Welcome To:

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, diet and weight loss, detoxification, cold laser therapy, family and pediatric 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:

We know that our patients have schedules to maintain and we want you to get the most out of your appointment, so **we do our best to run on time** and ask that you do your best to be on time for your appointment as well. If you are running late for an appointment, please call 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 existing patient office visits or phone consults 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):	$ 160.00
Active/Established patient visit (15 min. in-office visit or phone consultation):	$ 50.00
Ion Cleanse Therapy Detox/Footbath, 15-20 min**:**	$ 30.00
Low Level Light Therapy (Red Light), 5-15min**:**	$ 20.00
Infrared Sauna Therapy (plus color therapy), 10-30 min**:**	$ 30.00
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 $9. 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. We accept cash, check, credit cards, and some apps for payment. 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.

Signature____**Date**_________________________

SWS New Patient Evaluation

(Please fill out in pen)

Patient's Name: ____ Date: ___________________________

Moblie phone: _____________________ Home phone: ___________________ Mobile phone provider: _____________

Mailing Address:____

City:___________________________ State:_______ Zip:____________ E-Mail:_________________________________

Gender: M / F Birthday:_____/_____/_____ Age:______ Marital Status: M S D W # of Children_______

Occupation:_________________________________ Height:_______Weight:_______Blood Type: A AB B O - +

Emergency Contact Name: ____Phone #: _____________________________

Who referred you: ____________________________________ Affiliation w/Referral______________________________

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

____

____

2**. GOALS AND EXPECTATIONS FROM COURSE OF TREATMENT:** (What do you want to accomplish that you lack now?)

____

____

3. PRESCRIPTION AND OTC MEDICATIONS ONLY (not vitamins): (List by name, dose, condition, & duration of use)

____

____

4. SUPPLEMENTS (VITAMINS, MINERALS, HERBS, etc): (List name and why you are taking them)

____

____

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

____

____

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

____

____

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

____

____

My signature confirms that this information is true.

Signature: ____Date:_____________________________

SWS Health Overview

(Please circle where answers are given and fill in where answers are not given)

Diet: How many times a day do you eat? ___________________How often do you eat out? ________________________

Liquid Intake: What kind of water do you drink? tap, filtered, spring, reverse osmosis, distilled

Mark what you drink and how many a day (d) or week (w) you drink them:

milk________ coffee_______ tea________ herbal tea________ energy drinks________

soda________ beer________ wine________ liquor_________ protein drinks _________

Digestion: (circle) good, adequate, poor, acid reflux, burping, bloating, burning, pain, abdominal cramping

Other Complaints:____

Bowels: How many bowel movements per day______, per week________

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

Color: tan, brown, black, green **Other:** gas, mucus, blood, smell

Other Complaints: ____

Urination: (circle) every 2-3 hrs, too frequent, sense of urgency, burning, dribbling, bedwetting, wake up to urinate

Other Complaints:____

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

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? __________________

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

What are the main reasons for you stress? ____

How do you reduce stress? ____

Exercise: Do you exercise? Y N What kind of exercise? ____

How often? ______________________Duration of exercise regimen? ____________________________

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?______________________How long have you smoked?________

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 Pregnant? Y N Are you breastfeeding? Y N

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: ____

My signature confirms that this information is true.

Signature: ____Date:_________________________________

SWS Toxicity Questionnaire

Please circle a number in each of the following categories based on your health in the last 90 days.

1 = MILD symptom (occurs rarely or a few times a year)   DON'T CIRCLE IF SYMPTOM NEVER OCCURS OR DOES NOT APPLY

2 = MODERATE symptom (occurs several times a month)

3 = SEVERE symptom (is constant or occurs daily or very frequently)

DIGESTIVE:

Symptom	Rating
Gas, Belch, Bloating	1 2 3
Heartburn, Reflux	1 2 3
Nausea	1 2 3
Straining on bowel movement	1 2 3
Day without bowel movement	1 2 3
Diarrhea or Vomiting	1 2 3
Hemorrhoids	1 2 3
Total for section:	_______

HEART:

Symptom	Rating
Shortness of breath	1 2 3
Tightness in chest	1 2 3
Chest pain	1 2 3
Rapid, Skipped heartbeat	1 2 3
High, Low Blood Pressure	1 2 3
Total for section:	_______

EMOTIONS:

Symptom	Rating
Mood Swings	1 2 3
Anger, Irritability	1 2 3
Anxiety, Fear , Nervous	1 2 3
Panic Attacks	1 2 3
Sense of Despair	1 2 3
Depression	1 2 3
Total for section:	_______

ENERGY:

Symptom	Rating
Restlessness	1 2 3
Hyperactivity	1 2 3
Brain fog	1 2 3
Sluggishness	1 2 3
Fatigue, Tired	1 2 3
Swelling hands & feet	1 2 3
Total for section:	_______

SKIN, HAIR, NAILS:

Symptom	Rating
Flushing	1 2 3
Cold hands/feet	1 2 3
Acne	1 2 3
Dry skin /Oily Skin	1 2 3
Hives, rashes	1 2 3
Eczema, Psoriasis	1 2 3
Hair loss	1 2 3
Cracked heels on feet	1 2 3
Bruising	1 2 3
Brittle nails	1 2 3
Total for section:	_______

HORMONES:

Symptom	Rating
Oily skin, Acne	1 2 3
Pain during period	1 2 3
Breast tenderness	1 2 3
Irregular cycle	1 2 3
Weight gain	1 2 3
Cry easily	1 2 3
Vaginal dryness	1 2 3
Hot flashes	1 2 3
Loss of sex drive	1 2 3
Erectile dysfunction	1 2 3
Balding	1 2 3
Anger easily	1 2 3
Total for section:	_______

HEAD, EYES:

Symptom	Rating
Blurred vision	1 2 3
Pressure	1 2 3
Faintness	1 2 3
Dizziness	1 2 3
Headaches	1 2 3
Total for section:	_______

ALLERGIES:

Symptom	Rating
Watery, Itchy Eyes	1 2 3
Runny Nose	1 2 3
Sneezing	1 2 3
Itchy throat	1 2 3
Itchy skin	1 2 3
Post nasal drip	1 2 3
Total for section:	_______

IMMUNE:

Symptom	Rating
Frequent illness	1 2 3
Sore throat	1 2 3
Fever	1 2 3
Genital itch, Discharge	1 2 3
Yellow nail fungus	1 2 3
Total for section:	_______

URINARY TRACT:

Symptom	Rating
Frequent urination	1 2 3
Burning on urination	1 2 3
Dribbling urine	1 2 3
Leaky bladder	1 2 3
Blood in urine	1 2 3
Kidney stones	1 2 3
Total for section:	_______

EARS, SINUS, NOSE:

Symptom	Rating
Popping ears	1 2 3
Fluid in ears	1 2 3
Ringing ear,Hearing loss	1 2 3
Earaches, infections	1 2 3
Excessive mucous	1 2 3
Stuffy nose	1 2 3
Sinus headache	1 2 3
Nose bleeds	1 2 3
Total for section:	_______

MOUTH, THROAT, TEETH:

Symptom	Rating
Dry mouth	1 2 3
Canker sores	1 2 3
Cold sores	1 2 3
Tooth pain	1 2 3
Bleeding gums	1 2 3
Gagging, clearing throat	1 2 3
Total for section:	_______

LUNGS:

Symptom	Rating
Difficulty breathing	1 2 3
Chest congestion	1 2 3
Coughing	1 2 3
Asthma	1 2 3
Total for section:	_______

JOINTS, MUSCLE, BONE:

Symptom	Rating
Twitching	1 2 3
Cramping	1 2 3
Stiff & achy joints	1 2 3
Pain in joints	1 2 3
Swelling in joints	1 2 3
Muscle ache	1 2 3
Muscle pain	1 2 3
Osteoporosis	1 2 3
Numbness, Burning	1 2 3
Flat feet, Fallen arch	1 2 3
Total for section:	_______

SLEEP:

Symptom	Rating
Can't fall asleep	1 2 3
Wake up often	1 2 3
Nighttime urination	1 2 3
Wake up tired	1 2 3
Bad dreams, Nightmares	1 2 3
Night sweats	1 2 3
Total for section:	_______

Name:_______________________________________ **Date:**_________________________

TOTAL FOR PAGE = ____________

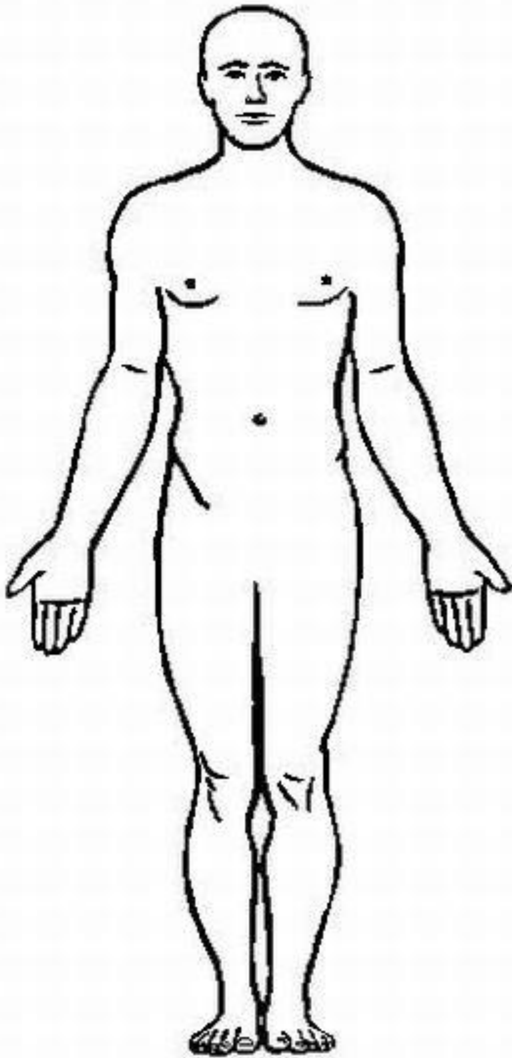
SWS Scar/Trauma Chart

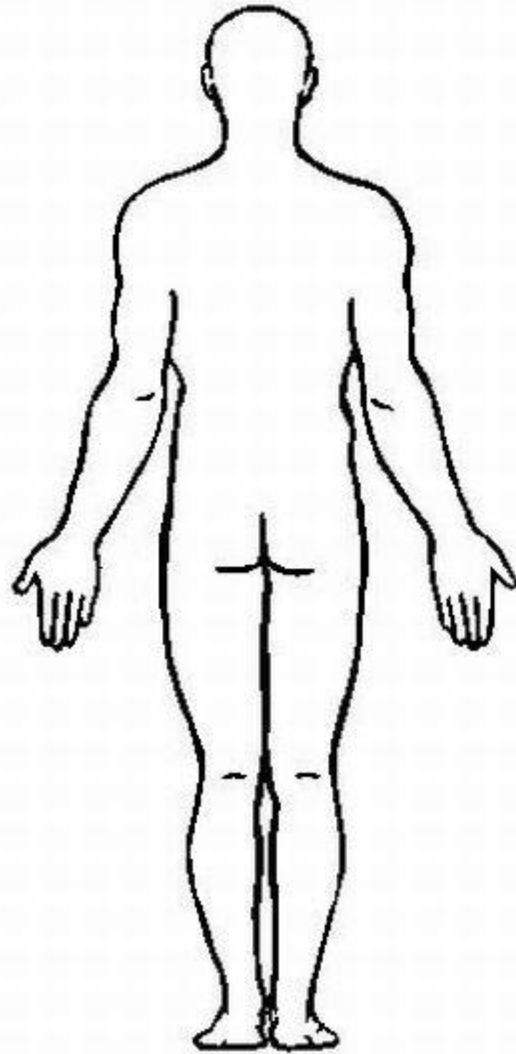
SCARS: Please *draw a line* on the drawing where you have scars, even if they are very old.
These scars may be from cuts, burns, stitches, surgeries, c-sections, episiotomies, vasectomies, punctures (from needles, vaccinations, tattoos, and body piercings), etc.

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.

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 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, EFT (Emotional Freedom Technique), diet and weight loss, detoxification, cold laser therapy, family and pediatric wellness, and providing quality therapy for athletes. He will utilize the aforementioned 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. Our doctor works with you to help you make an informed decision prior to being accepted as a patient.

DIAGNOSIS

Although the doctors at Stanton Wellness Solutions are experts in the analysis of the nutritional, neurological, and energetic aspects of the human body, they will not make a diagnosis outside of their scope of practice. Patients that require additional testing (MRI, XRAY, Blood, etc…) will be informed 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 aforementioned 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!

Signature: ____Date: ____________________

If patient is a minor,
Signature of parent or legal guardian: _____________________________________Date: ____________________

SWS Office Policies

Office policy on supplements:

As you may already know, the supplements that we use are VERY powerful, effective, and functional. About 95% 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 insure 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 <u>90 day</u> 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 insure 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 $160. 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 have to reschedule your in-office existing patient appointment we require 24 hours notice. You may 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 hours notice, it allows us to fill the spot with another patient on our waiting list. If we do NOT receive 24 hours notice you will be charged in the amount of the appointment missed. ($50 for existing patient, $160 for new patient) **Note:** The in-office new patient reschedule or cancellation policy is at least 1 weeks notice. Payment for all phone consultation appointments (new & existing) 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 get you well, and help keep you well and healthy.

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=stressful)? _______________

Birthing History:

How long were you pregnant?_____weeks.

Who delivered your baby? Circle: obstetrician, midwife, other: ____

How was your baby delivered? 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, 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 Signature: ____ Date: __________________________