

**Dan Cardellichio DC, MS**  
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Westfield, NJ 07090  
908-233-4200  
Doctor of Chiropractic  
Master of Science in Nutrition

## **Thank you for taking the first step toward better nutrition & healthy living!**

**Please be sure to arrive with all of your forms completed.** Here are the few things you will need to know/do in preparation for your appointment:

- Bring a list of any medications or supplements that you are currently taking, including the dosage.
- Drink plenty of water both the day before and the day of your visit.
- Bring with you a recent copy of any blood work or other medical testing
- Dr. Cardellichio advises all clients **NOT** to work out that day prior to their appointment
- Purchase the book "The Diet Cure" by Julia Ross and complete the "Quick Symptom Questionnaire" in the book prior to the first chapter.

Remember that our address is 134 S. Euclid Avenue, Westfield, NJ – 908-233-4200

**\*\*\*Please allow yourself enough time to arrive at your scheduled appointment time.\*\*\***

The paperwork should include:

- Client contact form
- Scope of care
- Missed appointment policy
- Insulin Sensitivity Form
- Vitality form
- Healthy Living Questionnaire
- Metabolic Type Questionnaire
- Quick Symptom Questionnaire (this is the one found in The Diet Cure)

**PLEASE DOUBLE CHECK TO ENSURE THAT YOU HAVE RECEIVED ALL FORMS.**

We look forward to seeing you. Also, we do require that we speak to you in person to confirm your appointment. If we leave a message for you, please call back to confirm. Thanks! Feel free to contact us with any questions.



Dan Cardellichio DC, MS

Agreement Concerning Scope of Care

I hereby attest to the following:

- I am here, on this and any additional visit, solely on my own behalf and not as an agent for any governmental agency on a mission of entrapment or investigation.
- I clearly understand that Dr. Cardellichio is not a medical doctor or practitioner and I am not here for medical diagnostic treatment procedures.
- The services performed by Dr. Cardellichio are at all times restricted to consultation on the subject of lifestyle and nutritional matters, intended for augmenting general health and do not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of disease.
- This agreement is being signed voluntarily and not under duress of any kind.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

*Dan Cardellichio DC, MS*

## Missed Appointment Policy

### **Effective Immediately**

- We require a 24-hour notice to reschedule or cancel an appointment.
- In the absence of notice, clients will be charged for the full amount of the office visit.
- Barring an absolute emergency, an appointment fee will be assessed.

I am in agreement with the terms of the Missed Appointment Policy outlined above.

Signed and Date:

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# Determining Your Sensitivity to Insulinogenic Foods and Eating Habits (Metabolic Typing)

Name: \_\_\_\_\_

Please Fill in this questionnaire to determine your relative sensitivity to insulinogenic foods and eating habits. Please answer YES or NO to every question.

- (5) \_\_\_\_\_ I have a tendency to higher blood pressure.
- (5) \_\_\_\_\_ I gain weight easily, especially around my waist and have difficulty losing it.
- (5) \_\_\_\_\_ I often experience mental confusion.
- (5) \_\_\_\_\_ I often experience fatigue and generalized weakness.
- (10) \_\_\_\_\_ I have diabetic tendencies.
- (4) \_\_\_\_\_ I get tired and/or hungry in the mid-afternoon.
- (5) \_\_\_\_\_ About an hour or two after eating a full meal that includes dessert, I want more of the dessert.
- (3) \_\_\_\_\_ It is harder for me to control my eating for the rest of the day if I have breakfast containing carbohydrates, than it would be if I only had coffee or nothing at all.
- (4) \_\_\_\_\_ When I want to lose weight, I find it easier not to eat for most of the day than to try to eat several small diet meals.
- (3) \_\_\_\_\_ Once I start eating sweets, starches, or snack foods, I often have a difficult time stopping.
- (3) \_\_\_\_\_ I rather have an ordinary meal that includes dessert than a gourmet meal that did not include dessert.
- (5) \_\_\_\_\_ After finishing a full meal, I sometimes feel as if I could go back and eat the whole meal again.
- (3) \_\_\_\_\_ A meal of only meat and vegetables leaves me feeling unsatisfied.
- (3) \_\_\_\_\_ If I am feeling down, a snack of cake or cookies makes me feel better.
- (3) \_\_\_\_\_ If potatoes, bread, pasta, or dessert are on the table, I will often skip eating vegetables or salad.
- (4) \_\_\_\_\_ I get sleepy, almost "drugged" feeling after eating a large meal containing bread or pasta or potatoes and dessert, whereas I feel more energetic after a meal of only meat or fish and salad.
- (3) \_\_\_\_\_ I have a hard time going to sleep at times without a bed time snack.
- (5) \_\_\_\_\_ I get irritable if I miss a meal or mealtime is delayed.
- (2) \_\_\_\_\_ At a restaurant, I almost always eat too much bread, even before the meal is served.

**Total** \_\_\_\_\_

(1-20) Carbohydrate Type

(21- 45) Mixed Type

(46-80) Protein Type

Dan Cardellicchio DC, MS

VITALITY SURVEY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

HOW OFTEN DO YOU: \_\_\_\_\_

	Score
1. Experience indifference (don't care)? _____	
2. Lose your sense of humor/take life too seriously? _____	
3. Experience doubt or indecision? _____	
4. Experience worry and anxiety? _____	
5. Feel over cautious or pessimistic? _____	
6. Lack self confidence or feel low self esteem? _____	
7. Experience stress or feel nervous or tense? _____	
8. Feel irritable or oversensitive? _____	
9. Experience difficulty concentrating and loss of clear thought? _____	
10. Experience inadequate energy (fatigue)? _____	
11. Have coffee, tea, tobacco, sugar or other stimulants as a pick up? _____	
12. Experience nervous indigestion? _____	
13. Experience loss of sex drive? _____	
14. Experience difficulty sleeping? _____	
15. Experience difficulty getting up in the morning? _____	
16. Feel run down? _____	
17. Feel depressed? _____	
18. Feel like crying for no reason? _____	
19. Find it difficult to sit quietly (without fidgeting, talking, reading, watching TV, etc.)? _____	
20. Find it difficult to express your feelings? _____	
21. Experience rapid heart beat or panic? _____	
22. Feel moody? _____	
23. Feel suicidal or wonder whether life is worth living? _____	
24. Have anxiety about not having enough money? _____	
25. Fear ill health? _____	
26. Fear criticism? _____	
27. Fear loss of love? _____	
28. Fear old age or death? _____	
29. Feel "something is the matter with me" but don't know what? _____	
30. Think you might be going crazy (losing it)? _____	

SCORING:

TOTAL \_\_\_\_\_

- 0 - 30 POINTS = Powerful Nerve Force - HIGH VITALITY
- 31-40 POINTS = Strong Nerve Force - GOOD VITALITY
- 41-50 POINTS = Moderate Nerve Force - AVERAGE VITALITY
- 51-60 POINTS = Low Nerve Force - LOW VITALITY
- 61-70 POINTS = Nervous Fatigue - NERVOUS FATIGUE
- 71-80 POINTS = Nervous Depletion - NERVOUS EXHAUSTION
- 81+ POINTS = Serious Nervous Exhaustion - SEVERE BURNOUT

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

Please list the 5 major health concerns in your order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

<b>Category I</b>			
Feeling that bowels do not empty completely . . . . .	0	1	2 3
Lower abdominal pain relief by passing stool or gas . . . . .	0	1	2 3
Alternating constipation and diarrhea . . . . .	0	1	2 3
Diarrhea . . . . .	0	1	2 3
Constipation . . . . .	0	1	2 3
Hard, dry, or small stool . . . . .	0	1	2 3
Coated tongue of "fuzzy" debris on tongue . . . . .	0	1	2 3
Pass large amount of foul smelling gas . . . . .	0	1	2 3
More than 3 bowel movements daily . . . . .	0	1	2 3
Use laxatives frequently . . . . .	0	1	2 3
<b>Category II</b>			
Excessive belching, burping, or bloating . . . . .	0	1	2 3
Gas immediately following a meal . . . . .	0	1	2 3
Offensive breath . . . . .	0	1	2 3
Difficult bowel movements . . . . .	0	1	2 3
Sense of fullness during and after meals . . . . .	0	1	2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools . . . . .	0	1	2 3
<b>Category III</b>			
Stomach pain, burning, or aching 1-4 hours after eating . . . . .	0	1	2 3
Use antacids . . . . .	0	1	2 3
Feel hungry an hour or two after eating . . . . .	0	1	2 3
Heartburn when lying down or bending forward . . . . .	0	1	2 3
Temporary relief from antacids, food, milk, carbonated beverages . . . . .	0	1	2 3
Digestive problems subside with rest and relaxation . . . . .	0	1	2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine . . . . .	0	1	2 3
<b>Category IV</b>			
Roughage and fiber cause constipation . . . . .	0	1	2 3
Indigestion and fullness lasts 2-4 hours after eating . . . . .	0	1	2 3
Pain, tenderness, soreness on left side under rib cage . . . . .	0	1	2 3
Excessive passage of gas . . . . .	0	1	2 3
Nausea and/or vomiting . . . . .	0	1	2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed . . . . .	0	1	2 3
Frequent urination . . . . .	0	1	2 3
Increased thirst and appetite . . . . .	0	1	2 3
Difficulty losing weight . . . . .	0	1	2 3

<b>Category V</b>			
Greasy or high-fat foods cause distress . . . . .	0	1	2 3
Lower bowel gas and or bloating several hours after eating . . . . .	0	1	2 3
Bitter metallic taste in mouth, especially in the morning . . . . .	0	1	2 3
Unexplained itchy skin . . . . .	0	1	2 3
Yellowish cast to eyes . . . . .	0	1	2 3
Stool color alternates from clay colored to normal brown . . . . .	0	1	2 3
Reddened skin, especially palms . . . . .	0	1	2 3
Dry or flaky skin and/or hair . . . . .	0	1	2 3
History of gallbladder attacks or stones . . . . .	0	1	2 3
Have you had your gallbladder removed . . . . .	Yes	No	
<b>Category VI</b>			
Crave sweets during the day . . . . .	0	1	2 3
Irritable if meals are missed . . . . .	0	1	2 3
Depend on coffee to keep yourself going or started . . . . .	0	1	2 3
Get lightheaded if meals are missed . . . . .	0	1	2 3
Eating relieves fatigue . . . . .	0	1	2 3
Feel shaky, jittery, or have tremors . . . . .	0	1	2 3
Agitated, easily upset, nervous . . . . .	0	1	2 3
Poor memory/forgetful . . . . .	0	1	2 3
Blurred vision . . . . .	0	1	2 3
<b>Category VII</b>			
Fatigue after meals . . . . .	0	1	2 3
Crave sweets during the day . . . . .	0	1	2 3
Eating sweets does not relieve cravings for sugar . . . . .	0	1	2 3
Must have sweets after meals . . . . .	0	1	2 3
Waist girth is equal or larger than hip girth . . . . .	0	1	2 3
Frequent urination . . . . .	0	1	2 3
Increased thirst and appetite . . . . .	0	1	2 3
Difficulty losing weight . . . . .	0	1	2 3
<b>Category VIII</b>			
Cannot stay asleep . . . . .	0	1	2 3
Crave salt . . . . .	0	1	2 3
Slow starter in the morning . . . . .	0	1	2 3
Afternoon fatigue . . . . .	0	1	2 3
Dizziness when standing up quickly . . . . .	0	1	2 3
Afternoon headaches . . . . .	0	1	2 3
Headaches with exertion or stress . . . . .	0	1	2 3
Weak nails . . . . .	0	1	2 3

<b>Category IX</b>				
Cannot fall asleep .....	0	1	2	3
Perspire easily .....	0	1	2	3
Under high amounts of stress .....	0	1	2	3
Weight gain when under stress .....	0	1	2	3
Wake up tired even after 6 or more hours of sleep ...	0	1	2	3
Excessive perspiration or perspiration with little or no activity .....	0	1	2	3
<b>Category X</b>				
Tired, sluggish .....	0	1	2	3
Feel cold - hands, feet, all over .....	0	1	2	3
Require excessive amounts of sleep to function properly .....	0	1	2	3
Increase in weight gain even with low-calorie diet ...	0	1	2	3
Gain weight easily .....	0	1	2	3
Difficult, infrequent bowel movements .....	0	1	2	3
Depression, lack of motivation .....	0	1	2	3
Morning headaches that wear off as the day progresses .....	0	1	2	3
Outer third of eyebrow thins .....	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair .....	0	1	2	3
Dryness of skin and/or scalp .....	0	1	2	3
Mental sluggishness .....	0	1	2	3
<b>Category XI</b>				
Heart palpitations .....	0	1	2	3
Inward trembling .....	0	1	2	3
Increased pulse even at rest .....	0	1	2	3
Nervous and emotional .....	0	1	2	3
Insomnia .....	0	1	2	3
Night sweats .....	0	1	2	3
Difficulty gaining weight .....	0	1	2	3
<b>Category XII</b>				
Diminished sex drive .....	0	1	2	3
Menstrual disorders or lack of menstruation .....	0	1	2	3
Increased ability to eat sugars without symptoms ...	0	1	2	3
<b>Category XIII</b>				
Increased sex drive .....	0	1	2	3
Tolerance to sugars reduced .....	0	1	2	3
"Splitting" type headaches .....	0	1	2	3

<b>Category XIV (Males only)</b>				
Urination difficulty or dribbling .....	0	1	2	3
Frequent urination .....	0	1	2	3
Pain inside of legs or heels .....	0	1	2	3
Feeling of incomplete bowel evacuation .....	0	1	2	3
Leg nervousness at night .....	0	1	2	3
<b>Category XV (Males only)</b>				
Decrease in libido .....	0	1	2	3
Decrease in spontaneous morning erections .....	0	1	2	3
Decrease in fullness of erections .....	0	1	2	3
Difficulty in maintaining morning erections .....	0	1	2	3
Spells of mental fatigue .....	0	1	2	3
Inability to concentrate .....	0	1	2	3
Episodes of depression .....	0	1	2	3
Muscle soreness .....	0	1	2	3
Decrease in physical stamina .....	0	1	2	3
Unexplained weight gain .....	0	1	2	3
Increase in fat distribution around chest and hips ...	0	1	2	3
Sweating attacks .....	0	1	2	3
More emotional than in the past .....	0	1	2	3
<b>Category XVI (Menstruating Females Only)</b>				
Are you perimenopausal .....	Yes	No		
Alternating menstrual cycle lengths .....	Yes	No		
Extended menstrual cycle, greater than 32 days .....	Yes	No		
Shortened menses, less than every 24 days .....	Yes	No		
Pain and cramping during periods .....	0	1	2	3
Scanty blood flow .....	0	1	2	3
Heavy blood flow .....	0	1	2	3
Breast pain and swelling during menses .....	0	1	2	3
Pelvic pain during menses .....	0	1	2	3
Irritable and depressed during menses .....	0	1	2	3
Acne breakouts .....	0	1	2	3
Facial hair growth .....	0	1	2	3
Hair loss/thinning .....	0	1	2	3
<b>Category XVII (Menopausal Females Only)</b>				
How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes .....	0	1	2	3
Mental fogginess .....	0	1	2	3
Disinterest in sex .....	0	1	2	3
Mood swings .....	0	1	2	3
Depression .....	0	1	2	3
Painful intercourse .....	0	1	2	3
Shrinking breasts .....	0	1	2	3
Facial hair growth .....	0	1	2	3
Acne .....	0	1	2	3
Increased vaginal pain, dryness or itching .....	0	1	2	3

How many alcoholic beverages do you consume per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times a week do you eat fish? \_\_\_\_\_

List the three worst foods you eat during the average week: \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how many times a day: \_\_\_\_\_

Rate your stress levels on a scale of 1-10 during the average week: \_\_\_\_\_

Please list any medications you currently take and for what conditions: \_\_\_\_\_

Please list any natural supplements you currently take and for what conditions: \_\_\_\_\_



## Female Quick Symptom Questionnaire

From *The Diet Cure* by Julia Ross

Here is a mini-questionnaire that will help us determine any imbalances in your body chemistry, if any.

*Circle the number next to any symptom that applies to you and follow the directions at the end of each section to calculate your score*

### **1. Is depleted brain chemistry the problem?**

- 4 Sensitivity to emotional (or physical) pain; cry easily
- 4 Eat as a reward for pleasure, comfort, or numbness
- 4 Worry, anxiety, phobia, or panic
- 4 Difficulty getting to sleep or staying asleep
- 3 Difficulty with focus, attention deficits
- 2 Low energy, drive, and arousal
- 4 Obsessive thinking or behavior
- 2 Inability to relax after tension, stress
- 3 Depression, negativity
- 4 Low self-esteem, lack of confidence
- 4 More mood and eating problems in winter or at the end of the day
- 3 Irritability, anger
- 4 Use alcohol or drugs to improve mood

**Total Score** \_\_\_\_\_ If your score is over **10**, you may have depleted brain chemistry.

### **2. Are you suffering because of low-calorie dieting?**

- 4 Increased cravings for and focus on food; overeating
- 4 Regain weight after dieting, more than was lost
- 3 Increased moodiness, irritability, anxiety, or depression
- 3 Less energy and endurance
- 3 Usually eat less than 2,100 calories a day
- 3 Skip meals, especially breakfast
- 3 Eat mostly low-fat carbohydrates (bagels, pasta, frozen yogurt, and others)
- 2 Constantly think about weight
- 2 Use aspartame (NutraSweet) daily
- 2 Take Prozac or similar serotonin-boosting drugs
- 2 Have become vegetarian
- 3 Have decreased self-esteem
- 4 Have become bulimic or anorectic

**Total Score** \_\_\_\_\_ If your score is over **12**, you may be experiencing weight gain and fatigue due to low-calorie dieting.

### **3. Are you struggling with blood sugar instability and stress?**

- 4 Crave a lift from sweets or alcohol, but later experience a drop in energy and mood after ingesting them
- 3 Dizzy, weak, or headachy, especially if meals are delayed
- 4 Family history of diabetes, hypoglycemia, or alcoholism
- 3 Nervous, jittery, irritable on and off throughout the day; calmer after meals
- 3 Crying spells
- 3 Mental confusion, decreased memory
- 3 Hear palpitations, rapid pulse
- 4 Frequent thirst
- 3 Night sweats (not menopausal)
- 5 Sores on legs that take a long time to heal
- 4 Crave salty foods
- 4 Often feel stresses, overwhelmed
- 4 Dark circles under eyes
- 4 More awake at night

**Total Score** \_\_\_\_\_ If your score is over **12**, you may have adrenal fatigue and/or hypoglycemia.

### **4. Do you have unrecognized low thyroid function?**

- 4 Low energy
- 4 Easily chilled (especially hands and feet)
- 4 Other family members have thyroid problems
- 4 Can gain weight without overeating; hard to lose excess weight
- 3 Have to force yourself to do even moderate exercise
- 4 Find it hard to get going in the morning
- 3 High cholesterol
- 3 Low blood pressure
- 4 Weight gain began near the start of menses, a pregnancy, or menopause
- 3 Chronic headaches
- 3 Use food, caffeine, tobacco, and/or other stimulants to get going

**Total Score** \_\_\_\_\_ If your score is over **15**, your thyroid may be suboptimal.

### **5. Are you addicted to foods you are actually allergic to?**

- 3 Crave milk, ice cream, yogurt, cheese, or doughy foods (pasta, bread, cookies, among others) and eat them frequently
- 3 Experience bloating after meals
- 4 Gas, frequent belching
- 3 Digestive discomfort of any kind
- 3 Chronic constipation and/or diarrhea
- 4 Respiratory problems, such as asthma, postnasal drip, congestion
- 3 Low energy or drowsiness, especially after meals
- 4 Allergic to milk products or other common foods
- 3 Under eat or often prefer beverages to solid food
- 3 Avoid food or throw up food because bloating after eating meals makes you feel fat or tired
- 4 Can't gain weight
- 3 Hyperactivity or manic-depression
- 3 Severe headaches, migraines
- 4 Food allergies in family

**Total Score** \_\_\_\_\_ If your score is over 12, food sensitivities are most likely.

### **6. Are your hormones unbalanced?**

- 4 Premenstrual mood swings
- 4 Premenstrual or menopausal food cravings
- 4 Irregular periods
- 3 Experienced a miscarriage, an abortion, or infertility
- 4 Use(d) birth control pills or other hormone medication
- 3 Uncomfortable period cramps, lengthy or heavy bleeding, or sore breasts
- 4 Peri- or postmenopausal discomfort (e.g., hot flashes, sweats, insomnia, or mental dullness)
- 3 Skin eruptions with period

**Total Score** \_\_\_\_\_ If your score is over 6, hormone imbalance may be present.

### **7. Do you have yeast overgrowth triggered by anti-biotics, cortisone, or birth control pills?**

- 4 Often bloated, abdominal distension
- 3 Foggy-headed
- 2 Depressed
- 4 Yeast infections
- 4 Used antibiotics extensively (at any time in life)
- 4 Used cortisone or birth control pills for more than one year
- 4 Have chronic fungus on nails or skin or athlete's foot
- 3 Recurring sinus or ear infections as an adult or child
- 3 Achy muscles and joints
- 3 Chronically fatigued
- 4 Rashes
- 3 Stool unusual in color, shape, or consistency

**Total Score** \_\_\_\_\_ If your score is over 13, yeast overgrowth is possible.

### **8. Do you have fatty acid deficiency?**

- 4 Crave chips, cheese, and other rich foods more than, or in addition to, sweets and starches
- 4 Have ancestry that includes Irish, Scottish, Welsh, Scandinavian, or coastal Native American
- 3 Alcoholism and depression in the family history
- 3 High cholesterol, low HDL levels
- 4 Feel heavy, uncomfortable, and "clogged up" after eating fatty foods
- 4 History of hepatitis or other liver or gallbladder problems
- 4 Light-colored stool
- 4 Pain on right side under your rib cage

**Total Score** \_\_\_\_\_ If your score is over 12, you may need an oil change.