THE YANUCK CENTER
for Life and Health

NEW PATIENT INFORMATION

Instructions from Dr. Yanuck…

The forms that follow provide you an opportunity to describe the details of your child's 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 child's case.

One of the most important elements in the history is the narrative that you write. This exercise can feel a bit intimidating at first, but you will find that it's a great way to clarify the information that gives me clues about what's going on. 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 child's 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 _____" "The problem got much worse in September of _____, when_____"

2. Key things that make it better or worse… "I noticed my child felt better with medication xyz… when they took supplement xyz… I noticed my child got worse when they got xyz infection… when we moved to a new house… when they changed their food…"

3. Key tests with dates… "…an MRI in June 2022 that was negative…" "…a blood test on March 10, 2023 that showed an xyz infection…"

In short, please make your narrative clear, sequential, detailed, and to the point.
I look forward to starting our work together.

- *Dr. Sam Yanuck*

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Child Health Questionnaire

(to be filled out by the parent(s) - if your child is old enough to fill this out, please use the adult questionnaire)

Full Name_____ Parent 1 _____

Address_____ Parent 2 _____

City_____State_____Zip_____ Emergency Contact _____

Date of birth ____/____/____ Sex _____ Relationship to child _____ Phone _____

Parent's phones: (cell 1) _____ (cell 2) _____ (email 1 / 2) _____

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

I, _____, have read and understand Dr. Yanuck's office policies listed at the end of these forms. I understand that I am personally responsible for payment at the time when services are rendered.

Signature_____ Date_____

Primary Concern

What is your child's primary health problem?_____

_____

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

Was there an event that created the problem?_____

Have your child had this or similar conditions in the past? _____ Is the problem getting worse? _____

What makes it better?_____ Worse?_____

Is this problem interfering with school?_____Sleep?_____Activity?_____Other?_____

What can your child not do now that he/she would like to do? _____

What are your goals for your child's treatment? _____

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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_____

_____

_____

_____

_____

Has your child ever seen a chiropractor? No Yes (Name: _____ Result: _____)

Does your child have any spinal abnormalities that you are aware of? _____

List **ALL** significant PAST illnesses _____

_____

_____

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

_____

List **ALL** surgeries your child has had, with dates and results _____

_____

Has your child ever been hospitalized other than for surgery?_____

Has your child ever been in an accident or seriously injured? List dates and describe_____

_____

Has your child ever had: whiplash? Yes___ No___ // a hard fall on the tailbone? Yes___ No___ // a seizure? Yes___ No___

Describe your child's worst injury ever, and any long lasting effects it has had on his/her health _____

_____

Describe any travel related illnesses _____

Is there a time in your child's life when he or she began feeling significantly less healthy? Yes _____ No _____ If yes, please describe… _____

How many root canals does your child have? _____ How many doses of antibiotics (total lifetime)? _____

How many times **per month** does your child take aspirin? ____ Ibuprofen? ____ Tylenol? ____ Antacids? ____ Laxatives? _____

For what purpose are these taken? _____

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Family History

Have any of your child's blood relatives (parents, brothers, sisters, aunts, uncles, grandparents), 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 your child.

Condition	**Yes**	**No**	**Age**	**Relationship**
Alcoholism / Drug Addiction	__	__	_____	_____
Allergies / Asthma	__	__	_____	_____
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	__	__	_____	_____
Thyroid disease	__	__	_____	_____
Uterine / Ovarian problems	__	__	_____	_____

List other problems that run in your family _____

Habits

Describe your child's exercise habits (activity / times per week) _____

Describe your child's current sleeping pattern (bedtime, waking time, napping, difficulty with sleep) _____

_____

Does your child have enough energy for normal activities? Yes____ No____ How long does your child watch TV each day?_____

What does your child do for fun / pleasure / relaxation? _____

Preventive Measures and Screening

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

General physical exam_____ CBC/chemistry_____

Dental exam_____ Eye exam_____ Hearing test_____

Other tests/scans (describe) _____

Has your child ever had an X-RAY, MRI or CT (CAT) scan? Yes____ NO____ If so, what for?_____

Has your child received the following vaccines:

Tetanus/Diptheria (Td)____ COVID-19_____ Flu____ Polio____ Measles/Mumps/Rubella____ Hepatitis B ____ Other_____

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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.) _____

Is your child particularly sensitive to the effects of medications? Yes _____ No _____

Has your child ever reacted to a medication in an unexpected way? Yes ___ No ___ If yes, please describe _____

Has your child had problems with damp or moldy places? Yes ___ No ___ Problems with new building materials? Yes ___ No ___

Nutrition

What does your child usually eat and drink on a typical weekday?

Breakfast _____

Morning snack _____

Lunch _____

Afternoon snack _____

Dinner _____

Evening snacks _____

Desserts _____

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

How many servings per day of the following: Fruits & Vegetables___ Coffee___ Tea____ Soda___ Diet Soda___

If your child takes nutritional supplements, is there a specific improvement in the way he/she functions?_____

How many meals each week are:

At home_____ Alone_____ In restaurant_____ At fast food place_____ TV Dinners or "convenience" food _____

While watching TV_____ From deli_____ At "health food" restaurant or takeout _____

Does your child eat if he/she is not hungry but feels depressed, anxious or bored? Frequently / Occasionally / Rarely / Never (circle)

Does your child ever: **a)** binge eat? Yes__ No__ **b)** sneak or hide foods? Yes__ No__ **c)** make him/herself vomit? Yes __ No __

d) eat slowly and chew his/her food well? Yes __ No __ **e)** use extra salt on food at the table? Yes __ No __

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

Does your child enjoy eating cheese? Yes____ No____ Drinking milk? Yes____ No____ If so, how much per day? _____

Does your child like sweets, pastries, cakes, donuts, etc.? Yes___ No___ How many servings per week? _____

Does your child eat sugarcoated cereal or add sugar to cereal? Yes___ No__ How many servings per week? _____

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Does your child use artificial sweeteners (in diet soda or other foods)? Yes___ No___ How many servings per week? _____

When your child eats bread, is it white or whole wheat?_____ After eating, does he/she feel: Better / Worse / No different (circle)

Does your child usually eat breakfast? Yes__ No__ Does your child feel better if he/she skips breakfast? Yes____ No____

Does your child snack between meals? Yes__ No__ Does your child frequently skip meals? Yes _____ No ____

What is your child's preferred snack food? _____

Is there one food that your child likes the most, eats a lot of, and craves when he/she doesn't have it? _____

Does your child have any reaction to eating food with MSG in it? Yes__ No__ If so, please describe: _____

Does your child have trouble with gaining weight too easily?…….....…Yes_____ No _____

Does your child have trouble with losing weight too easily? .....……Yes_____ No _____

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

Does your child have more than one meal a day that lacks a vegetable other than corn, potatoes, peas or beans? Yes_____No_____

Are there days when your child does not eat any raw vegetables? ..... Yes_____ No_____

List the three healthiest foods your child eats in the average week: _____, _____, _____

List the three un-healthiest foods your child eats in the average week: _____, _____, _____

Are there specific foods that irritate your child in any way? Yes ___ No ___ If yes, name the foods and describe the problem:

_____

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

_____

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

_____

List all vitamins, herbs and other supplements your child is now taking _____

_____

_____

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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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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

Please answer all that apply (Only for females for whom these questions are appropriate):

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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THE YANUCK CENTER
for Life and Health

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					
Chronic inflammation	0	1	2	3	4
High stress level	0	1	2	3	4
Autoimmune disease flares	0	1	2	3	4
Tendency to intestinal problems	0	1	2	3	4
Current intestinal problem	0	1	2	3	4
Catch colds that are going around	0	1	2	3	4
Stay sick longer once you get sick	0	1	2	3	4
Get cold sores	0	1	2	3	4
Tendency to bladder infections	0	1	2	3	4
Current bladder infection	0	1	2	3	4
Tendency to sinus infections	0	1	2	3	4
Current sinus infection	0	1	2	3	4
Tendency to respiratory infections	0	1	2	3	4
Current respiratory infection	0	1	2	3	4
Chronically elevated viral burden	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					

Th2 Modulation Factors					
Childhood asthma	No=0			Yes=3	
Childhood intestinal problems	No=0			Yes=3	
Childhood ear infections	No=0			Yes=3	
Tendency to asthma or other lung issues	0	1	2	3	4
Active or medicated asthma	0	1	2	3	4
Active or medicated other lung problem	0	1	2	3	4
Tendency to sinusitis	0	1	2	3	4
Headache in forehead, cheek, face	0	1	2	3	4
Current sinus problem	0	1	2	3	4
Produce copious nasal mucous	0	1	2	3	4
Mucous in stool	0	1	2	3	4
Allergy to environment (pollen, mold, etc.)	0	1	2	3	4
Food sensitivities/reactions	0	1	2	3	4
Tendency to IBS, SIBO, Dysbiosis, etc.	0	1	2	3	4
IBS, SIBO, Dysbiosis, other GI currently	0	1	2	3	4
Chronic Stress	0	1	2	3	4
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 your child is not currently experiencing pain.)

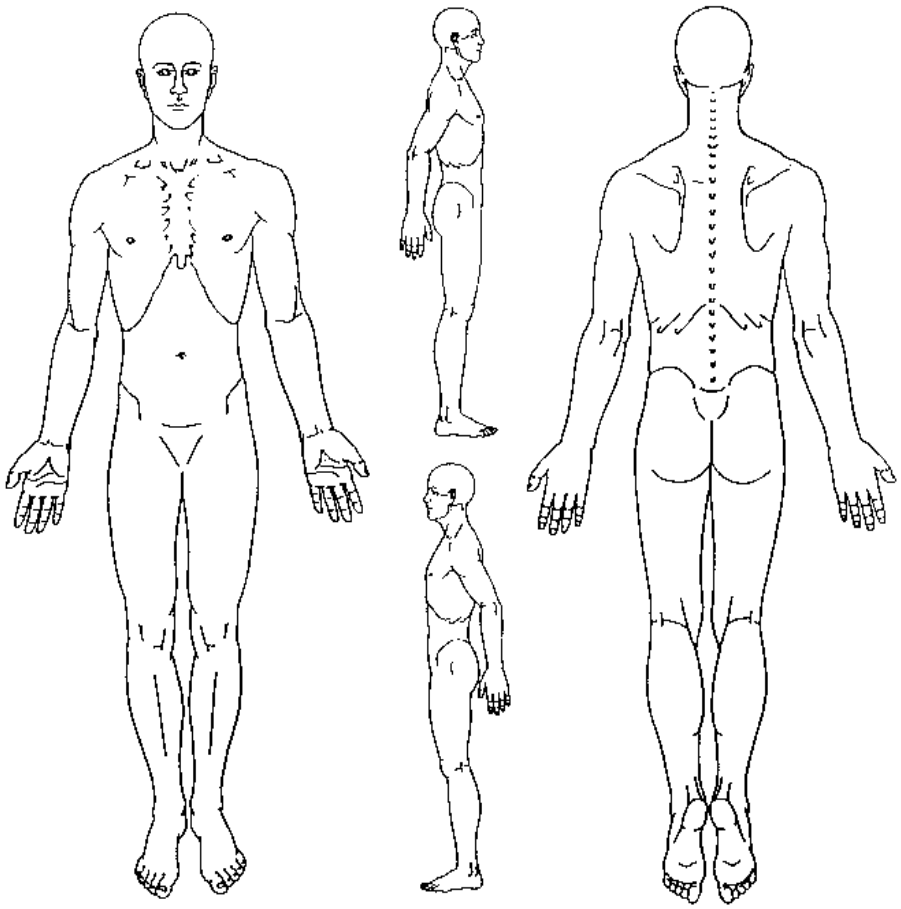
Name_____

Please place a single vertical line through the scale below at the point that best describes your child's 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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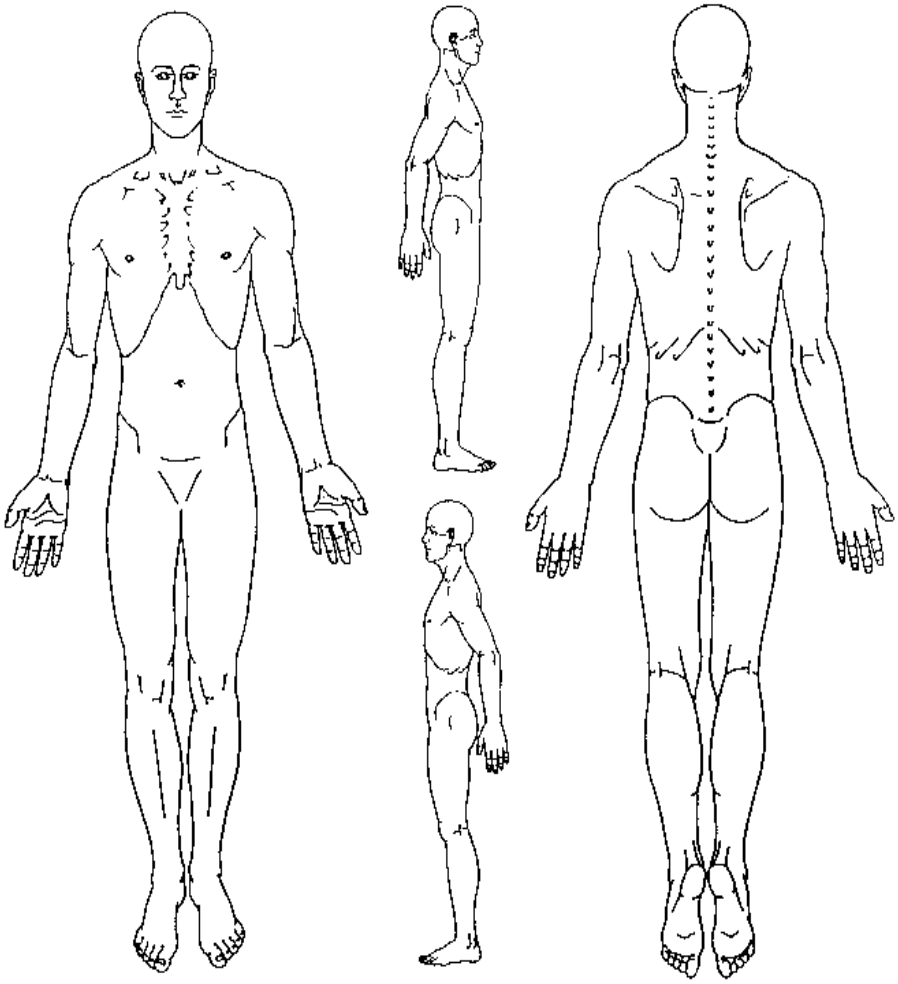
History of Injury

Name _____

Please mark with an "X" all the places where your child has 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. (tonsils, wisdom teeth, appendix, etc.).



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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, or their parent or guardian, 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 child's responses can vary. Always inform us of any concerning observations. 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 child's doctor may determine that the procedures listed below may be beneficial in the diagnosis or treatment of your child's condition. Upon your signed consent below, such operations or special procedures may be performed for your child by your doctor and/or by other technical staff selected by him or by other cliniicans or staff members to whom your child is referred (for example, by a phlebotomist at the lab where you go for a blood draw). This authorization applies both to the listed procedures and to advice given as part of your child's 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, when appropriate, each procedure will be discussed with you ahead of time, 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, exercise, heat, cold, phlebotomy, nutrition, orthopedic testing, neurologic testing, physical examination, rehabilitation exercises, dietary instructions.

Patient (Print): _____ Parent / Guardian (Print): _____

Signature of Parent or Guardian: _____ Date _____

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Informed Consent for Exercise, Training, and Rehabilitative Activities

In the course of your child's assessment and treatment process, elements of the work may involve exercise or rehabilitative activities. As with virtually any therapeutic modality, there exists a risk of injury. While problems with such activities are unlikely, this page describes your recognition of the risks involved in such 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 your child provide adequate feedback regarding any changes that they observe. When engaging in an exercise program, it is important to distinguish muscular pain due to fatigue as compared with pain experienced as a result of an injury. If an exercise causes pain, your child should stop that exercise immediately and inform us 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 us and do not perform the portion of the exercise that caused pain.

Any questions about the procedures used in any component of your child's care 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 any rehabilitation or exercise component of your child's care at any time.

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 child's exercise program.

Patient (Print): _____

Parent / Guardian (Print): _____

Signature of Parent or Guardian: _____

Date _____

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Patient Medication List

Your Child's Name__________________________________Date __________________

Please describe each of your child's medications. If a medication is giving your child 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 your child has taken in the past: ____

____

I ____understand that any changes to my child's regimen of medications must be made by, in coordination with, and under the instructions of the physician who prescribes them.

Signed ____Date _________________

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About Medications

As our work unfolds, your child's body may be better able to heal itself. Because of this, your child's cognitive functions, allergic responses, blood sugar levels, and other important bodily functions might improve. As the body changes, it is possible that the doses of medications your child is taking will need to be modified, to account for these changes. It is your responsibility, in coordination with your child's pediatrician, to monitor or have monitored those of your child's functions that relate to medications he or she is currently taking, to ensure that current doses do not become excessive or deficient in their effect on your child. These and any other changes to your child's regimen of medications must be made by and under the instructions of the physician who prescribed them.

All nutritional supplements should always be discontinued 10 days prior to any surgery and restarted with guidance from both Dr. Yanuck and the surgeon involved.

Additional Information

Please email any other relevant information to staff@yanuckcenter.com. This information will help Dr. Yanuck evaluate your condition. This might include medical records, lab results, consultation reports, and any other test or study results such as x-rays or CT scans. **For labs, if you are able, please send as a single pdf, not one pdf per test result.**

Please list the names of your child's pediatrician and other doctors, so Dr. Yanuck can send a report to them with the details of his findings in your child's 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.

_____ _____

_____ _____

_____ _____

_____ _____

☐ 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 child's case.

As parent/guardian, I _____ hereby authorize the treatment of

_____ by Dr. Samuel F. Yanuck, chiropractic physician. I understand that I will be

responsible for supervising all aspects of care, including follow up, home instructions, and any other needs that might arise.

Signature_____ Date_____

Relationship to the patient _____

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Dr. 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. **Help your child 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 child's visits as close as possible to the recommended time of your child's follow up. The timing is based on the specifics of your child's 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 bring your child to the Yanuck Center in person.

APPOINTMENTS

Dr. Yanuck spends significant time in preparation for each of your child's 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 child's appointments, but please also plan for delays in the start and end timing of your child's appointments. **Do not schedule other appointments close to the ending time of your child's appointments with Dr. Yanuck.**

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FEES AND BILLING

The fee per hour is $354. **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 your child has an emergency, call 911. If your child has 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 child's records. Your specific written permission is required to release information about your child's treatment to doctors, insurance companies, family members or others.

ACKNOWLEDGEMENT

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

Signed_____Date _____

Relationship to the patient _____

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