21135 Whitefield Place, Suite 107, Sterling, VA 20165
Phone: 703-421-7000 / Fax: 703-430-4830

Welcome!

We look forward to helping you with our specialized, therapeutic lifestyle program called First Line Therapy (FLT). It is very different from today's common medical approach. The FLT program works to more clearly identify and overcome the cause of ill health, and then improve total body function naturally by nourishing, balancing and revitalizing the whole individual. It is powerful, effective and rewards you with improved health and function that is long lasting!

Our consultation time with you is important! We analyze your personal and family health history, appropriate test results, current lifestyle and state of health, and clarify your health goals. We then guide you through a comprehensive, highly personalized, step-by-step program to achieve those goals. To ensure that you receive the maximum benefit from the time reserved for your consultation, please come prepared by following the steps below:

Please fill out paperwork included in your welcome packet before coming to our office.

1. Prepare for your Bioimpedance Analysis (BIA Test) by adhering to the following guidelines:
   a) Do no eat 4 hours prior to testing.
   b) Do not exercise for 12 hours prior to testing.
   c) Do not consume alcohol for 24 hours prior to testing.
   d) Drink plenty of water before testing. (1 qt 1 hour before test)
   e) Do not drink caffeine the day of your test.
   f) Ensure access to your right foot with removable footwear (no pantyhose)
2. Cancellations need to be made at least 24 hours in advance or you may be charged a fee of $25. We thank you in advance for your cooperation.

The FirstLine Therapy Program is a 12-week program, typically consisting of 6 visits (bi-weekly) during that period. Please plan on approximately 60-90 minutes for you initial consultation with a Lifestyle Educator and approximately 30 minutes for follow-up visits.

Our Special introductory package of $125 includes:

- Initial consultation with a Life style Educator
- FirstLine Therapy Workbook
- FirstLine Therapy Cookbook
- Body Impedance Analysis

Follow up Visits with our Lifestyle Educator are $45.
Follow up BIA $20.

Health History

Name ____________________ Date ____________

Address ____________________ City ____________ State ______ Zip Code ____________

Phone ____________________ Email ____________________

Occupation ____________________ Age _______ Height ________ Sex ________ Number of Children ___________

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? ____________ Are you pregnant? ____________

Reason for office visit ____________________ Date began ____________

____________________ ____________

____________________ ____________

List current health problems for which you are being treated: ____________________

____

____

____

What types of therapies have you tried for these problem(s) or to improve your health overall:

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs

☐ Other ____________________

Do you experience any of these general symptoms on a regular basis?

☐ Debilitating fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation ☐ Chronic pain/inflammation

☐ Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding

☐ Disinterest in sex ☐ Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Discharge

☐ Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

Current medications (prescription or over-the-counter): ____________________

____

____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

____

____

Outcome: ____________________

____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome
________	____________________	____________________
________	____________________	____________________
________	____________________	____________________
________	____________________	____________________

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): ____________________

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Healthy weight Your weight today: ____________

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ____________________

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)?

____

What are your current health goals: ____________________

____

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other ___________________________

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other ___________________________

____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other ___________________________

Date of last GYN exam______________

Mammogram ☐ + ☐ –

PAP ☐ + ☐ –

Form of birth control _______________

# of children ____________________

# of pregnancies __________________

☐ C-section ____________________

Age of first period ________________

Date of last menstrual cycle _________

Length of cycle _______________ days

Interval of time between cycles

___________________________ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other ___________________________

____

Health Habits

☐ Tobacco:

Cigarettes: # /day ________________

Cigars: # /day ___________________

☐ Alcohol:

Wine: # glasses/d or wk ___________

Liquor: # ounces/d or wk __________

Beer: # glasses/d or wk ___________

☐ Caffeine:

Coffee: # 6 oz cups/d______________

Tea: # 6 oz cups/d _______________

Soda w/caffeine: # cans/d __________

Other sources____________________

☐ Water: # glasses/d ______________

Exercise

- ☐ 5-7 days/wk
- ☐ 3-4 days/wk
- ☐ 1-2 days/wkk
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk: #days/wk _____________
- ☐ Run, jog, other aerobic - #days/wk

____

- ☐ Weight lift: #days/wk _____________
- ☐ Stretch: #days/wk _______________

Other ___________________________

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other _______________________

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) __________

Dark green or deep yellow/orange vegetables_______________________

Grains (unprocessed) ______________

Beans, peas, legumes ______________

Dairy, eggs _____________________

Meat, poultry, fish ________________

Eating Habits

☐ Skip meals (which ones) _________

____

- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening primrose/GLA
- ☐ Calcium, source _______________
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals (describe) _____________
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other ___________________________

I Would Like to:

Energy, Vitality

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

Body Composition

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress: Mental and Emotional

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

Life Enrichment

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

FLT058 020412 © 2012 Metagenics, Inc. FirstLine Therapy is a registered trademark of Metagenics, Inc. All Rights Reserved.

Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name ______________________________ Date ______________

Rate each of the following symptoms based on how you've been feeling for the: ☐ Past 48 hours ☐ Past week ☐ Past 30 days

Point Scale
0 — Never or almost never have the symptoms
1 — Occasionally have it; effect is not severe
2 — Occasionally have it; effect is severe
3 — Frequently have it; effect is not severe
4 — Frequently have it; effect is severe

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total _____

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or farsightedness)
Total _____

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
Total _____

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
Total _____

Mouth/Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, or lips
_____ Canker sores
Total _____

Skin
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
Total _____

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
Total _____

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
Total _____

Digestive Tract
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
Total _____

Joints/Muscles
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total _____

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
Total _____

Energy/Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
Total _____

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total _____

Emotions
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
Total _____

Other
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
Total _____

For Practitioner Use Only:
Urinary pH _________

Grand Total _______

FirstLine Therapy®
Lifestyle Medicine Programs by Metagenics

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
☐ Yes (1 pt.) ☐ No (0 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?
☐ Cimetidine (2 pts.) ☐ Acetaminophen (2 pts.) ☐ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
☐ Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
☐ Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
☐ Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
☐ Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently within the last 6 months have you regularly used tobacco products?
☐ Yes (2 pts.) ☐ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
☐ Yes (1 pt.) ☐ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

10. Do you have a personal history of:
☐ Environmental and/or chemical sensitivities (5 pts.)
☐ Chronic fatigue syndrome (5 pts.)
☐ Multiple chemical sensitivity (5 pts.)
☐ Fibromyalgia (3 pts.)
☐ Parkinson's type symptoms (3 pts.)
☐ Alcohol or chemical dependence (2 pts.)
☐ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
☐ Yes (1 pt.) ☐ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

Total _________

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction?
☐ Yes (1 pt.) ☐ No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?
☐ Yes (1 pt.) ☐ No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?
☐ Yes (1 pt.) ☐ No (0 pt.)

Total _________

Overall Score Tabulation

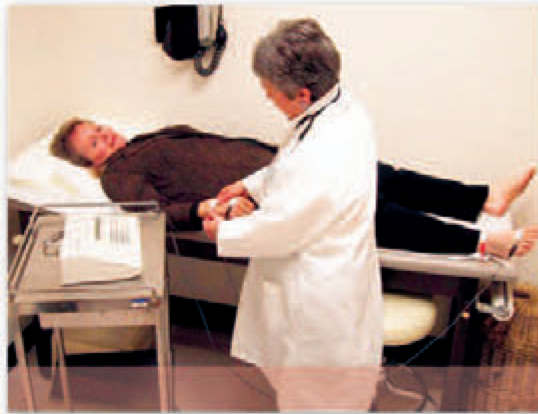
For Practitioner Use Only:

Part 1: Symptoms Grand Total _________ (High >50; moderate 15-49; low <14)
Part 2: XTT Total _________ (High >10; moderate 5-9; low <4)
Part 3: Alkalizing Assessment Total _________ (High ≥1)
Urinary pH _________

Notes:

- Patients with high Symptoms but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

FLT063 030413 © 2012 Metagenics, Inc. FirstLine Therapy is a registered trademark of Metagenics, Inc. All Rights Reserved.



What Is a BIA?
(And why do you need one?)

Bioelectrical Impedance Analysis or Bioimpedance Analysis (BIA) is a method of assessing your "body composition"—the measurement of body fat in relation to lean body mass. It is an integral part of a health and nutrition assessment.

Why Is Body Composition Important to My Health?

Research has shown that body composition is directly related to health. A normal balance of body fat is associated with good health and longevity. Excess fat in relation to lean body mass, known as altered body composition, can greatly increase your risks to cardiovascular disease, diabetes, and more. BIA fosters early detection of an improper balance in your body composition, which allows for earlier intervention and prevention. BIA provides a measurement of fluid and body mass that can be a critical assessment tool for your current state of health.

BIA also measures your progress as you improve your health. Improving your BIA measurement, or maintaining a healthy BIA measurement, can help keep your body functioning properly for healthy aging. Your BIA results can help guide us in creating a personalized dietary plan, including nutritional supplements when appropriate, and exercise to help you maintain optimal health and well-being for a lifetime.

How Does a BIA Work?

BIA is much more sophisticated than your bathroom scale, but just as simple—and almost as quick. BIA is performed in our office with the help of a sophisticated, computerized analysis.

This analyzer "calculates" and estimates your tissue and fluid compartments—using an imperceptible electrical current passed through pads placed on your hand and foot as you lie comfortably clothed on an exam table. In just minutes, we'll have detailed measurements to help create an effective, personalized program for you.

Follow-up Tests

We can conduct a series of follow-up BIA tests to monitor your health and measure your progress.

Guidelines for Assessment

For the most accurate results, the following guidelines should be followed:

1. **Do not eat for 4 hours prior to testing.**
2. **Do not exercise for 12 hours prior to testing.**
3. **Do not consume alcohol for 24 hours prior to testing.**
4. **Drink at least 1 quart of water one hour before your test.**
5. **Do not drink caffeine the day of your test.**
6. **Do not wear pantyhose.**
7. **Do not put lotion on your hands and feet.**

Follow-up Appointment:

FirstLineTherapy®

FirstLine Therapy is a registered trademark of Metagenics, Inc. © 2008

Metagenics® Genetic Potential Through Nutrition
www.metagenics.com

MET1323 6/5/08

Food & Lifestyle Journal - Day 1

Name____ Date_____________________

Day 1
Wake Up Time_______
Morning Meal Time_______
Morning Snack Time_______
Midday Meal Time_______
Afternoon Snack Time_______
Evening Meal Time_______
Evening Snack Time_______
Water/Drinks (not listed with meals above)
Activity/Exercise (detail type and duration)
Relaxation/Sleep (detail type and duration)

Please complete your "Diet & Exercise Log" every day.

1. Make note of the time you wake up.
2. List and describe in detail all foods and drinks, including the amount of each. Be sure to list everything, including condiments used (e.g., mayonnaise, mustard, relish). Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc.
3. Note the time of each meal or snack.
4. Include any strong feelings, symptoms or changes in energy that may arise either between meals or realtive to foods you are consuming (e.g. happiness, sadness, anger, indigestion, fatigue).
5. Keep track of how much water you drink and list the amount in ounces (or ml or l) in the section provided. Also note the type and amount of any other drinks you consume.
6. Write down any activity or exercise you do, listing the kind of exercise you did and for how long you did it.
7. Note any periods of relaxation and what kind of relaxation it was.
8. Note the time you go to sleep.

Notes ____

Food & Lifestyle Journal - Days 2 & 3

Name____ Date____________________

Day 2	Day 3
Wake Up Time_______	Wake Up Time_______
Morning Meal Time_______	Morning Meal Time_______
Morning Snack Time_______	Morning Snack Time_______
Midday Meal Time_______	Midday Meal Time_______
Afternoon Snack Time_______	Afternoon Snack Time_______
Evening Meal Time_______	Evening Meal Time_______
Evening Snack Time_______	Evening Snack Time_______
Water/Drinks (not listed with meals above)	Water/Drinks (not listed with meals above)
Activity/Exercise (detail type and duration)	Activity/Exercise (detail type and duration)
Relaxation/Sleep (detail type and duration)	Relaxation/Sleep (detail type and duration)

Name____Date_______________________

Day 4	Day 5
Wake Up Time_______	Wake Up Time_______
Morning Meal Time_______	Morning Meal Time_______
Morning Snack Time_______	Morning Snack Time_______
Midday Meal Time_______	Midday Meal Time_______
Afternoon Snack Time_______	Afternoon Snack Time_______
Evening Meal Time_______	Evening Meal Time_______
Evening Snack Time_______	Evening Snack Time_______
Water/Drinks (not listed with meals above)	Water/Drinks (not listed with meals above)
Activity/Exercise (detail type and duration)	Activity/Exercise (detail type and duration)
Relaxation/Sleep (detail type and duration)	Relaxation/Sleep (detail type and duration)

Name________________________________ Date________________

Day 6	Day 7
Wake Up Time_______	Wake Up Time_______
Morning Meal Time_______	Morning Meal Time_______
Morning Snack Time_______	Morning Snack Time_______
Midday Meal Time_______	Midday Meal Time_______
Afternoon Snack Time_______	Afternoon Snack Time_______
Evening Meal Time_______	Evening Meal Time_______
Evening Snack Time_______	Evening Snack Time_______
Water/Drinks (not listed with meals above)	Water/Drinks (not listed with meals above)
Activity/Exercise (detail type and duration)	Activity/Exercise (detail type and duration)
Relaxation/Sleep (detail type and duration)	Relaxation/Sleep (detail type and duration)