HEALTH RESOURCE CENTER

Gary Sconyers, ND
Bryan Sconyers, LMT, PHS

Health History QUESTIONNAIRE

FULL NAME _____ EMAIL _____

HOME PHONE _____ CELL PHONE _____

STREET ADDRESS _____ CITY, STATE, ZIP _____

OCCUPATION _____ MARITAL STATUS _____

BIRTHDATE _____ AGE _____ HEIGHT _____ WEIGHT _____ BIRTHPLACE _____

FAMILY PHYSICIAN _____ REFERRED BY _____

EMERGENCY CONTACT _____ PHONE _____

Have you been tested positive for Covid? If so, when? _____

Have you had the Covid vaccine? If so, when? _____

Have any members in your household had the Covid vaccine? If so, when?_____

PRIMARY CONCERN(S)

_____

_____

_____

_____

_____

HOW LONG HAVE YOU EXPERIENCED THESE SYMPTOMS? CAN YOU PINPOINT THE DATE OF ONSET?

_____

_____

HAVE YOU BEEN GIVE AN DIAGNOSIS FOR THIS PROBLEM? IF SO, WHAT?

_____

WHAT KIND OF TREATMENTS HAVE YOU RECEIVED FOR THESE SYMPTOMS, IF ANY?

_____

_____

WHAT, IF ANYTHING SEEMS TO IMPROVE OR HELP YOUR SYMPTOMS?

_____

MEDICATIONS CURRENTLY TAKING (IF NOT ENOUGH SPACE, WRITE ON BACK OR ON ADDITIONAL SHEET)

_____

_____

_____

SUPPLEMENTS, HERBS, TINCTURES CURRENTLY TAKING (IF NOT ENOUGH SPACE, WRITE ON BACK OR ON ADDITIONAL SHEET)

_____

_____

_____

_____

LIST ALL SURGERIES/ORGAN REMOVALS_____

_____

_____

ALLERGIES (DRUGS, CHEMICALS, FOODS, ETC.)

_____

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY):

	Self	Siblings	Mom/Maternal Grandparents	Dad/Paternal Grandparents
Seizures				
Heart Disease				
High Blood Pressure				
Lung Disease				
Cancer				
Diabetes				
Liver Disease				
STD				
Alzheimer's/Memory				
Parkinson's/ALS				
Seizures				
Mental Illness				
Autism				

Other _____

BIRTH HISTORY (VAGINAL, C-SECTION, PROLONGED DELIVERY, FORCEPS DELIVERY, ETC.)

_____

DO YOU KNOW OF ANY MAJOR TRAUMAS WHILE YOUR MOM WAS PREGNANT WITH YOU (MOVE, DIVORCE, ILLNESS, CHEMICAL/PHYSICAL ABUSE, ACCIDENTS, ETC)?_____

DID YOUR MOM HAVE COVID DURING PREGNANCY?_____

DID YOUR MOM GET THE FLU OR COVID VACCINE DURING OR JUST BEFORE PREGNANCY? _____

ARE YOU FULLY VACCINATED, PARTIALLY VACCINATED OR NOT AT ALL?_____

DID YOU GET THE HPV VACCINE?_____ IF SO, HOW MANY? 1, 2 OR ALL 3? _____

DO YOU DO ANNUAL FLU, SHINGLES OR PNEUMONIA VACCINES? IF SO, WHICH?_____

LIST ANY SIGNIFICANT PHYSICAL TRAUMAS (AUTO ACCIDENTS, FALLS, CONCUSSIONS, SPORTS INJURIES, ETC.)

_____

LIST ANY ONGOING OR ONE TIME EMOTIONAL TRAUMAS (VERBAL, PHYSICAL OR SEXUAL ABUSE, DIVORCE, DEATH OF CLOSE RELATIVE/FRIEND, MILITARY/WARTIME EXPERIENCE, ETC)

_____

LIST ANY RECENT HOUSEHOLD/WORKPLACE/ENVIRONMENTAL TRAUMA (FIRE, TORNADO, FLOOD, PIPES BURST, ETC)

_____

DO YOU WORK WITH CHEMICALS AT YOUR JOB/HOUSE/RANCH?_____

OCCUPATIONAL STRESS (CHEMICALS, NIGHT SHIFT, PHYSICAL, PSYCHOLOGICAL, JOB CHANGE, ETC.)

_____

DO YOU TRAVEL OUTSIDE THE COUNTRY/DO MISSION WORK? IF SO WHERE TO?_____

_____

HEALTH HABITS:

DO YOU HAVE A REGULAR EXERCISE PROGRAM? PLEASE DESCRIBE.

_____

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN ON A RESTRICTED/SPECIALIZED DIET? PLEASE DESCRIBE.

_____

DO YOU DRINK SPORTS DRINKS/ENERGY DRINKS/CAFFEINATED BEVERAGES? IF SO, WHICH AND HOW MUCH

OR MANY PER DAY OR WEEK?_____

DO YOU EAT/DRINK DAIRY PRODUCTS DAILY?_____

HOW OFTEN DO YOU EAT/DRINK SUGARY FOODS/BEVERAGES?_____

DO YOU CURRENTLY DRINK ALCOHOL? _____ IF YES, HOW MANY DRINKS PER DAY OR PER WEEK DO

YOU DRINK OF EACH WINE_____/DAY OR WEEK BEER_____/DAY OR WEEK LIQUOR_____/DAY OR WEEK

DO YOU SMOKE? IF SO, WHAT AGE DID YOU START? _____ HOW MUCH PER DAY?_____

IF YOU USED TO SMOKE, HOW MANY YEARS HAS IT BEEN SINCE YOU QUIT SMOKING?_____

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DO YOU CURRENTLY USE OR HAVE YOU EVER USED RECREATIONAL/ILLICIT DRUGS? _____

IF YES, WHICH TYPE AND HOW OFTEN? _____

WHAT TIME TO YOU GO TO BED AT NIGHT?_____ DO YOU GET 7-8 GOOD HOURS OF SLEEP?_____

WHERE IS YOUR PHONE WHEN YOU SLEEP AT NIGHT?_____

DO YOU TURN YOUR WIFI OFF AT NIGHT OR PHONE ON AIRPLANE MODE?_____

DO YOU PLAY VIDEO GAMES PRIOR TO BED OR LATE DURING THE NIGHT?_____

WHERE IS YOUR ELECTRIC METER IN RELATIONSHIP TO YOUR BED/BEDROOM? _____

DOES YOUR HOME HAVE A SMART METER?_____

WHICH OF THE FOLLOWING SMART OR WIFI APPLIANCES DO YOU HAVE/USE REGULARLY?

_____ ALEXA/GOOGLE HOME _____RING/DOOR MONITOR _____BABY MONITOR

_____ OVEN/FRIDGE _____ SECURITY _____ OTHER

DO YOU WEAR A SMART WATCH/RING?_____ DO YOU USE AIRPODS?_____

DO YOU HAVE A FILTER (SYSTEM) ON YOUR WATER FAUCET? IF SO WHAT TYPE? _____

DO YOU USE PESTICIDES ON YOUR LAWN?_____

MOLD HISTORY

HAVE YOU EVER HAD ANY (KNOWN)LEAKS OR WATER DAMAGE IN YOUR HOUSE? _____

DOES YOUR HOUSE SMELL MUSTY?_____ HOW OLD IS YOUR HOME? _____

IS YOUR FOUNDATION SLAB OR PIER AND BEAM?_____ HAS YOUR HOME BEEN TESTED FOR MOLD? IF SO, HAS

YOUR HOME BEEN TREATED/REMEDIATED FOR MOLD – LIST WHAT TYPE OF TREATMENT AND APPROXIMATE DATES?

_____

_____

IF YOUR HOUSE WAS MOLDY, DID YOU RECEIVE ANY TREATMENTS FOR MOLD?_____

PLEASE CHECK THE FOLLOWING SYMPTOMS EXPERIENCED IN THE PAST 3 MONTHS:

General

☐ Poor Appetite ☐ Poor Balance ☐ Weight Loss ☐ Localized Weakness
☐ Fevers ☐ Chills ☐ Strong Thirst ☐ Bleeding/Bruising Easily
☐ Sweats Easily ☐ Night Sweats ☐ Change in Appetite ☐ Peculiar Tastes/Smells
☐ Fatigue ☐ Cravings ☐ Poor Sleeping ☐ Sudden Energy Drop
☐ Weight Gain ☐ Tremors ☐ Other: _____

Skin & Hair

☐ Rashes ☐ Loss of Hair ☐ Pimples ☐ Change in Texture
☐ Itching ☐ Hives ☐ Eczema ☐ New Moles
☐ Dandruff ☐ Ulcerations ☐ Other:_____

Eyes, Ears, Nose & Throat

☐ Dizziness ☐ Poor Vision ☐ Cataracts ☐ Ringing in Ears
☐ Sinus Problems ☐ Grinding Teeth ☐ Headaches ☐ Recurrent Sore Throat
☐ Concussions ☐ Eye Strain ☐ Night Blindness ☐ Sores on Lip/Tongue
☐ Blurry Vision ☐ Poor Hearing ☐ Noe Bleeds ☐ Teeth Problems
☐ Migraines ☐ Eye Pain ☐ Earaches ☐ Color Blindness
☐ Spots in Vision ☐ Jaw Clicks/Pops ☐ Facial Pain ☐ Light Sensitivity
☐ Wear Hearing Aids ☐ Other: _____

Cardiovascular

☐ Blood Clots ☐ Chest Pain ☐ Low Blood Pressure ☐ High Blood Pressure
☐ Phlebitis ☐ Fainting ☐ Difficulty Breathing ☐ Irregular Heartbeat
☐ Dizziness ☐ Swelling of Hands/Feet ☐ Cold Hands or Feet
☐ Other: _____

Respiratory

☐ Cough ☐ Pneumonia ☐ Coughing Blood ☐ Pain with Deep Breath
☐ Bronchitis ☐ Asthma ☐ Phlegm
☐ Other: _____

Gastrointestinal

☐ Nausea ☐ Abdominal Pain/Cramps ☐ Rectal Pain ☐ Constipation
☐ Vomiting ☐ Diarrhea ☐ Black Stools ☐ Chronic Laxative Use
☐ Gas ☐ Belching ☐ Bad Breath ☐ Blood in Stool
☐ Indigestion ☐ Hemorrhoids ☐ Other:_____

Urinary

☐ Impotency ☐ Pain During Urination ☐ Frequent Urination ☐ Urgency to Urinate
☐ Blood in Urine ☐ Unable to Hold Urine ☐ Decrease in Flow ☐ Waking to Urinate
☐ Kidney Stones ☐ Other:_____

Reproductive (Female Only)

AGE AT FIRST MENSES _____ MENOPAUSE AGE _____

TIME BETWEEN MENSES _____ DO YOU USE BIRTH CONTROL? _____

TOTAL PREGNENCIES _____ TOTAL PREGNENCIES _____

☐ Unusual Menses ☐ Vaginal Discharge ☐ Blood in Urine ☐ Painful Periods

☐ Clots ☐ Kidney Stones ☐ Vaginal Sores ☐ Breast Lumps

☐ Irregular Periods ☐ Changes in Body/Psyche Prior to Period

☐ Other: _____

NUMBER OF:

BIRTHS _____ MISCARRIAGES _____ PREMATURE BIRTHS _____ ABORTIONS _____

Neuropsychological & Musculoskeletal

☐ Neck Pain ☐ Muscle Weakness ☐ Shoulder Pain ☐ Hand/Wrist Pains

☐ Back Pain ☐ Foot/Ankle Pain ☐ Knee Pain ☐ Muscle Pain

☐ Hip Pain ☐ Numbness ☐ Tingling ☐ Neuropathy

☐ Other: _____

☐ Anxiety ☐ Irritable ☐ Poor Memory ☐ Area of Numbness

☐ Dizziness ☐ Depression ☐ Lack of Coordination ☐ Easily Susceptible to Stress

☐ Loss of Balance ☐ Seizures ☐ Hear Voices ☐ Insomnia

☐ Addictions ☐ Hallucinate ☐ Panic Attacks ☐ Excessive fatigue

☐ Other: _____

HAVE YOU EVER CONSIDERED OR ATTEMPTED SUICIDE?_____

ARE YOU LIVING IN A "SAFE" PLACE?_____

HAVE YOU EVER BEEN TREATED FOR EMOTIONAL PROBLEMS?_____

Dental

DENTAL HISTORY (INCLUDE DATES): PLEASE LIST ORAL SURGERIES, ROOT CANALS, CAVITIES, FILLINGS + AMALGAMS, IMPLANTS, ETC.

Metal amalgams/fillings: Yes/#/Dates:_____

Root canals? Yes/#/Dates: _____

Implants? Yes/#/Dates:_____

Oral surgeries or any recent procedures?_____

Do you have (permanent) metal retainer or braces?_____

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ULTRASOUND INTAKE FORM

DATE:_____

NAME:_____ DOB:_____

EMAIL:_____CONTACT NUMBER:_____

ADDRESS:_____

WHOM SHALL WE THANK FOR YOUR REFERRAL:_____

IS THIS YOUR FIRST SCAN? _____ IF NOT, MONTH & YEAR OF LAST SCAN_____

WHAT ARE YOUR PRIMARY CONCERNS FOR YOUR VISIT TODAY? _____

_____

LIST ANY SURGERIES/ORGANS REMOVED:_____

_____

LIST CURRENT MEDICAL CONDITIONS:_____

_____

LIST ANY TRAUMAS, ACCIDENTS, MAJOR LIFE/JOB/RESIDENCE/RELATIONSHIP CHANGES SINCE YOUR LAST SCAN:

_____

LIST ANY CHANGES IN WATER SOURCE, SUPPLEMENTS, HEALTH PROGRAMS, ETC. SINCE LAST SCAN:_____

_____

LIST ANY FAMILY HEALTH CONDITIONS/EARLY DEATHS (PARENTS, GRANDPARENTS, SIBLINGS):_____

_____

LIST ANY MEDICATIONS/SUPPLEMENTS (Can continue on back) :_____

_____

DO YOU TRAVEL OUT OF THE COUNTRY/DO YOU DO MISSION WORK:_____

By signing your name, you understand this is NOT a diagnostic test. You understand this is research and we may refer you either in-house or to other practitioners for further testing, evaluation, and/or treatments. You understand and release Dr. Mary Blakely, Dr. Gary Sconyers, the doctor's heirs and staff, and their heirs from any and all liability for any untoward reaction that might result from this evaluation. This is binding on your heirs.

PRINTED NAME:_____ DATE:_____

PATIENT SIGNATURE: _____

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HIPPA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____**,** give my permission for **Health Resource Center** to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give Health Resource Center permission to:

(Initial) _____Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Forms of Disclosure:

(Initial) _____Electronic copy

(Initial) _____Hard copy

(Initial) _____Phone Call

(Initial) _____May leave voice mail or text

(Initial) _____In Person consult

Section III – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Relationship _____

Organization (If any): _____

Phone: _____

Name: _____

Relationship _____

Organization (If any): _____

Phone: _____

HIPPA FORM continued

Name: _____

Relationship _____

Organization (If any): _____

Phone: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section IV – Duration of Authorization

This authorization to share my health information is valid from the date signed below until I revoke this authorization to share my health data and can do so any time by submitting a request in writing to **Health Resource Center**:

Section V – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

Release of Liability/Express Assumption of Risk

Consent for Therapy and Waiver of Liability

In consideration of being allowed to participate as a client in Shine Through and/or Health Resource Center, I do hereby waive, release, and forever discharge the therapist from any and all claims, responsibilities, liabilities, injuries, actions, or causes of action arising from the therapy hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the therapist, to the fullest extent allowed by law. In my participation in the activities of these techniques, I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my safe participation in the activities of the therapy. However, knowing the material risks and appreciating, knowing, and reasonably anticipating that injuries are a possibility, I hereby expressly assume all of the delineated risks of injury, all other possible risks of injury or death, which occur by reason of my participation.

I have had the opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I understand that this is designed to be an ancillary health aid and not suitable for primary medical treatment for any condition. I subjectively understand the risks of my participation in this activity and, knowing and appreciating these risks, I voluntarily choose to participate, assuming all risks of injury or even death due to my participation. I understand and agree that this consent will apply to and govern the current and all future therapy sessions performed by the therapist.

Client Signature	Client Printed Name	Date

Witness Signature	Witness Printed Name	Date

Photo/Video Use Release Form

I, _____, (Participant) hereby grant and authorize Health Resource Center and/or ACIM (Company/We) the right to take, edit, alter, copy, exhibit, publish, distribute and make all use of any and all pictures or video taken of me, or related to me (house, property, family, pets, etc…) to be used and/or for legally promotional material including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits, and submissions to journalists, websites, social networking sites and print and/or digital communications without payment or any other consideration. This authorization shall continue indefinitely, unless we otherwise revoke and authorize in writing.

I understand and agree these materials shall become the property of Health Resource Center and/or ACIM and will not be returned.

I hereby hold harmless and release Health Resource Center and/or ACIM from all liability, petitions, executors, administrators and any other person(s) may make while acting on my behalf or on behalf of my estate.

Signature of Participant_____

Date_____ Name and Title _____

Signature of Company Employee_____

Date_____ Name and Title_____

_____ Initial Only If You Decline This Release Date _____

Welcome to Health Resource Center!

We value you as a new patient!

In our practice we believe it takes a partnership between our team and you to create the health and vitality you deserve! We hate that you or your loved one has suffered with an acute or chronic health issue such as Lyme, autism, pandas, viruses, brain injury, cancer, mold exposure or more. However, we know that you are in the right place with the right team that can help restore healthy brain, body, and life functioning! That being said, we know restoring your overall health requires several critical and consistent actions that you must address as a patient to achieve your goals. Please read the following regarding your new patient appointment as well as general health recommendations to begin on your own at home prior to your visit.

What to do or bring to your new patient appointment:

1. Please arrive to your appointment 10 minutes prior to your scheduled appointment time, i.e., if your appointment time is 9 AM, please arrive BY 8:50 AM.
2. Please have all new patient paperwork completed PRIOR to your visit. Ideally email or fax them to the clinic the day prior to your appointment. If you lack the technology to do so, please bring the completed paperwork with you to your appointment.
3. Please email, fax or bring copies of recent lab work or tests from the last year if you have any.
4. Please bring any and ALL supplements (the actual bottles, packages, containers, etc.) that you currently take with you to your appointment
5. Please refrain from eating a big meal or drinking caffeinated beverages 2 hours prior to your visit to ensure accurate testing. Feel free to bring snacks, water, or reading material to your visit, as sometimes visits may run long.
6. If you are doing an ultrasound please refrain from eating 6 hours prior to your appointment and be sure to drink at least 20-30 ounces of water prior to your appointment.

What to expect during your new patient appointment:

1. After you have turned in your new patient paperwork and copies of tests, one of our friendly staff members will begin a variety of assessments on you (which may include Blood Pressure, Heart Rate Variability, Brain Gauge or other).
2. Next you will complete your full body ultrasound and we will educate you about our findings as we go.
3. When the ultrasound is complete you will continue with Zyto testing (electrodermal screening) and interview process to assess various aspects of your health.
4. RELAX and know that there may be a GREAT AMOUNT of data produced by the Zyto scan as well as a great amount of information discussed during your visit.
5. If deemed necessary, we may order lab work for to complete prior to your consult with Dr. Sconyers. You will schedule to a consult with Dr. Sconyers to review the findings approximately a week after your initial testing day.

6. During your consult with Dr. Sconyers one our doctor's assistants or patient liaison will be taking detailed notes and provide you a copy of what is discussed as well as a summarized report from your Zyto scan. Our assistant or patient liaison will review your visit with you in person that day or by phone the following day to answer any questions and discuss your suggested treatment plan.
7. Once your visit with Dr. Sconyers is complete, he may begin a variety of therapies that same day such as LED detox, vibe plate, or EWOT (exercise with oxygen) which are included with your new patient appointment.
8. Your treatment plan may include any one or combination of the following. Please read the therapies attachment for detailed descriptions of each. Therapies with * have the ability to be performed at home (either via Skype, Zoom or with the purchase of equipment or technology)
    a. Supplements
    b. LED Detox
    c. EWOT*
    d. Full body ultrasound
    e. Body or cranial work
    f. Brain Mapping and Neurofeedback*
    g. EVOX*
    h. Nutritional consultation*
    i. IV therapies
    j. Infrared Sauna*
    k. Lymphatic work*
    l. Stem or Exosome therapy

After your new patient appointment

1. Know that you will be given a personalized written treatment plan to meet your health (physical, emotional, time, and financial) needs. We understand whether you are local or traveling a great distance to work with our clinic and try to provide a plan that "makes sense". You will most likely receive supplements to begin taking at home starting the day of your visit.
2. One of our staff members will review your suggested treatment plan with you that day or by phone within 24 hours. We will check in with you within 2 weeks to discuss your progress.
3. Your success depends on following the plan as well as completing health enhancing tasks at home that are mentioned in the following pages.
4. It is possible depending on the nature and severity of your condition that you may experience detox or die-off symptoms (headache, achy, fatigue, etc.). Rest assured it is common to become worse before you get better! We usually send patients home with detox remedies to assist in this process.
5. We recommend returning for follow up appointments with Dr Sconyers every 4-6 weeks after your new patient appointment. Obviously, you may return sooner and more regularly based on suggested therapies.

We feel that the following recommendations for you to work on at home before AND after your visit are CRITICAL for you to achieve the health you deserve. Supplements and in-office therapies alone *may not be the end all to improve your health*. It takes consistent work on your part. Start at the top of the list and work your way through until each of these is completed or becomes a routine part of your life.

1. **EMF Reduction** - Check for and reduce EMFs/Dirty Electricity in your home. We know that EMFs from a variety of sources including phones, smart watches, smart appliances, computers, lighting, 5G towers, and more modulate cell function and can have deleterious effects on your health. It has been studied and proven that EMFs modulate calcium channel pathways in your body, allowing more calcium proportionately to enter cells than is functionally necessary which may contribute to serious health issues including elevated blood sugar, heart disease, emotional health issues and more. We are also becoming more aware of how EMFs may modulate mycotoxins and pathogens, allowing them to mutate, morph, grow and become more virulent and resistant to therapies
    a. Visit Stetzer to purchase the microsurge meter for your home. (Or you can get it on Amazon as well). Test each plug in your home with the lights on and with the lights off. If any plug reads over 50 (especially with the lights off), consider purchasing microsurge filters for each affected plug. If the outlet measures more than 50 with the lights on, consider changing out the bulbs to incandescent bulbs.
    b. Identify where the electric (smart meter) is in your home in relationship to your (and your family member's) bedrooms. If it is near or on a bedroom wall and you are battling serious health issues, please consider moving your bed to a different room or wall. At THE LEAST consider purchasing a EMF reduction wrap for your meter from smartmeterguard.com.
    c. Turn off WIFI EACH AND EVERY NIGHT
    d. Turn phones to AIRPLANE MODE EVERY NIGHT
    e. Remove any wearable technology each night
    f. Keep any and all phones, even in airplane mode ACROSS the room or in the bathroom each night
    g. Get EMF reduction/protection for your cell phones, laptops, home appliances, headsets and more from Defender Shield for cell phones and tablets and from Aulterra, Planet Tachyon for everything else
    h. Order smart meter and router guards from smartmeterguard.com.

2. **Mold Testing** your house and work environment. Restoring health can be tricky. You may do everything on this list and everything clinically you can, but if you have a mold exposure on top of a brain injury, Lyme, autism, pans or chronic illness, even with the most diligent efforts, progress may be halted if not even REVERSED! Even if you think you live or work in a safe environment, please consider mold testing as a precaution.
    a. Order mold plates from the Citrisafe website and follow the company's directions to check for mold and send the plates off for an analysis. Be sure to put our information on the form so that we receive a copy of the report. Be sure to check your house (every room), school, and work.
    b. If you do discover that you have mold, take steps to remediate. Follow Citrisafe's guidelines. OR if you are in the DFW area we ONLY recommend fixAirX for mold remediation. DO NOT SKIMP on mold remediation. NOT ALL COMPANIES ARE THE SAME or complete the job correctly. If you have completed mold remediation with another company, we still HIGHLY RECOMMEND fixAirx coming out to confirm you are free and clear of mold.
    c. Both the Citrisafe and fixAirX websites have more tools to help dealing with mold, as well as the Surviving Mold website.

3. **Grounding Daily** - We know that reconnecting with the earth is a HUGE victory for our physical and emotional health. We are so overloaded with synthetic apparel and shoes, as well as constantly on the go in our cars, stores, and high-rise work and living spaces. We need our bare feet to touch the earth and re-establish healthy energy exchanges. Visit www.earthing.com for the "HOW TOs" on grounding as well as check into their grounding products. We highly recommend grounding (getting outside with bare feet on the ground – no cell phone – for 20-30 minutes EVERY DAY!!). When or as much as possible GO BAREFOOT or consider wearing only shoes with leather or fabric soles. We know our Lyme patients may feel weary and fearful about more outdoor time. It is critical. If going outside causes further anxiety, please consider obtaining grounding mat or devices to use inside.

4. **Healthy Sleep** – Your sleep behavior and home sleeping environment are CRITICAL to restore healthy brain function. Here are the MUSTS:
    a. Ideal bedtime is as close to 9 PM as possible. If you are having issues going to sleep this early work on a plan to back up your going to bedtime by 15-30 minutes each night. We understand if you have children, sports, work, etc. Just remember YOU MATTER!! Without causing yourself more stress about the 9 PM sleep time give yourself grace and get as close as possible. Ask for help with kids or chores when you can.
    b. If you are having trouble going to sleep or staying asleep consider supplements. ASK Dr Sconyers at your visit about supplements to improve your sleep if needed.
    c. If you have trouble going to sleep or staying asleep consider listening to whole tones prior to sleep, reading a book (not a kindle or IPad), or using red light therapy prior to bed (like Joov).
    d. No TV, Cell Phones, or technology 2 hours prior to bedtime – *DO YOUR BEST*
    e. We highly recommend using blue light reduction settings on all technology especially starting in the afternoon as well as wearing Blue Light reduction glasses ANY and EVERY time you are looking at technology, at work, or sitting in a classroom. Here are links to glasses brands that "look stylish" and have clear (not yellow) lenses : True Dark or Warby Parker
    f. Keep your bedroom as LOW EMF as possible. Unplug ALL electronic devices from the wall – lamps, clocks, etc. If have a cell phone, keep it at least 10 feet away from your bed – in the bathroom, closet, hall, etc. See above for more specifics on EMFs
    g. Consider sleeping in an EMF reduction bag

5. **Healthy Eating** – While eating specifics vary person to person, here are a few basics that the average person can follow:
    a. Eat the rainbow of organic vegetables and fruits. The more color and variety, the better!
    b. Eat free range, grass fed, antibiotic free, hormone free meats
    c. Avoid sugar and most sugar substitutes. Organic stevia for the most part is an acceptable sweetener.
    d. Avoid dairy products. Try alternative milks like almond, coconut, hemp, or macadamia. If you must eat cheese look for organic varieties
    e. Avoid any and all processed and packaged foods. Shop the perimeter of the store.

f. Avoid most gluten containing grains (Barley, Rye, Oats, Wheat, Spelt). Some people are sensitive to them. If you must consume grains, make sure they are organic or sprouted.
g. If you have thyroid or cortisol issues be sure to include carbohydrates from sweet potatoes, carrots, winter squashes and fruits. Too low of a carbohydrate intake may aggravate the thyroid and in some people with adrenal fatigue create havoc. Check with Dr. Sconyers to see if you need a nutrition consult with a specific eating plan.
h. Ask if intermittent fasting or fasting mimicking eating is a good idea for you

6. **Supplements** – Needs vary person to person, but these are the basics the average person should be taking daily. Dr Sconyers will make specific suggestions based on in clinic testing
    a. Vitamin D
    b. Magnesium
    c. Vitamin C
    d. Minerals

7. **Oxygen is CRITICAL!!!** Anyone with an acute or chronic illness or injury has reduced oxygen and blood flow to the affected areas. To restore health, it is critical to do oxygen therapy.
    a. We prefer a method called EWOT which can be done in our clinic or Live02 adaptive contrast units may be purchased for the home as well
    b. Option B is hyperbaric oxygen.
    c. Option C is Wimhoff breathing – see directions at the end of this packet

8. **Healthy Emotions –** Oftentimes our chronically ill or brain injured patients find themselves experiencing extremes in anxiety, depression, panic attacks, PTSD, attention deficit, lack of focus, brain fog and more. It is quite common. You are NOT ALONE! There are a few things already mentioned to help with improving this as well as the few helpful hints below.

a. Medications – if you are taking a class of anti-anxiety medications called Benzodiazepines like Xanax, Librium, Tranxene, Valium and Ativan we find that they SERIOUSLY INHIBIT the process of improving your health. If anything, we find they actually may make your symptoms worse. We can't recommend enough to wean (slowly) off of this class of medication with your physician's help and approval.
b. Try our Stress Reduction technique:
    i. While sitting, touch your left index finger to your left thumb. With your right hand grab around those two fingers
    ii. Imagine your happy or safe spot (the beach, mountains, bedroom, garden…whatever!) Engage every sense as you imagine it: sound, sight, taste, smell, touch
    iii. Breathe in through your nose for a 5 count, hold for a few seconds then breathe out for a 5 count. Repeat for 5 minutes or until you feel yourself calming down
c. Consider other natural products/supplements to improve your emotional health. Please ask Dr. Sconyers for specific help in this area
d. Avoid multitasking: i.e., like talking or texting on cell phone while doing other tasks
e. Avoid social media, video game playing, and internet surfing
f. Unload your schedule and delegate as much as you can.
g. If you have completed and EVOX session make it a habit to say your affirmations out loud multiple times per day, especially if you catch yourself feeling bad, having negative self-talk or experiencing anxiety. If you haven't completed EVOX consider finding your favorite scriptures, uplifting quotes or poetry and repeat those out loud several times per day, or pray with a friend or loved one.

9. **Lymphatic Work** – We can't encourage enough the value of lymphatic drainage. Getting the body and brain to release toxins is highly beneficial for your health and recovery.
    a. Dry brush daily
    b. Daily or several times per week use an infrared sauna
    c. Consider rebounding daily (mini trampoline or regular trampoline)

d. Vibe plate
e. Chi machine
f. Consider cranial work to drain the lymphatics around the skull sutures, neck and scalp.

10. **Reduce Chemical Load** – one reason you may have a chronic illness is because of daily exposure to toxins. You may even notice you are more sensitive to chemicals, scents, toxins, etc., as well as become more challenged to detox from the daily exposure to chemicals. Check out websites like "Think Dirty", "EWG", "Skin Deep", and Lara Adler for safer products and brands.
    a. In the kitchen
        i. Eliminate all plastic (reusable) containers, cups, Styrofoam, utensils, water bottles, and more. Choose glass or paper
        ii. Eliminate all Teflon coated pans. Choose stainless steel, seasoned cast iron, ceramic, stone, or glass cookware
    b. In the air
        i. Eliminate all plug-in fragrances and candles. Choose essential oils and diffusers
    c. In the laundry and cleaning departments
        i. Eliminate all products containing fragrances, phthalates, parabens, dyes and more.
        ii. Use a mixture of baking soda and vinegar and essential oils like orange or lemon
    d. In the cosmetic department
        i. Eliminate all products containing fragrances, mineral oil, phthalates, parabens, dyes, mono or sodium laurel sulfates
        ii. Safe brands include Beauty Counter, Doterra, Young Living, Juice Beauty and more

11. **Dental Health**–If you are experiencing deleterious health issues and have metal in your mouth (screws, braces, retainers, fillings), or have bridges, crowns, root canals, dry sockets, gum disease, multiple pulled teeth or more, we HIGHLY RECOMMEND visiting with a biological dentist ASAP. Biological dentists in the DFW area that we recommend include:

- **Dr Allen Sprinkle: 817-461-9998**
- **Dr Minaxi Mirkal: 617-838-8342**
- **Dr Stacy Cole: 817-731-9291**
- **Dr Svetlana Baranovitch: 469-640-1213**
- **Dr Steve Evens: 903-894-8757**
- **Dr Gottfried Olsen: 972-681-5936**

12. **EDUCATE YOURSELF ON THESE SERVICES WE OFFER IN OUR CLINIC WHICH MAY CONTRIBUTE TO RESTORING YOUR HEALTH**

a. **CLEAR MIND Mapping and Neurofeedback –** For some heal the gut the body follows. For others, heal the brain and the body follows. If you have experienced any kind of physical trauma, serious emotional trauma or abuse, Lyme, mold exposure, pans, or chronic illness then neurofeedback therapy may be critical to your success. Remote patients may want to consider a "Focus Unit" for home use.

- **Informational videos on what it is**

- Consistency in performing the neurofeedback is CRITICAL to success. Merely doing a session or two here and there WILL NOT WORK. This in addition to oxygen work and exosomes may be the BIGGEST contributors to your health success

- **EVOX Perception Reframing –** WE know that we carry our emotions in our connective tissues that can cause pain, inflammation and suffering. Sometimes by reframing our perceptions and emotions we can reduce our symptoms as well.
  - **Informational video on EVOX**
  - We know that chronic illnesses take a deleterious toll on emotional health. 5-6 EVOX sessions over the course of a few weeks to a few months may help remove the

emotional blocks to healing, help calm the brain down from trauma reducing anxiety, depression, panic attacks and PTSD symptoms, as well as restore healthy perceptions

- **IVs**
  - UBI – Blood Irradiation
  - Exosomes and Stem Cells for autism, pans, pandas, brain injuries, mold, Lyme, Alzheimer's, stroke, and chronic illnesses
  - Dr. Clendinen explains exosomes
  - Vitamin C
  - Myers Cocktails
  - Glutathione
  - Ozone

- **Depending on the severity of your illness, you may want to consider a full body ultrasound to identify, evaluate and track the health of your organs and vascular system. In a full body ultrasound, we evaluate the health of ALL of the following**

Brain stem	Carotids	Thyroid
Esophageal junction	Heart/Abdominal aorta	Musculoskeletal strength
Liver	Gall bladder	Kidneys
Bladder	Pancreas	Spleen
Uterus/Ovaries	Prostate	Breasts
Circulation		

WIM HOF Breathing

“Warnings: Always do the breathing exercise in a safe environment (e.g. sitting on a couch/floor) and unforced. Never practice it before or during diving, driving, swimming, taking a bath or any other environment/place where it might be dangerous to faint. The breathing exercise has a profound effect and should be practiced in the way it is explained.

1. Get comfortable

Find a comfortable place to do your breathing exercises where you won’t be disturbed. You can sit or lie on your back, but do not do this exercise while driving or standing up.

2. Do 30-40 power breaths

Once you’re comfortable, you can start to breathe in and out 30 times. This is essentially deep breathing at a steady pace in and out through the mouth. Inhale fully but don’t exhale all the way out. As you inhale you should feel your belly rise and on the exhale, you should feel your belly fall. It may feel a bit like you are hyperventilating, but you are in control. Like me, you may also feel a tingling or lightheaded sensation throughout your whole body, when you do this for the first time. This is perfectly normal.

3. Hold your breath

After doing 30-40 Wim Hof power breaths, empty your lungs of air and retain the breath for as long as you can without force. During the retention, I found it relaxing to close my eyes and focus on the space between my eyes. Just remember to set a stopwatch if you’re interested in recording your results. You might want to see how you progress with the breath retentions if you plan to do this regularly over a set period of time.

4. Breathe in for 10 seconds

After the breath retention, take a deep breath in and hold it for a further 10-15 seconds, before exhaling.

5. Repeat steps 1-4

Repeat the whole process for another three rounds. Remember to record your times down, so you can track your progression.

6. Meditate after 4 rounds of power breathing

After the power breaths, you can then go into your regular practice of meditation or prayer for 5 minutes or longer