Anita Sadaty, MD
Redefining Health

Thrive!

Health Information Form 1

How The Process Works

1. You will be asked to submit paperwork regarding your health history – please have these completed and submitted to the office so that we can schedule your appointment
2. Once you have completed and submitted the above paperwork, we will schedule the consultation appointment. Here Dr. Sadaty will provide an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice. She will determine which ADVANCED lab testing is required.
3. Once we receive the test results, you will schedule a follow up appointment to discuss your personalized wellness and treatment program.
4. Follow up consultations are scheduled as needed to monitor your clinical progress.

We invite you to contact us at 516.801.1313 or contact@drsadaty.com, if you have any questions. We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

Policies & Procedures

Payment is due at time of consultation

Methods of payment are: Check, Cash, Visa, MasterCard or American Express.

All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments

Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time.

We encourage you to book your appointments in advance.

Lab Tests

The results of your lab test(s) will be sent to Dr. Sadaty 2 to 4 weeks after mailing your specimens to the lab.

Please be sure to contact the company directly prior to mailing your samples to be clear on what your financial responsibility will be and avoid any problems AFTER they have processed your lab tests. Some testing is covered by insurance and some is not depending on the company and your insurance coverage policy.

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Health Information Form 2

Policies & Procedures (continued)

Cancellations

If you are unable to keep your scheduled appointment, you must notify our office a minimum of 48 hours before your scheduled time or you will be charged for the appointment.

Important Notes

» Thrive Medical Wellness Program is not an insurance based program. It is considered a high level, health and wellness optimization program using the Functional Medicine paradigm and cannot be submitted for insurance reimbursement.

» Laboratory fees may or may not be covered by your insurance carrier. This will be discussed with you at the time that you receive your lab kits.

» Blood work ordered by our office is generally a covered medical expense but is dependent on your personal insurance carrier's specific benefits and coverage.

» Please contact the office if you are unclear about any of the policies and procedures outlined in this document

I_____(please print your name) have read and understood the above referenced Policies and Procedures.

Patient's Signature:_____ **Date:**_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ **Date:**_____

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Health Information Form 3

Patient Health Information

Name:			Date:
Address:			
City:	State:	Zip/Postal Code:	Country:
Cell Phone:	Home Phone:	Work Phone:	Fax:
Email:			
Please mark your preference for occasional follow up communication from our office: ◯ Email ◯ Phone			
Age:	Birth date:	Sex: M F	Status: M S W D	Number of Children:

What are your top 3 health concerns you wish to address?

1.

2.

3.

How long has it been since you really felt good?

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Health Information Form 4

Patient Health Information

Please answer all questions frankly, completely and to the best of your ability:

WEIGHT:_____ HEIGHT:_____

1. ARE YOU PRESENTLY TAKING ANY MEDICATIONS, VITAMINS OR SUPPLEMENTS? PLEASE LIST:

_____

_____

2. IN THE PAST HAVE YOU USED, BIRTH CONTROL PILLS OR HORMONE REPLACEMENT?_____

   FOR HOW LONG DID YOU USE THESE? _____

3. IN THE PAST HAVE YOU USED ANTIBIOTICS?_____

   IF SO FOR WHAT CONDITIONS AND HOW LONG?_____

   _____

4. WERE YOU BORN BY: C-SECTION VAGINAL DELIVERY DON'T KNOW
5. WERE YOU BREAST-FED? YES NO DON'T KNOW
6. DID YOU HAVE FREQUENT INFECTIONS AS A CHILD? (CIRCLE ALL THAT APPLY)

   Ear infection Sinus infection Strep Throat Eczema Food Allergies Asthma Tonsillitis
7. DO YOU HAVE MERCURY FILLINGS? YES NO
8. DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? (CIRCLE ALL THAT APPLY)

   • Anemia • Frequent Headaches • Skin condition • Arthritis • Heartburn • Thyroid condition

   • High blood pressure • Unexplained weight change • Chest pains • High cholesterol • PMS

   • Asthma • Endometriosis • Fibroids • Chronic cold/flu symptoms • Hypoglycemia (low sugar)

   • Infertility • Recurrent Miscarriages • Chronic fatigue • Kidney problems • Breast disease

   • Breast Cancer • Fibroadenomas • Breast biopsies • Depression • Liver problems

   • Painful periods • Heavy Periods • Diabetes • Osteoporosis • Menopause • Vaginal dryness

   • Painful intercourse • Low Libido

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Health Information Form 5

Patient Health Information

9. HOW MANY HOURS DO YOU SLEEP A NIGHT ON AVERAGE? _____

   A. WHAT IS YOUR USUAL BEDTIME? _____

   B. HOW WOULD YOU DESCRIBE YOUR SLEEP? GREAT DISRUPTED OKAY

10. DO YOU HAVE ANY FOOD ALLERGIES OR SENSITIVIES? IF SO, WHICH ONES? _____

    _____

11. TOBACCO / ALCOHOL / RECREATIONAL DRUGS

    A. DO YOU SMOKE? Yes No IF YES, HOW MUCH DO YOU SMOKE? _____

    B. DO DRINK ALCOHOL? Yes No IF YES, HOW MUCH AND HOW OFTEN? _____

    C. DO YOU USE RECREATIONAL DRUGS? Yes No IF YES, WHICH DRUGS AND HOW OFTEN?

    _____

12. PLEASE LIST FOODS YOU TEND TO OVEREAT OR CRAVE:

    SWEETS BREADS FATTY FOODS MEAT DAIRY SUGAR CHOCOLATE

13. FAMILY HISTORY OF ANY OF THE FOLLOWING:

    ☐ DIABETES ☐ HEART DISEASE ☐ AUTOIMMUNE DISEASE ☐ OBESITY ☐ CANCER

14. WRITE BRIEFLY ABOUT YOUR WEIGHT GAIN/LOSS HISTORY: _____

    _____

    _____

    A. WHAT DO YOU FEEL TRIGGERED YOUR WEIGHT ISSUE?: (Circle All That Apply)

    HEREDITY STRESS EATING HABITS BOREDOM OTHER: _____

    B. WAS YOUR WEIGHT GAIN/LOSS?: (Circle All That Apply)

    SUDDEN GRADUAL A PROBLEM SINCE CHILDHOOD OTHER: _____

    C. WHAT METHODS HAVE YOU TRIED TO LOSE/GAIN WEIGHT: _____

    _____

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Health Information Form 6

Patient Health Information

15. HOW IS YOUR ENERGY LEVEL ON A SCALE OF 1 TO 10 (1 Low Energy – 10 High Energy) _____

    A. Are there times in the day that you feel best?_____ Worst?_____

    B. Are you happy in your life right now? Why or Why not?_____

    _____

16. WHAT ARE YOUR MAIN SOURCES OF STRESS?_____

    _____

17. HOW DO YOU DEAL WITH YOUR STRESS?_____

    _____

18. PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO:

    A. If I'm feeling down, a snack makes me feel better. YES NO

    B. I sometimes have a hard time going to sleep without a bedtime snack. YES NO

    C. I get tired and/or hungry in the mid-afternoon. YES NO

    D. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. YES NO

    E. Now and then I think I am a secret eater. YES NO

    F. At a restaurant, I almost always eat too much bread before the meal is served. YES NO

    G. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. YES NO

    H. I experience cravings for sugar, breads, pasta and baked goods. YES NO

    I. I feel shaky if I don't eat on time or if I don't snack. YES NO

    J. I often find myself irritable or angry. YES NO

    CHECK OFF ANY OF THE FOLLOWING THAT HAVE APPLIED TO YOU WITHIN THE LAST 30 DAYS:

    ☐ Do you feel nauseous? ☐ Do you have abdominal/intestinal pain? ☐ Do you have bloating?

    ☐ Do you get bloated after meals? ☐ Do you get heartburn? ☐ Do you have diarrhea?

    ☐ Do you have constipation? ☐ Do you travel outside of the U.S.? ☐ Do you belch following meals?

    ☐ Do your bowel movements alternate between constipation and diarrhea? ☐ Do you have gas?

    ☐ Are your stools compact/hard to pass? ☐ Do you have gurgles in your stomach?

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Health Information Form 7

Patient Health Information

19. SURGERIES STARTING WITH MOST RECENT List Year and Type of Surgery and ***WHY***:_____

_____

_____

_____

_____

_____

_____

20. HOSPITALIZATIONS? If so, please explain when and why:_____

_____

_____

_____

_____

_____

21. PLEASE LIST ANY COUNTRIES OUTSIDE OF THE UNITED STATES IN WHICH YOU HAVE TRAVELED OR LIVED:

Child/Teenager:_____

Young Adult:_____

Currently:_____

_____

_____

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