NEW PATIENT INFORMATION
for Dr. Sam Yanuck

Instructions

The forms that follow provide you an opportunity to describe the details of your case. **Please look over the forms now, as they may take you longer than you would expect to fill them out. Patients usually set aside two to three hours to complete them.** The more effectively you can convey information using these forms, the more efficiently I can come to the level of understanding necessary to properly manage your case.

One of the most important elements in the history is the narrative that you write. Patients find this exercise a bit intimidating at first, but you will find that it's a great way to clarify the experience of your illness and help me to identify important clues in your case. Patients who do this effectively often have the greatest success in our work together. It creates a starting point of clarity that sets the stage for a successful clinical process.

The narrative should be submitted as a Word document that you create and send to us by email to staff@yanuckcenter.com. This should be done in advance of your appointment (even if it is the same day) so that I have it in front of me on my computer during our initial discussion. The narrative should tell the story of your illness, from when it started, up to the present. It should include the following elements:

1. Relevant dates… "I first noticed a problem in June of 2014…" "The problem got much worse in March of 2022, when I…"
2. Key things that make it better or worse… "I felt better when I took medication xyz… when I took supplement xyz… when I started exercising… when I moved to a new house…"
3. Key tests you have had done… "I had a brain MRI that was negative…" "I had a blood test that showed an xyz infection…"

In short, please make your narrative clear, sequential, detailed, and to the point.

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Samuel F. Yanuck, DC, FACFN, FIAMA
A Professional Association
Tel: 919/401-9500
Fax: 919/401-9900

THE YANUCK CENTER
for Life and Health

NEW PATIENT INFORMATION
for Dr. Sam Yanuck

Full Legal Name _____ Preferred Name _____ Pronouns _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Date of birth ___/___/___ Sex assigned at birth _____

Phone (home)_____(work)_____(cell)_____Email address _____

Emergency Contact_____Relationship to you_____Phone _____

Whom may we thank for referring you?_____Relationship to you _____

I,_____, have read and understand Dr. Yanuck's office policy sheet. I understand that I am personally responsible for payment at the time when services are rendered.

Signature_____Date_____

Primary Concern

What is your primary health problem?_____

_____

Date of original problem:_____Date of most recent recurrence:_____

Was there an event that created the problem?_____

Have you had this or similar conditions in the past?_____Is the problem getting worse? _____

What makes it better?_____Worse?_____

Is this problem interfering with work?_____Sleep?_____Other activities? (list them)_____

What can you not do now that you would like to do? _____

What do you believe is wrong with you?_____

_____

What are your goals for treatment?_____

How long do expect it to take to accomplish your goals? _____

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Health History

List **ALL** other **CURRENT** problems **in their order of importance**

List other practitioners seen, treatments, self-care activities, and results

List **ALL** significant PAST illnesses

Please list **ALL** chronic infections (Epstein-Barr, herpes, chlamydia, hepatitis, HIV, bladder infections, respiratory infections, etc.)

List **ALL** surgeries you have had, with dates and results

Have you ever been hospitalized other than for surgery?

Have you ever been in an accident or seriously injured? List dates and describe

Have you ever had: whiplash? Yes___No___ // a hard fall on your tailbone? Yes___No___ // a seizure? Yes___No___

Describe your worst injury ever, and any long lasting effects it has had on your health

Describe any illness related to travel or living abroad

Is there a time in your life when you began feeling significantly less healthy? Yes_____No_____If yes, please describe…

How many root canals do you have?_____How many doses of antibiotics have you had in your lifetime? _____

How many times **per month** do you take aspirin?_____Ibuprofen?_____Tylenol?_____Antacids?_____Laxatives? _____

For what purpose do you take these?

Do you wear contact lenses?_____If so, do you wear one lens for near vision and one for far vision? _____

Have you ever seen a chiropractor? No Yes (Name: _____ Result: _____)

Do you have any spinal abnormalities that you are aware of? _____

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Family History

Have any of your blood relatives (parents, brothers, sisters, aunts, uncles, grandparents, or children), living or deceased, had any of the following problems? ***For each YES***, state the age of the person when the problem occurred and their relationship with you.

Condition	Yes	No	Age	Relationship
Alcoholism / Drug Addiction	____	____	_____	_____
Allergies / Asthma / Sinus Problems	____	____	_____	_____
Arthritis	____	____	_____	_____
Blood disorders	____	____	_____	_____
Cancer (type_____)	____	____	_____	_____
Diabetes	____	____	_____	_____
Digestive Disorders (type_____)	____	____	_____	_____
Heart attack before age 55	____	____	_____	_____
Heart attack after age 55	____	____	_____	_____
High blood pressure	____	____	_____	_____
Kidney or Liver disease	____	____	_____	_____
Lung disease / tuberculosis	____	____	_____	_____
Mental health problems/ depression	____	____	_____	_____
Seizure Disorder	____	____	_____	_____
Stroke or Blood Vessel Problems	____	____	_____	_____
Thyroid disease	____	____	_____	_____
Uterine / Ovarian problems	____	____	_____	_____

List other problems that run in your family _____

Habits

Describe your use of cigarettes/tobacco_____Alcohol_____Other drugs_____

Describe your exercise habits (activity / times per week / heart rate)_____

Describe your current sleeping pattern (when you usually go to sleep, wake up, napping, difficulty with sleep) _____

_____

Do you have enough energy for your normal activities? Yes____No_____ How long do you watch TV each day?_____

What do you do for fun / pleasure / relaxation? _____

Preventive Measures and Screening

When did you last receive the following (leave blank if it does not apply to you). Circle the test if you've had an abnormal result

Physical exam_____Blood Tests_____Rectal exam_____Bone Density _____

Colonoscopy_____Skin exam_____TB Skin test_____Chest x-ray _____

Dental exam_____Eye exam_____Hearing test_____Pap smear _____

Mammogram_____Other tests/scans_____

Have you ever had an MRI or CT (CAT) scan? Yes No If so, what for?_____

Have you ever had x-rays? Yes No If so, what for? _____

Have you ever had an EKG or other heart study? Yes No If so, what for? _____

Please list any abnormal labs or other test results: (OK to attach copies instead) _____

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Allergies and Sensitivities

Please list any allergies you are aware of (**foods / medications / other**): _____

Please list any chemical sensitivities you are aware of: (bleach, solvents, perfumes, etc.) _____

Are you particularly sensitive to the effects of alcohol or medications? Yes_____No _____

Have you ever reacted to a medication in an unexpected way (for example, feeling more calm if you took a stimulant)?
Yes____No____If yes, please describe _____

Have you had problems with damp or moldy places? Yes____No____Problems with new building materials? Yes____No ____

Nutrition

What do you usually eat and drink on a typical weekday?

Breakfast_____

Morning snack _____

Lunch_____

Afternoon snack _____

Dinner_____

Evening snacks _____

Desserts _____

How many glasses of water do you drink per day?_____**Circle** those that apply: tap water, distilled, bottled, well-water, other

How many servings do you have per day of the following: Fruits & Vegetables___Coffee___Tea____Soda___Diet Soda___

If you are taking nutritional supplements, do you notice a specific improvement in the way you feel? _____

How many meals each week are:

At home_____Alone_____In restaurant_____At fast food place_____TV Dinners or "convenience" food _____

At your desk_____While watching TV_____At "health food" restaurant or takeout _____

Do you eat when you are not hungry but feel depressed, anxious or bored? Frequently / Occasionally / Rarely / Never (circle one)

Do you ever binge eat? Yes___No____ Do you sneak or hide foods? Yes___No____ Do you make yourself vomit? Yes____No ____

Do you eat slowly and chew your food well? Yes____No____Do you use extra salt on your food at the table? Yes_____No ____

Have you had molars removed that reduce your chewing on one side? Yes No If so, which side do you chew on? Right Left

List the oils or fats you use in cooking/preparing food: _____

Do you enjoy eating cheese? Yes____No_____Do you drink milk? Yes_____No_____If so, how much per day? _____

Do you like sweets, pastries, cakes, donuts, etc.? Yes___No____ How many servings do you eat per week? _____

Do you eat sugarcoated cereal or add sugar to your cereal? Yes___No____ How many servings do you eat per week? _____

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Do you use artificial sweeteners with coffee and food? Yes___No___How many servings do you use per week? _____

When you eat bread, is it white or whole wheat?_____After eating, do you usually feel: Better / Worse / No different (circle)

Do you usually eat breakfast? Yes No_ Do you feel better if you skip breakfast? Yes_____No_____

Do you snack between meals? Yes No_ Do you frequently skip meals? Yes_____No _____

When you have a snack, what type of food do you prefer? _____

Is there one food that you like the most, eat a lot of, and crave when you don't have it? _____

Do you have any reaction to eating food with MSG in it? Yes No If so, please describe: _____

Do you have to watch what you eat to avoid gaining weight?…….....…Yes_____No _____

Do you have to watch what you eat to avoid losing weight? .....……Yes_____No _____

What was your weight in high school?_____What is your current weight?_____At what age your weight start to change? _____

If your weight has changed, please describe the circumstances involved _____

Do you have more than one meal a day that lacks a vegetable other than corn, potatoes, peas or green beans? Yes_____No_____

Are there days when you do not eat any raw vegetables? ..... Yes_____No_____

What foods do you especially like? _____

What foods do you dislike? _____

List the three healthiest foods you eat in the average week:_____,_____, _____

List the three un-healthiest foods you eat in the average week:_____,_____, _____

Are there particular foods that seem to irritate you in any way? Yes ___ No ___ If yes, name the foods and describe the problem:

_____

Please describe any ways in which you feel your diet is excessive: _____

_____

Please describe any ways in which you feel your diet is deficient: _____

_____

List all vitamins, herbs and other supplements you are now taking _____

_____

_____

List all hormones that you take now or have taken in the past. Please indicate the form of delivery (pill, cream, injection, etc.)

_____

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Metabolic Assessment

Please CIRCLE the appropriate number on all questions. 0 = lease/never. 3 = most/always.

Category I - C

Feeling that bowels don't empty completely……..	0	1	2	3
Lower abdomen pain relief passing stool or gas…….	0	1	2	3
Alternating constipation and diarrhea …….	0	1	2	3
Diarrhea……	0	1	2	3
Constipation …….....	0	1	2	3
Hard, dry, or small stool……..	0	1	2	3
Coated tongue or "fuzzy" debris on tongue……	0	1	2	3
Pass large amount of foul-smelling gas……	0	1	2	3
More than 3 bowel movements daily ……..	0	1	2	3
Use laxatives frequently (more than twice a month) …..	0	1	2	3

Category II - P

Increasing frequency of food reactions …….	0	1	2	3
Unpredictable food reactions ……	0	1	2	3
Aches, pains, and swelling throughout the body …..	0	1	2	3
Unpredictable abdominal swelling ……	0	1	2	3
Frequent bloating and distention after eating ……	0	1	2	3
Abdominal intolerance to sugars and starches ……..	0	1	2	3

Category III - Chem

Intolerance to smells …….	0	1	2	3
Intolerance to jewelry ……	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc. ..…..	0	1	2	3
Multiple smell and chemical sensitivities ……	0	1	2	3
Constant skin outbreaks ……..……	0	1	2	3

Category IV – HCL -

Excessive belching, burping, or bloating…….	0	1	2	3
Gas immediately following a meal……..	0	1	2	3
Offensive breath……	0	1	2	3
Difficult bowel movements……..	0	1	2	3
Sense of fullness during and after meals……..	0	1	2	3
Difficulty digesting fruits and vegetables; Undigested food visible in stool…….	0	1	2	3

Category V – HCL +

Stomach pain, burning, or ache1-4 hours after eating	0	1	2	3
Use antacids……..	0	1	2	3
Feel hungry an hour or two after eating……	0	1	2	3
Heartburn when lying down or bending forward…….	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages……..	0	1	2	3
Digestive problems subside with rest and relaxation...	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine…..	0	1	2	3

Category VI - SI

Roughage and fiber cause constipation……	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating…	0	1	2	3
Pain, tenderness, soreness on left side under rib cage..	0	1	2	3
Excessive passage of gas……..	0	1	2	3
Nausea and/or vomiting……	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed……..	0	1	2	3
Frequent urination ……	0	1	2	3
Increased thirst and / or appetite……..	0	1	2	3
Difficulty losing weight ……..	0	1	2	3

Category VII - GB

Greasy or high-fat foods cause distress ……..	0	1	2	3
Lower bowel gas and/or bloating hours after eating …..	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin ……...	0	1	2	3
Yellowish cast to eyes …….....	0	1	2	3
Stool color alternates from clay colored to normal…..	0	1	2	3
Reddened skin, especially palms …….	0	1	2	3
Dry or flaky skin and / or hair …….	0	1	2	3
History of gallbladder attacks or stones ……..	0	1	2	3
Have you had your gallbladder removed ……..	Yes		No	

Category VIII - LV

Acne and unhealthy skin ……..	0	1	2	3
Excessive hair loss …….	0	1	2	3
Overall sense of bloating ……..	0	1	2	3
Bodily swelling for no reason ……..	0	1	2	3
Hormone imbalances …….	0	1	2	3
Weight gain …….	0	1	2	3
Poor bowel function ……...	0	1	2	3
Excessively foul-smelling sweat ……..	0	1	2	3

Category IX - HG

Crave sweets during the day ……..…….	0	1	2	3
Irritable if meals are missed ……..……..	0	1	2	3
Depend on caffeine to get started or keep going …….	0	1	2	3
Get light headed if meals are missed ……..……..	0	1	2	3
Eating relieves fatigue …….	0	1	2	3
Feel shaky, jittery, or have tremors …….	0	1	2	3
Agitated, easily upset, nervous ……	0	1	2	3
Poor memory / forgetful ……..	0	1	2	3
Blurred vision ……..	0	1	2	3

Category X - IR

Fatigue after meals ……..	0	1	2	3
Crave sweets during the day ……	0	1	2	3
Eating sweets does not relieve craving for sugar …….	0	1	2	3
Must have sweets after meals ……..	0	1	2	3
Waist girth is equal or larger than hip girth ……	0	1	2	3
Frequent urination ……	0	1	2	3
Increased thirst and appetite ……	0	1	2	3
Difficulty losing weight ……...	0	1	2	3

Category XI – A-

Cannot stay asleep at night ……..	0	1	2	3
Crave salt …….	0	1	2	3
Slow starter in the morning ……..	0	1	2	3
Afternoon fatigue …….	0	1	2	3
Dizziness when standing up quickly ……	0	1	2	3
Afternoon headaches ……	0	1	2	3
Headaches with exertion or stress ……	0	1	2	3
Weak nails ……	0	1	2	3

Category XII – A+

Cannot fall asleep ……	0	1	2	3
Perspire Easily …….	0	1	2	3
Under high amount of stress ……	0	1	2	3
Weight gain when under stress ……	0	1	2	3
Wake up tired even after 6 or more hours of sleep …..	0	1	2	3
Perspire excessively or with little activity ……	0	1	2	3

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Metabolic Assessment

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Category XIII - pH

Edema and swelling in ankles and wrists ……	0 1 2 3
Muscle cramping ……	0 1 2 3
Poor muscle endurance ……	0 1 2 3
Frequent urination ……	0 1 2 3
Crave salt ……	0 1 2 3
Abnormal sweating from minimal activity ……	0 1 2 3
Alteration in bowel integrity ……	0 1 2 3
Inability to hold breath for long periods ……	0 1 2 3
Shallow, rapid breathing ……	0 1 2 3

Category XIV – T-

Tired, sluggish ……	0 1 2 3
Feel cold – hands, feet, all over ……	0 1 2 3
Require lots of sleep to function properly ……	0 1 2 3
Increase in weight gain even with low-calorie diet ….	0 1 2 3
Gain weight easily ……	0 1 2 3
Difficult, infrequent bowel movements……	0 1 2 3
Depression, lack of motivation……	0 1 2 3
Morning headaches that wear off during the day ……	0 1 2 3
Outer third of the eyebrow thins ……	0 1 2 3
Thinning of hair on scalp, face, or genitals or Excessive falling hair ……	0 1 2 3
Dryness of skin and / or scalp ……	0 1 2 3
Mental Sluggishness ……	0 1 2 3

Category XV – T+

Heart palpitations ……	0 1 2 3
Inward trembling ……	0 1 2 3
Increased pulse even at rest ……	0 1 2 3
Nervous and emotional ……	0 1 2 3
Insomnia ……	0 1 2 3
Night sweats ……	0 1 2 3
Difficulty gaining weight ……	0 1 2 3

Category XVI – P-

Diminished sex drive ……	0 1 2 3
Menstrual disorders or lack of menstruation ……	0 1 2 3
Increased ability to eat sugars without symptoms …...	0 1 2 3

Category XVII – P+

Increased sex drive ……....	0 1 2 3
Reduced tolerance sugars ……	0 1 2 3
"Splitting" type headaches ……..	0 1 2 3

Category XVIII (Males Only)

Urination difficulty or dribbling ……	0 1 2 3
Frequent urination …..……..	0 1 2 3
Pain inside of legs or heels ……..……	0 1 2 3
Feeling of incomplete bowel evacuation ……	0 1 2 3
Leg nervousness at night ……	0 1 2 3

Category XIX (Males Only)

Decreased libido ……..……	0 1 2 3
Decrease in spontaneous morning erections. ……..….	0 1 2 3
Decrease in fullness of erections ……..……	0 1 2 3
Difficulty in maintaining morning erections ……	0 1 2 3
Spells of mental fatigue ……	0 1 2 3
Inability to concentrate ……	0 1 2 3
Episodes of depression ……	0 1 2 3
Muscle soreness ……....	0 1 2 3
Decrease in physical stamina ……....	0 1 2 3
Unexplained weight gain……..	0 1 2 3
Increase in fat distribution around chest and hips ……	0 1 2 3
Sweating attacks ……....	0 1 2 3
More emotional than in the past ……..	0 1 2 3

Category XX (Menstruating Females Only)

Are you perimenopausal (going through the transition into menopause) ……	Yes No
Alternating menstrual cycle lengths ……..	Yes No
Extended menstrual cycle, greater than 32 days ……...	Yes No
Shortened menses, less than every 24 days ……...	Yes No
Pain and cramping during periods ……...	0 1 2 3
Scanty menstrual flow ……	0 1 2 3
Heavy menstrual flow ……	0 1 2 3
Breast pain and swelling during menses ……	0 1 2 3
Pelvic pain during menses ……...	0 1 2 3
Irritable and depressed during menses ……	0 1 2 3
Acne breakouts ……	0 1 2 3
Facial hair growth ……	0 1 2 3
Hair loss / thinning ……....	0 1 2 3

Category XXI (Menopausal Females Only)

How many years have you been menopausal ……. _____	
Hot flashes ……..	0 1 2 3
Disinterest in sex ……	0 1 2 3
Depression ……....	0 1 2 3
Shrinking breasts ……	0 1 2 3
Acne ……	0 1 2 3

Since menopause, do you ever have bleeding?	Yes No
Mental fogginess ……..	0 1 2 3
Mood swings ……	0 1 2 3
Painful intercourse ……	0 1 2 3
Facial hair growth ……	0 1 2 3
Increased vaginal pain, dryness or itching ……	0 1 2 3

Please answer all that apply (Females Only):

Age at which you first had symptoms of perimenopause (transition from normal menstruation to menopause): _____

Did you / do you have significant symptoms during perimenopause?_____If yes, please describe: _____

Number of pregnancies_____Number of deliveries_____Difficulties with child birth _____

Birth control method you are using currently_____Have you ever used an IUD? _____

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Symptom Survey

Please *check the appropriate boxes :* → → → **C = Current P = Past**

C	P	Headache
☐	☐	Base of Skull
☐	☐	Entire Head
☐	☐	Forehead
☐	☐	Top of Head
☐	☐	Temples
☐	☐	Throbbing
☐	☐	Migraine
☐	☐	Visual Disturbance
☐	☐	Vomiting
☐	☐	Dizziness
☐	☐	Double Vision
☐	☐	Lightheaded
☐	☐	Ringing in Ears

C	P	Neck
☐	☐	Grinding Noise
☐	☐	Head Feels Heavy
☐	☐	Sharp Pain
☐	☐	Dull Ache
☐	☐	Stiffness
☐	☐	Goiter
☐	☐	Lumps in Neck
☐	☐	Swollen Glands

C	P	Arms / Hands		
☐	☐	Arms "fall asleep"		
☐	☐	Arm pain	L	R
☐	☐	Wrist pain	L	R
☐	☐	Hand pain	L	R
☐	☐	Muscles twitch	L	R
☐	☐	Loss of grip	L	R

C	P	Mid-Back
☐	☐	Ache
☐	☐	Sharp pain
☐	☐	Breathing hurts
☐	☐	stiff

C	P	Shoulders		
☐	☐	Shoulder Bursitis	L	R
☐	☐	Can't raise arm	L	R
☐	☐	Rotator cuff	L	R
☐	☐	Ache	L	R
☐	☐	Sharp pain	L	R
☐	☐	Ache into neck	L	R
☐	☐	Stiff	L	R

C	P	Low Back / Hips / Legs		
☐	☐	Cold feet		
☐	☐	Legs fall asleep		
☐	☐	Legs restless at night		
☐	☐	Leg muscles twitch		
☐	☐	Leg pain	L	R
☐	☐	hip pain	L	R
☐	☐	ankle pain	L	R
☐	☐	Unstable ankle	L	R
☐	☐	Unstable knee	L	R
☐	☐	Unstable hip	L	R
☐	☐	Leg cramps with walking		
☐	☐	Legs cramp at night		
☐	☐	Hip bursitis		

C	P	Muscles and Joints
☐	☐	TMJ (Jaw problems)
☐	☐	Osteoarthritis
☐	☐	Degenerative joints
☐	☐	Rheumatoid arthritis
☐	☐	Gout
☐	☐	Swollen joints
☐	☐	Tendinitis
☐	☐	Muscle aches
☐	☐	Eyelids or other facial muscles twitch

C	P	Low Back Pain with:
☐	☐	Bending
☐	☐	Cough / sneeze
☐	☐	Lifting
☐	☐	Sitting
☐	☐	Standing
☐	☐	Twisting
☐	☐	Driving
☐	☐	Sleeping

Please list areas where you have any numbness or swelling

_____

_____

_____

C	P	Psychological
☐	☐	Anxiety
☐	☐	Bipolar disorder
☐	☐	Depression
☐	☐	Insomnia/difficult sleep
☐	☐	Irritability
☐	☐	Brain Fog
☐	☐	Mental Disorganization
☐	☐	Nervousness
☐	☐	Poor memory
☐	☐	Suicidal ideas
☐	☐	Violent thoughts

C	P	Cardiac
☐	☐	Arrhythmia
☐	☐	Chest pain
☐	☐	Chest tightness
☐	☐	Heart attack
☐	☐	Heart murmur
☐	☐	High blood pressure
☐	☐	High cholesterol
☐	☐	Palpitations
☐	☐	Racing heartbeat
☐	☐	Rheumatic fever
☐	☐	Shortness of breath
☐	☐	Swelling in feet
☐	☐	Trouble breathing

C	P	Respiratory
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Cough
☐	☐	Emphysema
☐	☐	Pneumonia
☐	☐	Sputum
☐	☐	Tuberculosis
☐	☐	Wheezing

C	P	Peripheral Vascular
☐	☐	Blood clots
☐	☐	Bruise easily
☐	☐	Leg cramps
☐	☐	Poor circulation
☐	☐	Varicose veins

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T Cell Polarization Assessment

Please CIRCLE the number that reflects whether the statement applies to you:

0 = Does not apply | 1 = Rarely applies | 2 = Sometimes applies | 3 = Applies | 4 = Strongly applies

Th1 Polarization Support Factors						Th2 Modulation Factors					
Chronic inflammation	0	1	2	3	4	Childhood asthma	No=0			Yes=3	
High stress level	0	1	2	3	4	Childhood intestinal problems	No=0			Yes=3	
Autoimmune disease flares	0	1	2	3	4	Childhood ear infections	No=0			Yes=3	
Tendency to intestinal problems	0	1	2	3	4	Tendency to asthma or other lung issues	0	1	2	3	4
Current intestinal problem	0	1	2	3	4	Active or medicated asthma	0	1	2	3	4
Catch colds that are going around	0	1	2	3	4	Active or medicated other lung problem	0	1	2	3	4
Stay sick longer once you get sick	0	1	2	3	4	Tendency to sinusitis	0	1	2	3	4
Get cold sores	0	1	2	3	4	Headache in forehead, cheek, face	0	1	2	3	4
Tendency to bladder infections	0	1	2	3	4	Current sinus problem	0	1	2	3	4
Current bladder infection	0	1	2	3	4	Produce copious nasal mucous	0	1	2	3	4
Tendency to sinus infections	0	1	2	3	4	Mucous in stool	0	1	2	3	4
Current sinus infection	0	1	2	3	4	Allergy to environment (pollen, mold, etc.)	0	1	2	3	4
Tendency to respiratory infections	0	1	2	3	4	Food sensitivities/reactions	0	1	2	3	4
Current respiratory infection	0	1	2	3	4	Tendency to IBS, SIBO, Dysbiosis, etc.	0	1	2	3	4
Chronically elevated viral burden	0	1	2	3	4	IBS, SIBO, Dysbiosis, other GI currently	0	1	2	3	4
Age: add 2 points for every 5 years over 50						Chronic Stress	0	1	2	3	4
Total of the numbers you circled plus any for age						Work with toxic chemicals	0	1	2	3	4
						Age: add 2 points for every 5 years over 50					
						Total of the numbers you circled plus any for age					

Number of days with symptoms of autoimmune flare in the past month ____ in the past week ____

Number of days with symptoms of inflammation in the past month ____ in the past week ____

Can be body inflammation (aches & pains, body fatigue, GI symptoms, etc.) or brain inflammation (mental fatigue, brain fog, etc.)

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Pain Questionnaire

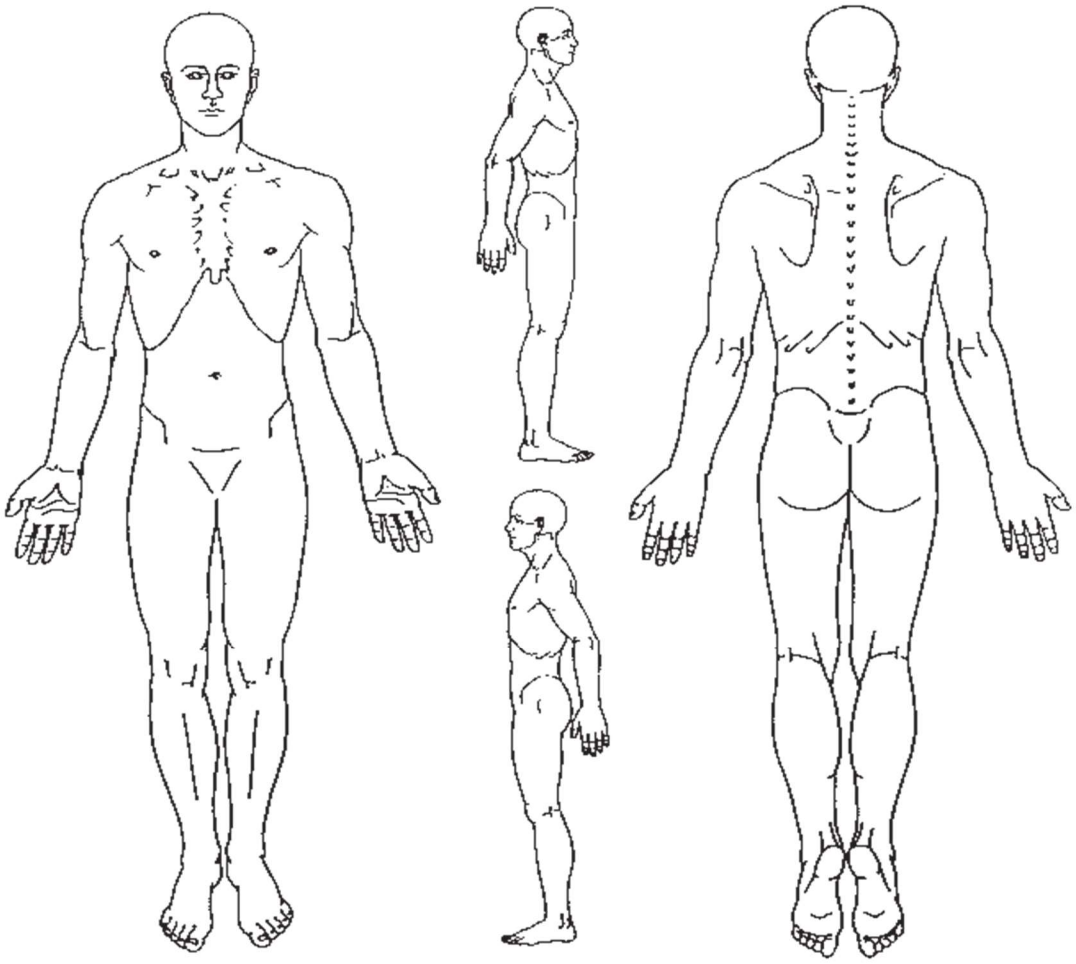
(Skip to the next page if you are not currently experiencing pain.)

Please place a single vertical line through the scale below at the point that best describes your pain.
(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

Mark the areas on your body where you feel the following sensations.
Use the appropriate symbol. Include all affected areas.

Ache ^ ^ ^ ^ ^ ^	Burning x x x x x x x x	Numbness --- --- --- --- --- ---
Pins & Needles o o o o o o	Stabbing / / / / / / / /	Throbbing T T T T T T



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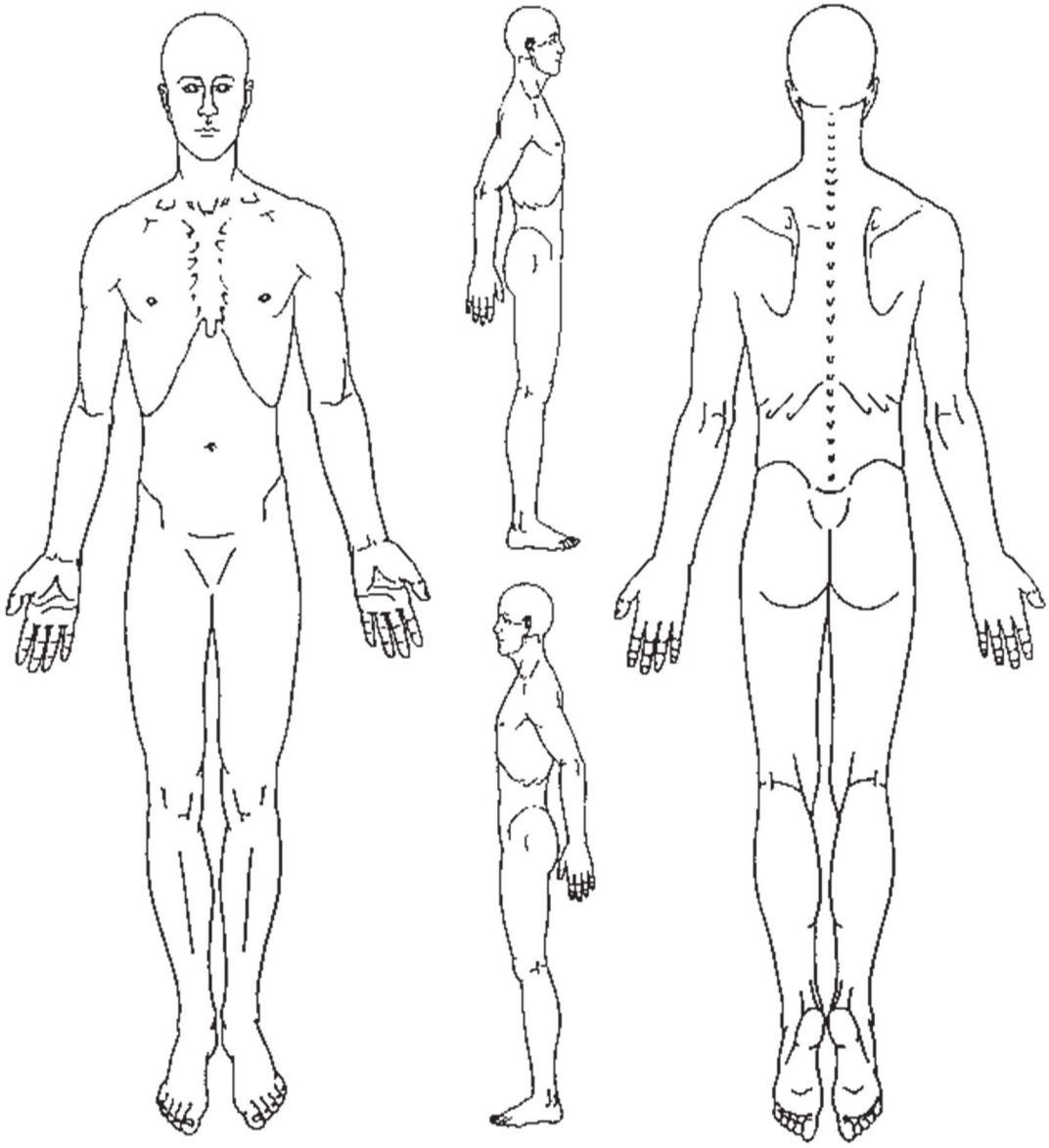
History of Injury

Please mark with an "X" all the places on your body which have ever been injured (sprains, strains, burns, broken bones, scars from surgeries or accidents, severe bruises, concussions, hard blows to the head, falls, etc.).

Be sure to note any organs that have been operated on or removed, including cosmetic surgeries, radiation therapy sites, etc. (tonsils, wisdom teeth, appendix, C-section, IUD placement, miscarriage, etc.).



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Patient Medication List

Your Name____Date __________________

Please describe each of your medications clearly. If a medication is giving you specific side effects, list them.

Drug____________________Prescribed by__________________Dose_________Started________Planned End Date _______

Purpose for Taking____Is it working? ________________________________

Side Effects ____ Nutrient Depletion _______________________________

Drug____________________Prescribed by__________________Dose_________Started________Planned End Date _______

Purpose for Taking____Is it working? ________________________________

Side Effects ____ Nutrient Depletion _______________________________

Drug____________________Prescribed by__________________Dose_________Started________Planned End Date _______

Purpose for Taking____Is it working? ________________________________

Side Effects ____ Nutrient Depletion _______________________________

Drug____________________Prescribed by__________________Dose_________Started________Planned End Date _______

Purpose for Taking____Is it working? ________________________________

Side Effects ____ Nutrient Depletion _______________________________

Drug____________________Prescribed by__________________Dose_________Started________Planned End Date _______

Purpose for Taking____Is it working? ________________________________

Side Effects ____ Nutrient Depletion _______________________________

Please list medications you have taken in the past: ____

____

I____understand that any changes to my regimen of medications must be made in coordination with and under the instructions of the physician who prescribed them.

Signed____Date ___________________

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About Medications

The treatment that Dr. Yanuck provides is intended to improve all aspects of your health. As your care progresses, your body may be better able to heal itself in all respects. Because of this, your blood pressure, blood sugar levels, blood clotting characteristics, and other important bodily functions may improve. **If this occurs, it is possible that the doses of medications you are taking will have to be modified, to account for your improvement. It is your responsibility to monitor or have monitored those functions that relate to medications you are currently taking, to ensure that your current dose does not become excessive or deficient in its effect on you. These and any other any changes to your regimen of medications must be made in coordination with and under the instructions of the physician who prescribed them.**

Please discontinue all nutritional supplements 10 days prior to any surgery. Restart after surgery only with guidance from both Dr. Yanuck and the surgeon who performed the procedure.

Additional Information

Please arrange to have any other relevant information sent to our office. This might include medical records, lab results, consultation reports, and any other test or study results such as x-rays or CT scans. This will help Dr. Yanuck evaluate your condition. Short documents like lab results or MRI reports may be faxed to (919) 401-9900. Longer documents like overall patient records should be copied and sent to the office.

Please list the names of your primary care doctor, gynecologist (if applicable), and/or other doctors, so Dr. Yanuck can send a report to them with the details of his findings in your case, should it become appropriate for him to do so. List each doctor's full name and as much of the address information as you know.

_____ _____

_____ _____

_____ _____

_____ _____

Thank you for completing this questionnaire. The information that you have provided gives Dr. Yanuck a more complete understanding of you and your health concerns. Sharing these details helps you receive the highest quality care.

☐ Please check this box if you wish to give Dr. Yanuck permission to send a report of his impressions to the doctors listed above, and give Dr. Yanuck and the doctors listed above permission to discuss your case.

☐ Please check this box if you **DO NOT** want our office to leave messages about appointments or other such information on your home telephone number.

Signature_____Date_____

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THE YANUCK CENTER
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Authorization For And Consent To Treatment

This clinic maintains personnel and facilities to assist your doctor in the performance of various manipulative procedures and other diagnostic and therapeutic procedures. These manipulative and ancillary procedures all may involve calculated risks or complications, injury or even death, from both known and unknown causes and no warranty or guarantee has been made as to the result or cure. Except in emergency or exceptional circumstances, procedures are not performed upon patients unless and until the patient has had an opportunity to discuss them with the doctor.

Each patient has the right to refuse any proposed procedure, process, or therapy, at any time during each visit.

Due to the uniqueness of each case and each individual, including his or her willingness and ability to implement the treatment recommendations provided, no guarantees of successful treatment can be offered. In addition, responses to each aspect of treatment can be potentially unique and idiosyncratic. Though the intent of care is improvement, your responses can vary. If you have a problem that requires immediate attention, call 911, or have someone take you to the hospital emergency room. If you notice an adverse reaction to one of the components of your health plan, you should call our office and inform us of what you are observing. Medications prescribed by other physicians with whom you are working are not to be discontinued except through consultation with the doctor who prescribed each medication. You further acknowledge that, unless you initiate a specific doctor-patient process with her, Dr. Cheryl Yanuck is not in any way involved in your case.

Your doctor may determine that the procedures listed below may be beneficial in the diagnosis or treatment of your condition. Upon your signed consent below, such procedures may be performed for you by your doctor and/or by other technical staff selected by him. This authorization applies both to the listed procedures and to advice given as part of your care. In your doctor's absence, this consent applies to the doctor or staff selected to provide coverage for emergencies.

Your signature below constitutes your acknowledgment that: (I) you have read and agreed to the foregoing: (2) You understand that each procedure will be discussed with you before it is done, and that if this discussion is not sufficient to provide your understanding, it is your responsibility to request more information (3) You authorize and consent to the performance of procedure(s) or specific tests (4) You consent to the performance of procedures and tests in addition to or different from those specified below whether or not arising from presently unforeseen conditions which your doctor or his associates or assistants may consider necessary or advisable in the course of the procedure(s) specified below: (5) No guarantee of a cure has been promised to you. In addition to other procedures discussed at the time they are performed, procedures may include the following: manipulation, traction, exercise, heat, cold, phlebotomy, nutrition, orthopedic testing, neurologic testing, physical examination, deep muscle therapy, rehabilitation exercises, dietary instructions.

Questions:_____Questions (if any) Answered & Witness by: _____

Patient Name (Print): _____

Patient Signature:_____Date_____

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INFORMED CONSENT FOR EXERCISE, TRAINING, AND REHABILITATIVE ACTIVITIES

The undersigned hereby voluntarily consents to engage in a program of exercise, training, and/or rehabilitative activities as the clinician deems appropriate to your case. In the course of this process, it is vital that you provide adequate feedback regarding any changes that you observe. When participating in any program involving neurological rehabilitation, it is vital that you give feedback related to any change that you observe of any sort. When engaging in an exercise program, it is important to distinguish muscular pain due to fatigue ("burning") as compared with pain experienced as a result of an injury. If an exercise causes pain, you are to stop that exercise immediately and inform the doctor or his assistant so that the exercise can be either modified or discontinued. Likewise, when a particular exercise causes pain only in a portion of the range of motion, notify the doctor or his assistant immediately and do not perform the portion of the exercise that caused pain.

As with virtually any therapeutic modality, there exists a certain risk of injury. Every effort will be made to minimize these risks through preliminary examination and by engaging in communication on the basis of your feedback.

Any questions about the procedures used in your rehabilitation or exercise program are encouraged. If you have any doubts or questions, please ask for further explanations.

It is understood that you may withdraw consent and discontinue participation in the rehabilitation or exercise program at any time by notifying the doctor.

Finally, the undersigned releases and discharges this facility, their officers, agents, staff, physicians, technicians and any others connected therewith from all claims or damages whatsoever that the undersigned or his/her representatives may have arising from, or incident to your neurologic rehabilitation or exercise program.

I have read this form and I understand the procedures that I will perform. I consent to participate in the neurological rehabilitation and/or exercise program deemed appropriate to my care by the doctor.

SIGNED_____DATE_____

WITNESS_____DATE_____

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THE YANUCK CENTER
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Dr. Sam Yanuck's Office Policies

YOUR RESPONSIBILITIES

Every effort will be made to accomplish the maximum result in the most efficient manner.
You have three primary responsibilities in support of this goal:

1. **Follow the instructions** that Dr. Yanuck gives you. These may include changes in food, nutrition, sleep management, activity levels, or other instructions.
2. **Keep the schedule** of your visits as close as possible to the recommended time of your follow up. The timing is based on the specifics of your case. Waiting longer than recommended can mean missed opportunities to give feedback and get important course corrections in the process of moving toward normal function.
3. **Dr. Yanuck sees patients remote-only.** If/when Dr. Yanuck determines that it is appropriate to return to in-person visits, you will be informed of the change. At that point, it is your responsibility to come to the Yanuck Center in person.

APPOINTMENTS

Dr. Yanuck spends significant time in preparation for each of your appointments. Missing an appointment is a significant disruption to the flow of that preparation process. Dr. Yanuck allocates substantial time to each patient's appointments. Please note the following policies regarding missed or cancelled appointments:

For one-hour appointments: If a one-hour appointment must be rescheduled, no charge will be incurred **provided if you give us notice at least two business days in advance**. You need to call before 5pm Thursday to change a Monday appointment, or before noon Friday to change a Tuesday appointment. If this is not done, the full amount of the visit fee will be charged.

For 90-minute and two-hour appointments: If a 90-minute or two-hour appointment must be rescheduled, no charge will be incurred **if you give us notice at least five business days (ONE WEEK) in advance**. If this is not done, the full amount of the visit fee will be charged.

Dr. Yanuck does his best to run on time. However, because he works with each patient until he has accomplished what needs to be done in that session, Dr. Yanuck often runs behind schedule. So, please be available for an on-time start to your appointments, but please also plan for delays in the start and end timing of your appointments. **Do not schedule other appointments close to the ending time of your appointments with Dr. Yanuck.**

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FEES AND BILLING

The fee per hour is $345. **Payment is due at the end of each session. You are solely responsible for the charges you incur in the office.** If you request them, you will be given forms to submit to your insurance company.

The initial consultation is scheduled for two hours and typically takes 90 minutes to two hours to complete. Subsequent sessions usually last an hour. If sessions go longer or shorter, the fee is adjusted accordingly. Brief sessions are from 5 to 15 minutes. Phone consultations are billed at the hourly rate. There is no charge for brief questions sent by email, provided this function is kept within reason. Complex questions cannot be answered by email.

Dr. Yanuck bills as a chiropractor, so insurance policies that cover chiropractic may be expected to reimburse a modest portion of the fee for his services, though **there is no guarantee they will do so**. Submitting forms to your insurance company is your responsibility, if you wish to do so.

EMERGENCIES

If you have an emergency, call 911. If you have a circumstance that is not an emergency, that involves an urgent need to connect with Dr. Yanuck, call our office and relay the information to the staff. Your call will be returned as soon as possible.

CONFIDENTIALITY

Our work together is completely confidential, as are your records. Your specific written permission is required to release information about your treatment to doctors, insurance companies, family members or others.

ACKNOWLEDGEMENT

I,_____, have read these policies and agree to abide by them.
(print your name)

Signed_____Date _____

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