Natural Healthcare Center
Integrated Health & Wellness Programs

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Long Branch, NJ 07740
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www.Naturalhealthcarecenter.com

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New Patient Questionnaire

Please print clearly Today's Date: _____

Name (First)_____ (Last) _____

Address _____**City**_____ **State** _____ **Zip** _____

Social Security # _____ **Gender** ☐ Male ☐ Female **Date of Birth**: _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Spouse Name** _____
Language preference: ☐ English ☐ Spanish ☐ Other:_____ **Ethnicity** (Italian, Polish,etc.):_____

Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Middle-Eastern ☐ Pacific Islander ☐ Native American

Home Phone# _____ **Work/Cell Phone#** (please circle one) _____

Email Address: _____ **Contact Preference** (email, cell etc.) _____

Parent/Guardian Name:_____

Parent/Guardian Phone: _____ **Parent/Guardian email address:** _____

Emergency Contact Name:_____ **Relation:**_____ **Phone:**_____

How were you referred to our office? _____

Your Occupation _____Employer_____

Address _____City_____ State _____ Zip _____

Person who holds primary health insurance, if other than yourself: Name _____
Date of Birth _____ Relation: _____Employer: _____ Insurance Carrier: _____
Person who holds secondary health insurance, if other than yourself: Name _____
Date of Birth _____ Relation: _____Employer: _____ Insurance Carrier: _____

Do you have an HSA/FSA (Health Savings or Flexible Spending Account)? ☐ Yes ☐ No If so, who administers? _____

Primary Care Provider: Do you have a primary care physician? ☐ Yes ☐ No

Doctor's name: _____ Office Address:_____

Phone #: _____ Fax #: _____

Are you seeing any other Medical providers at this time? ? ☐ Yes ☐ No If yes please list Doctors names:

1) Doctor's name: ____ _____ Phone number: _____
2) Doctor's name: _____ _____ Phone number: _____

Would you like to subscribe to dr. proodian's BLOG ? ☐ Yes ☐ No

Physical Medicine **DO YOU HAVE A PACEMAKER: ☐ Yes ☐ No** **ARE YOU PREGNANT ☐ Yes ☐ No**

Your Height: _____ft. _____inches Weight: _____lbs.

Do you smoke? ☐ Yes ☐ No If no, have you quit within the past 24 months (2 years)? ☐ Yes ☐ No

Have you been diagnosed with the following? ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Hypertension

If you are 65 years of age or older, have you received a Pneumonia Vaccination? ☐ Yes ☐ No If yes, when? _____

If you are between the ages of 50-75, have you received appropriate screening for Colorectal Cancer, such as colonoscopy, fecal blood testing or sigmoidoscopy? ☐ Yes ☐ No If yes, when? _____

Name:_____Date_____

Men Please check all that pertain:
☐ Frequency/difficulty with urinating ☐ Difficulty with erection ☐ Loss of libido ☐Prostate enlargement

Women Only: Menstrual Cycle
If you are between the ages of 40-69, have you received a mammogram to screen for Breast Cancer?☐Yes☐No ☐When? _____
Age of first menstruation: _____ Days of Cycle (period to period): # _____Average # of days you bleed: _____
Could you be pregnant? ☐ Yes ☐No Pregnancies: ___ ___ Miscarriages: _____ Children's ages:_____
Type of Contraception: _____
Please describe your pregnancies (full-term, complications, vaginal births…): _____
_____
Check if you have had any of these conditions?
☐PMS ☐Pain Between Cycles ☐Ovarian Cysts☐Irregular periods ☐Endometriosis☐Incontinence ☐D&C☐Menopause
☐Pain During Intercourse ☐Painful periods ☐Yeast Infections ☐Loss of periods ☐Birth control pills ☐Cervical Dysplasia
☐Fibrocystic breasts ☐Frequent Urination ☐Difficulty Urinating

Medications

Date Started	Medication	Dosage
_____	_____	_____
_____	_____	_____

Allergies to Medication

Medicine	Reaction
_____	_____
_____	_____

Hospitalizations (last 5 years)

Date	Reason
_____	_____
_____	_____

Family Medical History:

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Depression ☐ Seizure
☐ Hepatitis ☐ Alcoholism ☐ High Blood Pressure ☐ Thyroid Disease ☐ Other: _____

Nutritional/Acupuncture
Have you ever experienced any significant weight change in the past three months? ☐ Yes ☐No
If yes, please describe change _____
Do you drink alcohol? Yes No How much/when? _____ Do you drink caffeine every morning? ☐Yes ☐No
Do you have food allergies, restrictions, or sensitivities?
_____
_____
Describe your daily energy levels: _____
Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? ☐Yes ☐No
Do you crave certain foods? ☐Yes ☐ No If so, which foods and when _____
Do You crave any of the following?
☐ Sugar ☐ Meat ☐ Fat ☐ Chocolate ☐ Fish ☐ Alcohol
☐ Desserts ☐ Milk ☐ Bread ☐ Fried foods ☐ Salt ☐ Other _____
Do you take any nutritional supplements or vitamins?☐Yes ☐No If so, which ones? (Be specific. Attach sheets if necessary)
_____
_____
How is your dental health? _____ Do Your Gums Bleed? ☐ Yes ☐No
How many bowel movements do you have a day? _____What is the color of your urine? ☐Clear ☐Yellow ☐Dark ☐Cloudy
How many hours do you sleep? _____ Do you sleep throughout the night?☐Yes ☐No
Rank your skin without lotion: ☐Very ☐Dry ☐ Dry ☐Normal ☐Oily ☐Combination
Does your skin bruise easily? ☐Yes ☐ No
Do you do aerobic exercise? ☐Yes ☐No Times/Week _____ Minutes/Session _____
Do you do strengthening exercise?☐Yes ☐No Times/Week _____ Minutes/Session _____

Name:_____Date_____

Have you had or currently have any of the following conditions?

Gastrointestinal

- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Gastritis or Peptic Ulcer Disease
- ☐ GERD (reflux)
- ☐ Celiac Disease
- ☐ Other _____

Cardiovascular

- ☐ Heart Attack
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Other _____

Metabolic/Endocrine

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hypoglycemia
- ☐ Metabolic Syndrome
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Endocrine Problems
- ☐ Infertility
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Frequent Weight Fluctuations
- ☐ Bulimia
- ☐ Anorexia
- ☐ Eating Disorder (non-specific)
- ☐ Other _____

Cancer

- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Other _____

Genital and Urinary Systems

- ☐ Kidney Stones
- ☐ Gout
- ☐ Frequent Yeast Infections
- ☐ Erectile or Sexual Dysfunction

Musculoskeletal/Pain

- ☐ Osteoporosis/Osteopenia
- ☐ Scoliosis
- ☐ Muscle Pain
- ☐ Arm Numb/Tingling
- ☐ Leg Numb/Tingling
- ☐ Neck Pain
- ☐ Middle Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Hand/Wrist Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Joint Pain _____
- ☐ Other _____

Inflammatory/Autoimmune

- ☐ Chronic Fatigue Syndrome
- ☐ Autoimmune Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus SLE
- ☐ Immune Deficiency Disease
- ☐ Poor Immune Function (Frequent Infections)
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Multiple Chemical Sensitivities
- ☐ Latex Allergy
- ☐ Other _____

Respiratory Diseases

- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Other _____

Skin Diseases

- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Melanoma
- ☐ Skin Cancer: Type _____

Neurologic/Mood

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Headaches
- ☐ Migraines
- ☐ ADD/ADHD
- ☐ Memory Problems
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Other Neurological Problems

_____

Preventative Tests and Date of Last Test

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ EBT Heart Scan _____
- ☐ EKG _____
- ☐ Hemoccult Test-stool test for blood

_____

- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

Surgeries

- ☐ Appendectomy _____
- ☐ Hysterectomy _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement Knee/Hip

_____

- ☐ Heart Surgery – Bypass Valve

_____

- ☐ Angioplasty or Stent

_____

- ☐ Pacemaker

_____

- ☐ Other

_____

- ☐ None

The Provider and the Patient, by signing below, affirm that they have read pages one through three of this Agreement, understand its contents, have had all of their questions answered, if any, in this regard, and agree to all of the provisions contained therein.

Signature (☐ self ☐ parent or legal guardian): _____ Date: _____

Provider Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

HIPAA (the Health Insurance Portability & Accountability Act of 1996) was passed to provide rules for how medical care providers might use your Protected Health Information (PHI). It also provides you with certain rights pertaining to that information. As a provider of healthcare services, Natural Healthcare Center (NHC) fully complies with all HIPAA regulations. These regulations require that we provide you with the **HIPAA Notice of Privacy Practices**, which is reproduced below.

Please sign below to acknowledge receipt of this information, and return this form to us at the time of your first visit. Thank you.

I have received the HIPAA Notice of Privacy Practices information from Natural Healthcare Center.

Patient Name: _____ Patient Date of Birth: _____

Signature (☐ self ☐ parent or legal guardian):_____ Date: _____

Parent or Legal Guardian Name (if applicable):_____

* *

This notice describes how medical information about you may be used and disclosed as per HIPAA regulations, and describes your rights regarding access to this information. Please review it carefully.

This Notice of Privacy Practices describes how Natural Healthcare Center may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, acknowledge referrals and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 of HIPAA.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

1. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

2. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

   Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

4. **You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically.)**

5. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

6. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections please ask to speak with our HIPAA Compliance Officer in person or by phone at 732-222-2219.

I have received the HIPAA Notice of Privacy Practices information from Natural Healthcare Center.

Patient Name: _____ Patient Date of Birth: _____

Signature (☐self ☐parent or legal guardian):_____ Date: _____

Parent or Legal Guardian Name (if applicable):_____

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General Informed Consent

Name _____ Date _____

I have sought the clinical and health care services of Natural Healthcare Center – for my personal healthcare or for my child or children who are minors. I understand that this health practice uses some approaches and methods that are known as complementary, alternative, holistic or functional in nature. This may not be covered by my insurance plan or might not be generally accepted by mainstream medicine. The terms complementary, holistic, alternative or functional refer to therapies that may include, but are not limited to, dietary and nutritional supplement advice, yoga, acupuncture, certain dietary/exercise protocols to follow, and certain metabolic tests that are used for informational purposes. Furthermore, the information gained from laboratory and evaluation tests may be interpreted differently from mainstream medical doctors. Approaches for improving general health and nutrition may be based upon the tests/evaluations and philosophies of complementary/functional/holistic/alternative medicine and may or may not be consistent with mainstream medical tests/evaluations and philosophies.

Although prescriptions and over-the-counter medications are used when your physician deems it necessary, foods, vitamins, minerals, enzymes, herbs, and other nutritional approaches may also be chosen as therapy or as adjunctive to medical therapies. It is your responsibility to ensure you inform your medical doctor of all supplements/diets you will be partaking in so that he/she can make sure there are no contraindications to your medicine. We will be glad to discuss and confer with your medical doctor concerning these supplements/diets if he or she wishes to do so and with your approval.

In addition to recommending oral nutritional supplements it is not uncommon that our office might use products/approaches that are not FDA (Food and Drug Administration) approved or evaluated for any condition though are in compliance and permitted to be used pursuant to the federal Dietary Supplement Health and Education Act of 1994.

Our nutrition and weight loss programs are exclusively an office based operation. We are not affiliated with a local hospital. As a result, WE STRONGLY RECOMMEND THAT IN ADDITION TO OUR SERVICE YOU MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFIED TO CARE FOR YOUR INDIVIDUAL HEALTH CONDITIONS. For example, in case of children we advise you seek the advice of a pediatrician; if you have cardiovascular disease consult a cardiologist; and if you have cancer consult with a oncologist; if you have any other degenerative conditions like, Diabetes, Lupus, Lou Gehrig's disease (ALS), Multiple Sclerosis, or any other auto-immune disease seek the advice from the appropriate medical professional. We often refer clients to these and other healthcare professionals when it is deemed necessary. These physicians can provide you and your family with emergency care if hospitalization is needed and ongoing follow-up care. We are happy to communicate and cooperate with your doctor(s) regarding your medical condition(s), options or any other health related issues.

As with many health related services, there are certain potential complications which may arise during the receipt of these services. Those complications range from discomfort through serious health concerns requiring emergency medical care. The probability of these complications are rare but you are being made aware of the full range of possibilities that may occur and assume the risk of proceeding with care by signing this agreement. I have been informed of alternatives to receiving the health care services proposed in my treatment plan, including no treatment at all, and have agreed to move forward with the proposed plan of treatment. All of my questions have been answered concerning the proposed plan of treatment to my satisfaction.

Our office and its employees make no representations, claims, or guarantees regarding the efficacy of our recommendations. The protocols we recommend are based upon a combination of our clinical experience and knowledge of scientific and medical literature. With this information individualized protocols may be offered and applied as either adjunctive or primary protocols for certain conditions. The undersigned is also expressly notified that some personnel providing training and nutritional services are engaged in the process of obtaining certification as a CSCS strength and conditioning specialist and/or CNS-Certified nutrition specialist and/or obtaining a Master's of Science degree in these areas. Such personnel, upon request, will be identified and the status of their certification, education and training provided upon request. If no such request is made, it is assumed that the undersigned consents to the provision of these services by these individuals.

By signing this informed consent you agree to hold harmless Natural Healthcare Center, its owners, employees and contractors from all professional and personal liability, negligence, or other legal liability. You agree to be responsible for all legal costs and fees that may result from action(s) on your part or on the part of your representative(s) against us. If a legal case is brought against us, you agree that we shall be judged by the standard principles of complementary/holistic/alternative/functional medicine and not the standards and principles of consensus of conventional/allopathic medicine. You have the right to have this consent reviewed by your lawyer before accepting any services from our office and we suggest that you exercise this right.

Our office makes available nutritional supplements and other health related products. You are in no way obligated to purchase these products from our office or any other specific location or company. You may freely choose to purchase such
products from any source(s) you wish. Natural Healthcare Center and its employees may profit from the sale of supplements and other products we make available to our clients.

Most insurance plans cover services that they consider medically necessary and/or reasonable and customary. Many of our services such as nutritional consults, exercise programs, dietary protocols and testing (blood/urine/saliva), and/or acupuncture are often not considered by insurance companies to be necessary or a "covered service" and, therefore, reimbursable, based upon their own criteria. Our office does not accept insurance assignment. By signing this form you accept full financial responsibility for all non-covered services; including consultations, acupuncture, massage, blood/saliva/urine and other laboratory tests and procedures.

SIGNATURE ON FILE: I request that the provider make either to me or on my behalf payment of authorized benefits to Natural Healthcare Center for services furnished to me. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services

Your signature verifies and affirms that you have not been told to discontinue treatments with any other medical specialists or other health care providers.

Your signature is being given prior to rendering any services, advice, and/or recommendations whatsoever from Natural Healthcare Center.

It is the responsibility of the client to follow-up with our office for results of all testing and laboratory procedures. It should not be assumed on the part of the client that if they are not contacted by Natural Healthcare Center, or its employees, or if the client does not schedule or keep consultation, that test results are normal (or without abnormalities), and may not require further follow ups or advice. Health/medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

The client is further notified that some tests, or all, may not be covered by their insurance company. The client assumes full responsibility for the costs of non-covered tests. Natural Healthcare Center does not assume responsibility for costs of non-covered tests. Natural Healthcare Center does not assume full responsibility for costs incurred regarding non covered and/or potentially-covered services, including procedures, lab tests (blood, urine, saliva, etc.), acupuncture, massage, and our consultations.

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy therapeutics and diagnostic x-rays as well as acupuncture and/or massage as deemed applicable by my treating doctor. The chiropractic treatment may be performed by the Doctor of Chiropractic and/or other licensed Doctors of Chiropractic working at this clinic or office and/or a licensed Chiropractic Assistant. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as back up for the Doctor of Chiropractic. Acupuncture treatment shall be provided by a New Jersey licensed acupuncturist and massage shall be provided by a massage therapist certified by the New Jersey Board of Massage and Somatic Therapy.

I have had the opportunity to discuss with the Doctor of Chiropractic, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all. I understand, and I am informed that, there are some risks to chiropractic examination and treatment.

Natural Healthcare Center also recommends that you get medical clearance from your MD before you partake in any of the exercise modalities we might suggest. Natural Healthcare Center does not allow their sessions with any client to be recorded on any kind of device, if a client wants to record a session Natural Healthcare Center has to give its consent.

Acupuncture is generally a very safe method of treatment with few, but some possible side effects, including bruising, numbness at the needle site, dizziness or fainting. Bruising is a common side effect of cupping and Gua Sha.

By entering your signature below you are acknowledging that you have read this entire agreement, understand all terms, verbiage (language) and concepts herein, and agree to proceed with care. By signing below you agree that you have weighed the risks and benefits of proceeding with the services and have decided that it is in your best interest to obtain the services proposed. Having been informed of the potential risks, I hereby give my consent or the consent of the minor to which I am legal guardian for said services.

I understand this consent agreement and have executed it freely and willingly.

NATURAL HEALTHCARE CENTER REQUIRES 24 HOURS NOTICE UPON CANCELLING AN APPOINTMENT. IF PRIOR NOTICE IS NOT GIVEN, YOU WILL BE CHARGED THE FEE ASSOCIATED WITH THE SCHEDULED APPOINTMENT. SIGNING THIS AGREEMENT CONFIRMS YOUR CONSENT TO THESE TERMS.

Print Name: _____ Patient Date of Birth: _____

Signature (☐ self ☐ parent or legal guardian):_____ Date: _____

Parent or Legal Guardian Name (if applicable):_____

Witness: _____ Date: _____

Natural/Integrative/Holistic/Functional/Alternative Approaches refers to services, theories, concepts, and recommendations including, but not limited to, dietary suggestions, nutritional supplements, lifestyle suggestions, herbs, stress reduction, exercise, and non-standard tests and or evaluations.