Stanton Wellness Solutions (SWS)

21715 Kingsland Blvd, #100, Katy, TX 77450
Phone: 281-402-6528 Fax: 281-402-6538

About Dr. Brian Stanton BS, DC, ACN:

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

At your appointment:

You must make an appointment to be treated or consult with the doctor. We know that our patients have schedules to maintain and so **we do our best to run on time**. If you are running late for an appointment, please call or text us and give us notice.

Office Fees:

Our fees are based on the time that you spend with the doctor. A new patient office visit or phone consult is 45-60 minutes with the doctor and follow-ups (office visits or phone consults) for active patients are 15 minutes. If you do not consult with the doctor, either by an in-office appointment or a phone consultation, **within 6 months**, you will be required to have another new patient visit due to the need for a re-evaluation.

New patient visit (45-60 min. in-office visit or phone consultation):	$180.00
Active/Established patient visit (15 min. in-office visit or phone consultation):	$50.00
Ion Cleanse Therapy Detox/Footbath, 15-30 min**:**	$30.00
Far Infrared Sauna Therapy Session, 30 min:	$30.00
Light Therapy (Infrared + Red), 5-15min**:**	$20.00
Interpretation Fee (Dr. time to review labwork and diagnostics):	$40.00

(The interpretation fee also applies to labwork and diagnostics brought in from other doctors/locations that you want Dr. Stanton to interpret or evaluate.)

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

*We are happy to mail supplements for a flat shipping fee of $10. An order of $100 or more is free shipping. Overnight shipping excluded. Outside of U.S. shipping is charged at the rate at which it costs.

Payment:

Payment is due at the time of services rendered. Acceptable forms of payment include cash, credit cards, apps and checks. We provide you with information so that you may file with your insurance, if you choose.

I have read and understand the above information and I accept the policies of SWS.

Patient/Legal Guardian (17 or under): Print_____Signature_____Date_____

SWS New Patient Evaluation

(Please fill out in pen)

Patient's Name: _____ Date: _____

Mobile phone: _____ Mobile phone provider: _____ E-Mail: _____

Mailing Address:_____

City:_____ State:_____ Zip:_____ Gender: M / F Marital Status: M S D W

# of children___ Your birthday: ____/____/____ Age: ___ Height: _____ Weight: _____ Blood Type: O, A, B, AB (- +)

Occupation: _____ Currently play sports? Y N if yes, what? _____

Emergency Contact Name: _____Phone #: _____

Who referred you: _____ Affiliation w/Referral_____

HEALTH CONDITIONS AND COMPLAINTS (Please number them and list them in order of severity from most to least)

_____

_____

GOALS AND EXPECTATIONS FROM COURSE OF TREATMENT: (Why are you seeking help?)

_____

_____

SUPPLEMENTS (VITAMINS or HERBS): (List name and why you are taking them)

_____

_____

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

_____

_____

ALLERGIES: (List any known food, environmental, chemical, and drug allergies)

_____

_____

SURGERIES: (List surgeries/operations, plastic surgery &trauma and the month and year it occurred)

_____

_____

COVID VAX or BOOSTERS? Y/N: (If yes, list brand and approximate dates of procedures)

_____

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

_____

My signature below confirms that this information is true.

Patient/Legal Guardian (17 or under): Print_____Signature_____Date_____

SWS Holistic Health Overview

(Please ***fill in*** where answers are not given. Please ***circle*** where choices are given and if you are ***currently experiencing*** or ***within the last 4 months*** have experienced the symptoms or medical conditions)

Family History: Please circle those that apply and mark if sibling (S), parent (P), or grandparent (G)

Cancer_____(and type) _____

Alzheimer's_____ Cardiovascular Disease_____ Diabetes Type II_____ Osteoporosis_____ Asthma_____

Diet: How many times a day do you eat? _____How often do you eat out each week? _____

Number how many servings of the following you eat each day (D) or, if not daily, how many each week (W):

Fruits_____ Vegetables (excluding potatoes) _____ Bread/Pasta_____

Processed (bacon, lunchmeats, hot dogs) _____ Cold water fish (tuna, salmon, cod) _____ Protein/food bars___

Sugar (candy, concentrated/processed fruit juices, pasta, potatoes, bread) _____ Artificial sweeteners_____

Do you have any known allergies or sensitivities to the following: (circle) gluten, dairy/cow's milk products, soy, corn, tomatoes, eggs, peanuts, shellfish

Liquid Intake: What type of water do you drink? (circle) tap, filtered, spring, reverse osmosis, or distilled

Number how many of the following you drink each day (D) or, if not daily, how many each week (W):

Milk_____ Coffee_____ Tea_____ Herbal tea_____ Energy or pre-workout drinks_____

Soda_____ Beer_____ Wine_____ Liquor_____ Protein drinks/shakes_____

Digestion: (circle) good, adequate, poor, heartburn, reflux, nausea, vomiting, burp/belch, bloating, abdominal pain, cramping

Other Complaints: _____

Bowels: How many bowel movements per day_____, per week_____

Consistency: normal, hard, soft, diarrhea **Amount:** normal, too big, too small (pellets)

Color: tan, brown, black, green, blood in stool **Other:** gas, mucus, smelly, straining, hemorrhoids,

Other Complaints: _____

Urination: (circle) every 2-3 hrs, too frequent, sense of urgency, burning, dribbling, bedwetting, wake up to urinate, blood in urine, kidney stones, history of UTIs, frequent UTIs

Other Complaints: _____

Sleep: (circle) restful, restless, hard to fall asleep, wake up often, wake up tired, bad dreams/nightmares, night sweats

What time do you go to sleep?_____Number of hours of sleep per night?_____

Sunlight: How many hours of sunlight do you get daily?_____weekly?_____

How many hours daily do you spend under fluorescent lights? _____

Mental Stress: (circle) anxiety, fear, depression (mild, mod, severe), panic attacks, sense of despair, anger easily, irritable, nervousness, restlessness, mood swings

Please rate your current stress level on a scale of 1 to 10, 10 being the highest stress: _____

What are the main reasons for your stress? _____

How do you reduce stress? _____

Mental Energy/Focus: (circle) no problems, occasionally lack mental focus, daily lack mental focus/concentration

Physical Energy: (circle) no problems, hyperactive, occasionally experience fatigue, experience fatigue daily

Exercise: Do you exercise? Y N What type of exercise? _____

How often? _____Duration of exercise regimen? _____

Sun Exposure: How much direct sun exposure do you get each day on average? (circle) -20 min, 20-60 mins, +60 min

SWS Holistic Health Overview (continued)

Electromagnetic pollution: Do you live by power lines? Y N How many hours do you spend daily…
Watching TV? _____Working on a computer?_____Talking on a phone?_____
Wearing a watch?_____Wearing a hearing aid?_____Riding in a car?_____

Smoking: Do you smoke? Y N If yes, how much per day and for how long? _____Ex-smoker? Y N
Are you exposed to second-hand smoking? Y N Do you vape? Y N

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

***Women Only:** Are you trying to conceive? Y N If yes, for how long in months____ Are you Pregnant? Y N If yes, when is your due date? _____ Are you breastfeeding? Y N
(circle) breast tenderness, vaginal dryness, low libido, weight gain, hot flashes, cry easily, oily skin, acne
Menstrual Cycle: Do you have monthly periods? Y N #of days of flow_____heavy, light, spotting, normal
Last period date_____ Have you stopped having periods? Y N Are you in menopause? Y N
Circle if you experience: cramping, bloating, weakness, mood swings, cravings, pain, bright blood, dark clotting
Other menstrual complaints: _____
_____

***Men Only:** (circle) nighttime urination, enlarged prostate, low libido, ED, muscle atrophy

Joints/Muscle/Bones: (circle) muscle pain, muscle stiffness, muscle cramps or twitching, joint pain, joint stiffness, joint swelling, arthritis, numbness, tingling, bone loss, bruise easily, flat feet/fallen arch
Describe any current issues: _____
_____

Dental/Oral History: (circle) infections, cavities, root canals, crowns, bridges, implants, gum disease, bleeding gums, tooth pain, canker sores, cold sores
Describe any current or recent issues: _____
_____
When was your last teeth cleaning? _____

Immune History: (circle) frequent illness, recurrent illness, sore throat, postnasal drip, frequent cough, yeast infections, nail fungus, genital itch/discharge, excessive mucous/phlegm, sinusitis, sinus headaches, nose bleeds, earaches, ear infections, fluid in ears, ear discharge, stuffy nose, chest congestion
Describe any current or recent issues: _____
_____

Allergies/Sinus: (circle) seasonal allergies, itchy/watery eyes, runny nose, sneezing, headaches,

Skin/Hair/Nails: (circle) acne, dry skin, oily skin, itchy skin, hives, rashes, eczema, psoriasis, cracked skin on heels, brittle nails, hair loss, bruise easily, flushing skin

Circulation/Cardiovascular: (circle) high BP, low BP, chest pain, tightness in chest, shortness of breath, rapid pulse, cold hands, cold feet, swelling hands, swelling feet, history of heart problems_____

Head/Respiratory: (circle) tension headaches, migraines, sinus headaches, dizziness, faintness, blurred vision, difficulty breathing, asthma, exercise-induced asthma

Any other information you wish to share: _____
_____

My signature below confirms that this information is true.

Patient/Legal Guardian (17 or under): Print_____Signature_____Date_____

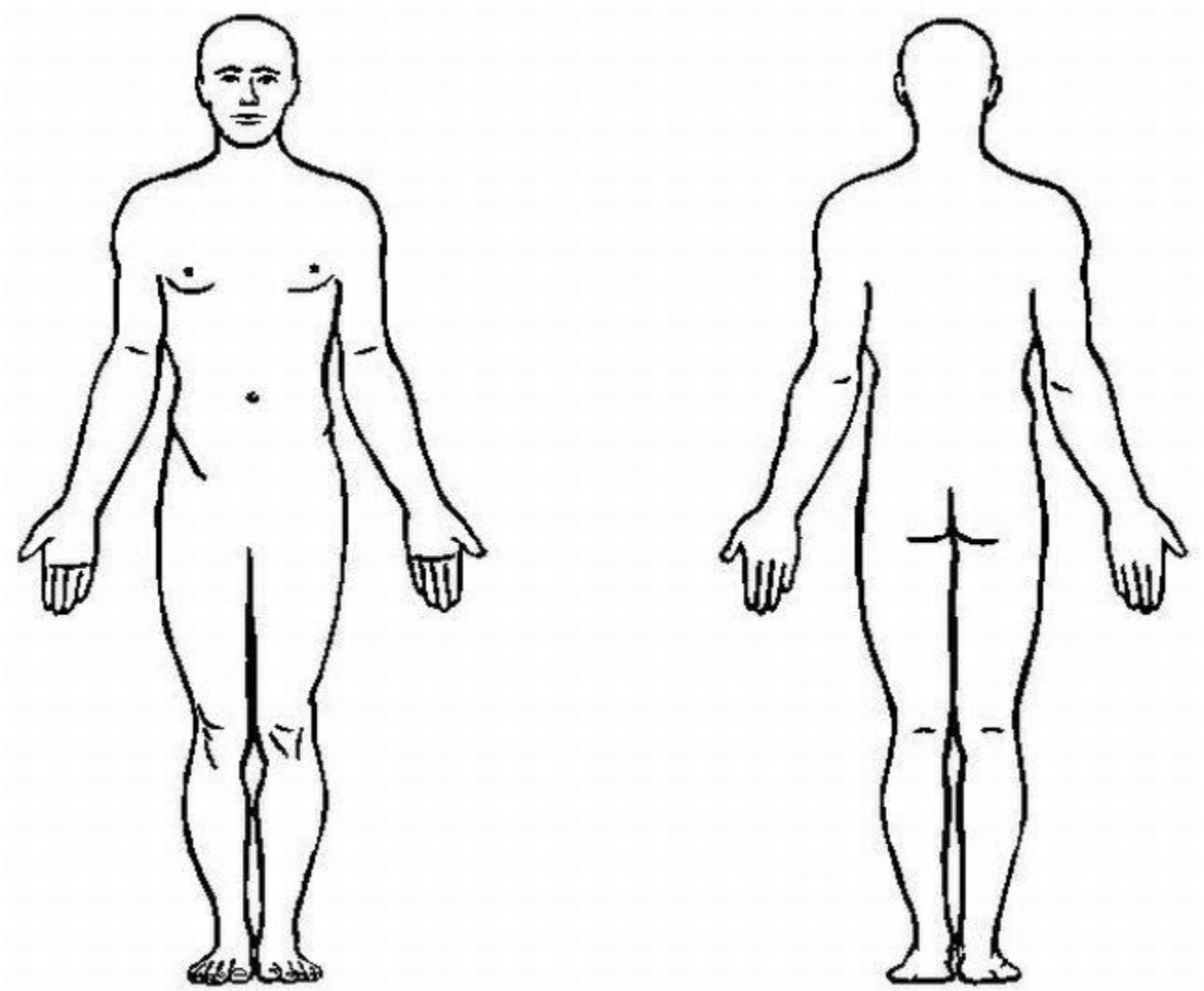
SWS Scar/Trauma Chart

SCARS: Please *draw a line* on the figure below where you have scars, even if they are very old.
These scars may be from cuts, burns, stitches, surgeries, c-sections, episiotomies, vasectomies, punctures (from needles, vaccinations, tattoos, and body piercings), etc.

TRAUMA Areas: Please *put an "X"* where you have had trauma even if it is very old.
These may be from fractures, falls, sprains, strains, whiplash, radiation, etc…

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

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



My signature confirms that this information is true.

Patient/Legal Guardian (17 or under): Print_____Signature_____Date_____

Stanton Wellness Solutions

Doctor-Patient Informed Consent

HEALTH AND WELLNESS

We want our patients to be informed about our goals, philosophies, and expectations at Stanton Wellness Solutions in regards to how we work to achieve health and wellness for you and your family. It is our premise that nutrition, energy, and a properly functioning nervous system are the building blocks of life. When these foundational aspects are balanced, it allows the body the opportunity to optimize its own naturally occurring recuperative abilities. With this in mind, we seek to restore health through natural means without the use of drugs or surgery (If medication or surgery is warranted, we advise the patient accordingly). We do this by balancing nutritional needs and restoring optimal neurologic and electrical communication with a myriad of techniques. We believe by supplying our patients with the building blocks of life, we give their body the maximum opportunity to utilize its inherent recuperative powers. We do not claim to treat or cure any specific disease or condition. The doctors at Stanton Wellness Solutions provide a specialized, unique, non-duplicating, holistic health service and are licensed in their special areas of practice.

ANALYSIS AND APPROACH

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

RESULTS

The purpose of office visits is to promote natural health through the stabilization of the nutritional, neurological, and energetic systems of your body. Due to the individuality of each patient, it is difficult to predict the healing time. Most often the response is incredible as to how quickly the body begins to heal, however, in some cases there is a gradual healing process. Two or more similar conditions may respond differently to the same type of care and actual response time is unpredictable. Many conditions that the medical field has not found much improvement, have found significant benefit through the approach we use at Stanton Wellness Solutions. He works with you to help you make an informed decision prior to being accepted as a patient.

DIAGNOSIS

Although Doctor Stanton is an expert in the analysis of the nutritional, neurological, and energetic aspects of the human body, he will not make a diagnosis outside of his scope of practice. Patients that require additional testing (MRI, XRAY, Blood, etc…) will be informed, referred for proper diagnostic testing, and have access to those reports at any time.

INFORMED CONSENT

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

Patient/Legal Guardian (17 or under): Print_____Signature_____Date_____

SWS Office Policies

Office policy on supplements:

As you may already know, the supplements that we use are VERY powerful, effective, and functional. Most of the supplements that we carry can only be sold by a doctor. This is a huge responsibility that we take very seriously at SWS. In order to ensure that you are taking the proper supplements that work best for you, we will only sell you the supplements that Dr. Stanton has prescribed for you. (We cannot refund any opened supplements or containers.) **In addition, if you do not consult with the doctor at least once within a 90-day period via an in-office appointment or a phone consultation, we will be unable to sell you our supplements until you consult with the doctor.** This is to ensure that the supplements that you are taking will only better your health and will assure that you are on a path to wellness. However, if you continue to take such powerful supplements without being evaluated to make sure that you need them, it could create a negative health situation. This is obviously not desirable, in addition, we would never want anyone to waste their money on a supplement that they don't even need. Just think about how quickly your body can heal and rejuvenate! By complying with this policy, we help to protect you from any negative situations and supply you with the up-to-date regimen that will assist you in reaching your wellness goals! Additionally, for optimal results, we ask that you come in at the doctor-recommended intervals.

Office policy on visits/phone consultations:

We do require a full re-evaluation if it has been more than 180 days (6 months) since your last visit. We enforce this because so much can change in 6 months. It is our duty to give you the best care possible and if you have not seen the doctor in more than 6 months, a regular office visit would be inadequate time to re-evaluate your health. Therefore, if you have not had an office visit or phone consultation in the past 6 months, you will need to fill out the New Patient Paperwork and plan for a 45-minute office appointment or phone consultation in which you will be charged the new patient price of $180. We believe that your health is very important and would never want to give you sub-par care or inadequate time. If you have an appointment within the 6-month period of your last visit, you are considered an active/established patient and may schedule regular appointments for the times of your convenience.

Office policy on payment, rescheduling, or cancellations:

Payment for all in-office appointments is due at the time the service is rendered. If for any reason you need to reschedule your in-office active patient appointment, we require 24 hours' notice. You can do this by phone or email. (If we do not answer the phone, please leave your name and number with the answering service.) By giving us 24-hour notice, it allows us to fill the spot with another patient on our waiting list. If we do NOT receive 24-hour notice, you will be charged the amount for the appointment missed. ($50 for active patient, $180 for new patient)

Note: The in-office new patient reschedule or cancellation policy is at least 1 week notice. Payment for all phone consultation appointments (new & active) is due at the time of scheduling and is nonrefundable.

Thank you for your help in making sure that your health is appropriately tended to!

We are excited to have the opportunity to serve you, help you get well, and help keep you well and healthy.

My signature below confirms that I understand and accept the SWS Office Policies.

Patient or Legal Guardian (17 or under): Print_____Signature_____Date_____

SWS Pediatric Form

(Fill out **ONLY** if patient is **5 years old or under)**

Prenatal History:

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

Did you take any medications while pregnant? Y N Why? _____

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

Birthing History:

How long were you pregnant?_____weeks.

Who delivered your baby? (circle) obstetrician, midwife, other: _____

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

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

What was your baby's APGAR score? _____

Infant or Toddler:

What is the number one complaint today?

_____

How long has it been going on?

_____

What makes the situation worse?

_____

What makes the situation better?

_____

***Please circle all that your child is having trouble with:**

Eyes, Ears, Nose, Throat, Heart, Lungs, Breathing, Gassy, Diarrhea, Constipation, Latching, Vomiting, Seizures, Skin, Learning Disorders, Emotional Disorders, Behavioral Disorders, Genetic Disorders, ADD, ADHD

What does your child's diet consist of?

_____

Is there anything else that may be important?

_____

Mother's Information:

How many past pregnancies?_____How many were delivered? _____

Do you take vitamins? Y N What kind? _____

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

*** Continue form if you are breastfeeding***

Do you drink alcohol? Y N What kind? _____How much?_____How often? _____

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

Do you drink coffee?____How many cups per day? _____

Do you consume dairy products?_____How much per day? _____

What food do you eat regularly? _____

_____

My signature confirms that this information is true.

Legal Guardian: Print_____Signature_____Date_____