

CORSELLO COMMUNICATIONS

Corsello Dispensary
119 W. 23rd St., Suite 400
New York, NY 10011

Tel: 212-727-3600
Toll Free: 888-461-0949
Fax: 212-727-3636
www.corsellodispensary.com

Dear Corsello Communications Patron:

Welcome to your first visit with Dr. Corsello.

Enclosed are your intake forms which need to be completed **in full** prior to your visit. On your first visit you will be seeing Dr. Corsello for your Orthomolecular/Nutritional Lifestyle Evaluation.

Services and the purpose of your subsequent visits will be discussed at this time. Depending on the complexity of the case, we might spend upwards of 1 to 1 ½ hours in this process. For this reason, we have a **4 day** cancellation policy for initial visits.

Your initial visit is best utilized when the enclosed paperwork is **fully** completed. We make every attempt to keep our schedule timely, but please understand that, occasionally, unforeseen problems will arise and can disrupt our schedule. Therefore we ask that you keep your available time very flexible for your first visit.

It is very helpful to us if you bring copies of any pertinent information that may be helpful in evaluating your protocol.

The cost of this visit has been lowered from \$500 to \$395 since the service is purely educational and is not reimbursable.

Again, do your best to **fully** complete the enclosed forms, and bring them to your first appointment.

We are looking forward to be of assistance to you in your healing journey.

Sincerely,
Corsello Communications Administration

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INFORMATION FORM

Please PRINT or ask to have this form filled out for you

Name: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M__ F__ Birth date: ___/___/___ SS#: _____ - _____ - _____

Email: _____

GUARANTOR: (Responsible Party If Not You)

Name: (please print) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M__ F__ Birth date: ___/___/___ SS#: _____ - _____ - _____ Relationship to you: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Address: _____

Telephone: (____) _____

EMERGENCY CONTACT:

Name of nearest relative, not living with you: _____

Address: _____

Telephone: (____) _____ Relationship to you: _____

Name of person to call in an emergency? _____

Address: _____

Telephone Number: (____) _____ Relationship to you: _____

REFERRAL SOURCE: Please circle one or more of the codes listed below:

WWC = Corsello website	HFS = Health Food Store	YEP = Yellow Pages
HCP = (name of referring healthcare provider)	BKS = Ageless Woman Book	ACAM = Amer. Colleg. For Advan. Med.
TVI = Television Interview	MISC = Miscellaneous or other	PTH = Former Patient/Client
FAIM = Foundation for Adv. in Innov. Med.		

SYMPTOM QUESTIONNAIRE

NAME: _____

Date: _____

Please CIRCLE all CURRENT symptoms or complaints which apply to you:

SKIN

Hives
Eczema
Pallor
Bruising
Ridging of Nails
Fungal Infections of Nails
Frequent Itching

Rashes
Dermatitis
Lumps
Brittle Nails
Psoriasis
Acne

HEAD

Headaches
Dizziness
Sleepiness after meals
Feeling of fullness in head
Tendency to hair loss

Migraines
Convulsions
Fainting

EYES

Dry eyes
Double vision
Blurred vision
Glaucoma
Date of last eye exam: _____
Surgeries: _____

Watery eyes
Itchy eyes
Discharge
Cataracts

EARS

Frequent earaches
Ear drainage
Hearing loss
Feeling of fullness in ears
Surgeries: _____

Itchy ears
Recurrent infections

NOSE

Runny Nose
Nasal Stuffiness
Postnasal drip
Surgeries: _____

Recurrent sinusitis
Nosebleeds
Nasal polyps

THROAT & MOUTH

Frequent sore throats
Sore tongue
Canker sores
Hoarseness
Voice changes

Gagging
Enlarged nodes
Hoarseness
Gum disease

Itching- roof of mouth
Extensive Dental Work

RESPIRATORY

Difficulty in breathing
Difficulty in breathing - lying down
Shortness of breath
Persistent cough
Sputum Production
Coughing up blood
Bronchial asthma

Wheezing

CARDIOVASCULAR

Palpitations
Chest pain
Rapid heart beat
Date/Results of last EKG: _____
Date/Results of other Cardiac Tests: _____

Irregular rhythm
High blood pressure
Heart murmur

GASTROINTESTINAL

Low appetite
Change in weight: +____/-____ lbs
Yellow jaundice
Diarrhea
Flatulence
Bloating after meals
Colitis
Nausea/Vomiting
Difficulty swallowing
Hepatitis: Type _____
Date of last GI series: _____
Date of last colonoscopy _____
Date of last sigmoidoscopy _____
Date of last sonogram _____
Any other GI exams _____

Excessive appetite
Constipation
Rectal bleeding
Hemorrhoids
Rectal polyps
Abdominal cramps
Vomiting Blood

GENITOURINARY

Urinary frequency

Inability to hold urine
Hesitancy during urination
Burning pain upon urination
Frequent night urination
Blood in urine
Repeated urinary tract infections
Repeated bladder infections
Kidney stones / Kidney infections
Yeast infections
Syphilis / Gonorrhea / Herpes
Trichomonas
Women - Vaginal discharge
Men-Penile discharge / Impotence

MUSCULAR / SKELETAL

Chronic fatigue
Muscle aches / pains / weakness
Joint aches / pains / swelling
Leg cramps when walking
Leg cramps at night
Osteoarthritis
Osteoporosis
Color change in:
Circle appropriate one
fingers OR hands OR feet
Numbness or tingling in:
Circle appropriate one
fingers OR hands OR feet

Rheumatoid arthritis

SLEEP PATTERN

Difficulty falling asleep
Difficulty staying asleep
Frequent awakenings
Night sweats
Nightmares

OTHER MAJOR SYMPTOMS AND/OR COMPLAINTS:

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____

DATE OF LAST PHYSICAL EXAM: _____

Please list your worst symptoms in order of severity/importance:

- 1) _____ Date first experienced: _____
- 2) _____ Date first experienced: _____
- 3) _____ Date first experienced: _____
- 4) _____ Date first experienced: _____

What (if any) care did you seek in the past for the above? _____

What was the outcome of the care you had? _____

Are you currently receiving any treatments for the above conditions? YES NO

If yes, please describe: _____

What experiences have you had with Complementary - Nutritional medicine in the past?

What is your personal goal at our Center? _____

PAST MEDICAL HISTORY: Please indicate approximate date for all those that apply

Abnormal chest x-ray	___	Duodenal Ulcer	___	Hypoglycemia	___
Abnormal EKG	___	Dysentery	___	Impotence	___
Allergies	___	Ear Infections	___	Irritable Bowel Syndrome	___
Alzheimer's	___	Emotional Problems	___	Kidney Disease	___
Anemia	___	Emphysema	___	Melanoma	___
Angina	___	Endometriosis	___	Menopause	___
Anxiety Disorder	___	Epilepsy	___	Migraine Headaches	___
Arthritis	___	Fibroids	___	Multiple Sclerosis	___
Asthma	___	Gall Bladder Disease	___	Osteoporosis	___
Bleeding Disorder	___	Glaucoma	___	Overactive Thyroid	___
Blindness	___	Goiter	___	Panic Attacks	___
Blood clot	___	Gonorrhea	___	Phlebitis	___
Breast Disease	___	Gout	___	Premenstrual Syndrome	___
Broken Bone(s)	___	Hay Fever	___	Prostate Enlargement	___
Cancer	___	Heart Disease	___	Polio	___
Type: _____		Heart Murmur	___	Raynaud's	___
Carpal Tunnel Syndrome	___	Hemorrhoids	___	Skin Cancer	___
Cataract(s)	___	Hepatitis	___	Syphillis	___
Depression	___	Type: _____		Tuberculosis	___
Diabetes	___	Herpes	___	Underactive thyroid	___
Insulin Dependent?	___	Type: _____		OTHER: _____	
Diarrhea (chronic)	___	High Blood Pressure	___	_____	
Diverticulitis	___	High Cholesterol	___	_____	
Diverticulosis	___			_____	

PAST SURGICAL HISTORY: List all previous surgeries and dates _____

CURRENT MEDICATIONS: List all prescribed medications and dosages _____

OVER THE COUNTER MEDICATIONS (non-prescription) _____

CURRENT SUPPLEMENTS & VITAMINS: _____

ASSISTIVE DEVICES: Please circle all that apply: Hearing aid Contacts/Dentures
 Cane Pacemaker Walker Leg Brace Wheelchair Neck Brace Back Brace

IMMUNIZATIONS: Please circle all that you have received: Polio Tetanus Measles
 Rubella (German measles) Mumps Hepatitis B Flu Lyme OTHER: _____

ALLERGIES:

Drug Allergies: Are you aware of any drug (medication) allergies? Yes ____ No ____

If yes, please list all drug allergies: _____

Environmental / Inhaled Allergies: Please circle all that apply: Grass Tree Pollen Mold
Chemicals Perfumes Dyes Animals Insect Bites Dust Fumes Cosmetics
Latex Adhesives OTHER: _____

Food Allergies: Please circle all that apply: Eggs Dairy Wheat Soy Shellfish
OTHER: _____

HEALTH SCREENING EXAMS: Please indicate approximate date of tests you have had

Chest x-ray _____ Sonogram _____ Mammogram _____
EKG _____ Organ: _____ Pap Smear _____
Stress Test _____ CAT Scan _____ Cervical Biopsy _____
Echocardiogram _____ Organ: _____ Pelvic Sonogram _____
Pulmonary Function _____ MRI _____ Digital Rectal Exam _____
Organ: _____ PSA Blood Level _____
Prostate Biopsy _____

Please describe any abnormal findings: _____

OB / GYN HISTORY (for women):

Age at first period: _____ Description of cycles: Regular Irregular Absent
Approximate length of cycle (days between periods): _____ days. Length of period _____ days.
Description of menstrual flow: Heavy Medium Light Date of last menstrual period: _____

How many times have you been pregnant: _____ Number of live births: _____ Number of miscarriages: _____
Number of abortions: _____ Age at first pregnancy: _____

What method of birth control do you use? _____

Have you ever taken the birth control pill? YES NO ; If YES, when and for how long _____

Have you ever been on Hormone Replacement Therapy? YES NO ; If YES, when, for how long, and what type: _____

Have you ever experienced frequent vaginal infections? YES NO ; If YES, please describe: _____

FAMILY HISTORY:

Mother: Living, age _____ Deceased, at what age _____ Ethnicity _____
Major illness: _____ Cause of death _____

Father: Living; age _____ Deceased; at what age _____ Ethnicity _____
Major illness: _____ Cause of death _____

Maternal Family History: Major illnesses: _____

Paternal Family History: Major illnesses: _____

How many siblings do you have? _____ # Brothers _____ # Sisters _____

What number (birth order) are you? _____ Are all siblings living? YES NO

FAMILY HISTORY (Continued):

If LIVING, do any of them have any medical problems? _____

If DECEASED, what was the cause of death? _____

How many children do you have? _____ #Sons _____ # Daughters _____ #Living _____ #Deceased _____

Please give ages of LIVING children and any known medical problems: _____

Please give ages of DECEASED children and cause of death _____

To the best of your knowledge, having any of your blood relatives been diagnosed with the following (please circle and indicate which relative):

Alcoholism _____

Birth Defect _____

Epilepsy _____

Allergies _____

Bleeding Disorder _____

Heart Disease _____

Alzheimer's _____

Cancer _____

High Blood Pressure _____

Anemia _____

Depression _____

Kidney Disease _____

Asthma _____

Diabetes _____

Stroke _____

OTHER: _____

SOCIAL HISTORY:

Birth weight: _____ Place of Birth: _____ Trauma at Birth: _____ Breast Fed: YES NO

Tobacco: YES NO ; Type: _____ How many per day _____ How many years _____ Currently YES NO

Alcohol: YES NO ; Type: _____ Amount Weekly _____ How many years _____ Currently YES NO

Recreational Drugs: YES NO ; Type _____ Frequency _____ How many years _____

Currently YES NO

Marital Status: Single Married Divorced Separated Widow(er)

Residence: Private home Apartment College dorm Condo

Do you live: ALONE or WITH Spouse & Children Spouse Roommate Significant Other

How many years of education completed: High school: _____ College: _____ Graduate School: _____

What is your occupation? _____ How many hours per week do you work: _____

Do you exercise regularly? YES NO ; If YES, how often and type of exercise: _____

What are your hobbies? _____ Do you do volunteer work? _____

Do you sleep well? YES NO ; How many hours per night? _____

How is your energy level? _____ Do you have dental fillings or root canals? _____

Bowel Habits: Normal, how many per day? _____ Diarrhea _____ Tendency to constipation _____

Have you traveled outside of the United States? YES NO ; Any illness related to travel: _____

Do you have any pets in your home (past and present); what kind? _____

NUTRITIONAL HISTORY:

DO YOU eat organic? YES NO SOMETIMES Eat free range meats? YES NO SOMETIMES

Drink filtered/bottled water? YES NO SOMETIMES

Are you a vegetarian? YES NO If YES, what type? _____

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CLIENT CONSENT FORM

PRACTICE PHILOSOPHY:

The focus of our practice is long-term maximum wellness. To this end we are in partnership with you and we require your full cooperation. It is important to remember that we do not use conventional pharmaceutical medications. Our commitment is to provide you with the best innovative, non-toxic and non-invasive care. Protocols ***are aimed at long-term, gentle alleviation of presenting problems and underlying causes.*** Should you encounter any problems with your prescribed program, please call our office regarding the nutrient in question. If the office is unavailable at that time, leave a message and discontinue the troublesome nutrient. Temporarily stopping a nutrient will not pose a health risk to you.

We are not an emergency medicine or crisis intervention center. You are therefore required to maintain the service of a primary care physician (i.e. internist, cardiologist, oncologist, gynecologist, etc.). **If you do not have a physician, we will be delighted to refer you to one.**

Given the likelihood that our protocols will be unfamiliar to you, we suggest that you read Dr. Corsello's book, "The Ageless Woman". You can obtain a copy from our office or by calling **Corsello Dispensary, Inc.** at **212-727-3600**. This book will give you a more thorough understanding of our wellness philosophy and anti-aging protocols.

CANCELLATION POLICY:

Dr. Corsello requires **48 hours cancellation notice**. FIRST TIME VISITS REQUIRE 4 DAY CANCELLATION NOTICE. You will be billed a full service fee for failure to give ample notice. To this end, your credit card number is required when scheduling the initial appointment.

FINANCIAL RESPONSIBILITIES:

Payments for First Initial Appointments are due in advance and follow-up payments are due the day of appointment. We accept checks, cash, MasterCard, Visa, American Express and Discover. Any returned checks will incur an additional processing fee of **\$25.00 each**.

INSURANCE INFORMATION:

I understand that this service is not a medical intervention but solely an EDUCATIONAL plan of action and will generate no insurance form. I furthermore agree to notify Corsello Communications on any change in my health status.

My signature below attests that I have read and understood all of the information contained herein and agree to abide by the above Office Policies set forth by Corsello Communications.

Client Name (please print): _____ Date: _____

Client Signature: _____

Client Signature (if client is a minor): _____