle)

Are you or anyone close to you concerned about how much you drink? ___ No ___ Yes

DRUGS: (Please describe your use of mind altering drugs, including type [marijuana, cocaine, pills not prescribed to you, ecstasy, etc.] and how much, and provide details.) ***Please be honest. We ask for medical reasons. This is confidential.***

___never used
___quit (please list types of drugs, how many years, and when you quit)

___currently using (please list types of drugs, when you started, and how often you use)

Are you or anyone close to you concerned about your drug use? ___ No ___ Yes

CAFFEINE: (Please describe how much caffeine you consume, including coffee, tea, sodas, etc.)

Coffee:	_____ cups	per	day	week	(circle)
Tea:	_____ cups	per	day	week	(circle)
Soda:	_____ cans/btls	per	day	week	(circle)
Energy Drinks:	_____ cans/shots	per	day	week	(circle)

RELATIONSHIP STATUS

Please circle current status: single • married • committed relationship • divorced • separated • widowed

Sexual Activity: (circle) currently active • never active • not currently active

If sexually active, do you use birth control? [ ] No [ ] Yes If so, method: _____

Do you feel safe in your current relationship? [ ] No [ ] Yes [ ] N/A

FAMILY HISTORY: Please complete to the best of your ability.

RELATIONSHIP	GENDER	LIVING?	YEAR OF BIRTH	MEDICAL PROBLEMS	AGE OF DEATH	CAUSE OF DEATH (if applicable)
Mother						
Father						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						
Siblings						
Pregnancies/Births						

OTHER SIGNIFICANT FAMILY HISTORY _____

_____

_____

REVIEW OF SYSTEMS: Please circle any problems or symptoms you are having.

GENERAL: fever ◆ chills ◆ fatigue ◆ weight loss ◆ weight gain ◆ other:

EYES: blurred vision ◆ double vision ◆ watery eyes ◆ blindness ◆ eye pain ◆ other:

EARS: decreased hearing ◆ clogged ears ◆ ear pain ◆ ringing ◆ dizziness ◆ ear discharge ◆ other:
NOSE/SINUS: runny nose ◆ sinus congestion ◆ sinus pain ◆ bloody nose ◆ sneezing ◆ other:
MOUTH: dental problems ◆ cold sores ◆ tongue problems ◆ mouth/jaw pain ◆ other:
THROAT: sore throat ◆ post nasa drip ◆ painful swallowing ◆ burning in throat ◆ enlarged tonsils ◆ other:

RESPIRATORY: shortness of breath ◆ wheezing ◆ coughing ◆ asthma ◆ COPD ◆ other:

CARDIOVASCULAR: chest pain ◆ heart failure ◆ palpitations ◆ heart murmur ◆ aneurysms
high blood pressure ◆ lightheadedness ◆ swollen ankles ◆ cold hands and feet
leg cramping with walking ◆ anemia ◆ varicose veins ◆ other:

DIGESTIVE: decreased appetite ◆ difficulty swallowing ◆ heartburn ◆ stomach upset ◆ abdominal pain
nausea ◆ vomiting ◆ diarrhea ◆ constipation ◆ bloody bowel movements ◆ black bowel movements
hemorrhoids ◆ liver problems ◆ jaundice ◆ other:

KIDNEY: frequent urination ◆ painful urination ◆ blood in urine ◆ kidney stones ◆ kidney failure
difficulty passing urine ◆ waking at night to urinate often ◆ other:

GENITAL (WOMEN): painful periods ◆ heavy periods ◆ irregular periods ◆ painful intercourse
sexual difficulties ◆ vaginal dryness ◆ ovarian cysts ◆ fibroids ◆ difficulty getting pregnant ◆ PMS
endometriosis ◆ breast pain ◆ breast lumps ◆ nipple discharge ◆ other:

GENITAL (MEN): lump in testicles/scrotum ◆ pain in testicles/scrotum ◆ sexual difficulties
prostate problems ◆ difficulty with fertility ◆ other:

ENDOCRINE/GLANDS: intolerance to heat ◆ intolerance to cold ◆ thyroid problems
adrenal gland problems ◆ menopause issues ◆ ow testosterone ◆ hair loss ◆ other:

SKIN: moles ◆ acne ◆ skin lumps/bumps ◆ eczema ◆ psoriasis ◆ skin cancers ◆ dry skin ◆ oily skin
rash ◆ nail problems ◆ hair problems ◆ itching ◆ other:

MUSCULOSKELETAL: back pain ◆ neck pain ◆ shoulder pain ◆ elbow pain ◆ wrist pain ◆ hand pain
hip pain ◆ knee pain ◆ ankle pain ◆ foot pain ◆ arthritis ◆ muscle pain ◆ gout ◆ other:

IMMUNE SYSTEM: frequent illness ◆ allergies ◆ swollen glands ◆ autoimmune disease ◆ HIV
rheumatoid arthritis ◆ Lyme Disease ◆ other:

NEUROLOGIC: headaches ◆ passing out ◆ stroke ◆ memory problems ◆ seizures ◆ confusion
muscle weakness ◆ lack of coordination ◆ difficulty walking ◆ decreased sensation ◆ tremors
attention problems ◆ nerve pain ◆ other:

PSYCHOLOGICAL: anxiety ◆ depression ◆ obsessive/compulsive disorder ◆ mania ◆ insomnia
stress ◆ sadness ◆ seasonal affective disorder ◆ suicidal thoughts ◆ other: