

GUT REST

— DIAGNOSTICS —

New Client Pack

Client Agreement & New Client Intake

A testing led approach to long standing digestive complaints. Everything in this pack can be completed on screen, then saved and emailed back. No printing required.

Prepared for

Date

Gut Rest Diagnostics is a digestion and nutrition consultancy and is not a medical facility. We do not diagnose or treat disease. Please keep a licensed physician on your healthcare team.

SECTION ONE

Client Agreement

Gut Rest Diagnostics takes a testing led approach to long standing digestive complaints. Dr. Michael Erdman trained as a physician in the United Kingdom and has spent over ten years as a digestion and nutrition consultant. He works from detailed diagnostics and a careful reading of your results to find what is driving your symptoms and to build a natural plan that supports healthy digestive function. The terms below explain how we work together.

ABOUT GUT REST DIAGNOSTICS

Gut Rest Diagnostics is a digestion and nutrition consultancy. It is not a medical facility. The Digestion Consultant does not diagnose or treat disease, prescribe medication, or renew prescriptions. We do not accept health insurance, Medicare, or any government program. Our work may identify issues that need a licensed physician, so please keep one on your healthcare team.

COMMUNICATION

We may contact you about appointments, results, and your care using the details you provide. Please reach us by telephone or email, and email us for anything health related. Please do not use text for urgent matters. If you have not heard back when you expected to, please call.

FEES AND PAYMENT

- All services are paid in full at the time of service. You are responsible for all charges, and we may keep a card on file and charge it for any open balance.
- A nonrefundable deposit of \$100 secures a new Client appointment.
- Please give at least 24 hours notice to change or cancel. For Monday appointments, notify us by the prior Friday at noon. A missed or late cancelled appointment may be charged \$100.
- No refund is given once a visit has begun. A late fee of 15 percent may apply to balances unpaid after 30 days.

TELEHEALTH VISITS

Consultations are by secure video or telephone. When in person testing is needed, it is arranged separately at a qualified site. A telehealth visit is not the same as being in the same room, and there are risks such as interruptions or technical failure. You may instead see a provider in your local area, and either you or the Digestion Consultant may end the visit if the connection is inadequate. We use reasonable safeguards, but no electronic communication can be guaranteed to be fully secure.

YOUR RECORDS AND PRIVACY

We protect your health information and share it only as needed for your care or as the law requires. You may share records from other providers by emailing them to us. To request a copy of your records, email us at hello@gutrest.com and we will respond within 15 days. A reasonable copying fee may apply.

SUPPLEMENTS

We offer supplements only to established Clients. Read each product's label and ingredients, and discuss its use with your other providers, since interactions and intolerances are possible. Stop any product and contact us if you have a reaction. Please tell us if you are pregnant or planning to be.

NO GUARANTEES

We make no promise or guarantee about the outcome of any service, and no guarantee has been made to you about the results of any recommendation or assessment.

ENDING THE RELATIONSHIP

Either you or the Digestion Consultant may end this agreement at any time without giving a reason. If the consultant ends it, you will be given at least 15 days notice.

CLIENT CONSENT REQUIRED

I have reviewed and understand all of the Terms in this Policies and Agreements pack. I agree to comply with all of the Terms, Policies, and Agreements documented here, in their entirety. By signing below, I confirm that I have had ample opportunity to ask questions and that my questions have been answered to my satisfaction.

Client name (print)

Date

Signature

SECTION TWO

New Client Intake

Welcome to Gut Rest Diagnostics. This intake helps us understand your digestive health before your first consultation, so the time we spend together is about you rather than paperwork. Please complete what you can. If a question does not apply, leave it blank. You can email any results or reports to hello@gutrest.com.

ABOUT YOU

Date of birth

Email

Phone Best time to reach you

Preferred contact

Mailing address

City, state, ZIP

Emergency contact

Name

Phone Relationship

Height ft in Weight lbs

Recent weight gain Amount Over

Recent weight loss Amount Over

Lowest adult weight Age Highest adult weight Age

YOUR HEALTHCARE TEAM

We work alongside your medical team, not in place of it. Please tell us who else cares for you.

Primary care physician

Name

Phone Email

Date of last physical Date of last blood work

Other providers

Name	Type or specialty	Phone or email

YOUR MAIN CONCERN AND GOALS

What is the main digestive concern that brings you to us?

When did it begin, or how long have you had it?

What is it like on a typical day?

What makes it better or worse?

What have you already tried? Include tests, treatments, diets, and practitioners.

What would a good outcome look like for you?

Your current overall health rating, 0 to 10

DIGESTIVE SYMPTOMS AND BOWEL PATTERN

Please tick any symptoms you currently experience.

Heartburn or acid reflux

Regurgitation

Bloating

Excess gas

Belching

Nausea

Vomiting

Early fullness

Abdominal pain or cramping

Upper abdominal discomfort

Constipation

Diarrhea

Alternating bowel habit

Urgency

Undigested food in stool

Difficulty swallowing

Loss of appetite

Fatigue after meals

Bowel movements per day or week

Bristol stool form (1 to 7)

Blood or mucus in stool

Anything else about your digestion you would like to add?

DIET AND LIFESTYLE

Typical day of eating. Briefly list breakfast, lunch, dinner, and snacks.

Foods you avoid or react to.

Caffeine, type and amount

Alcohol, type, amount, frequency

Smoking, amount

Recreational drug use

Regular exercise, type and frequency

Daily stress level, 0 to 10

Sleep weeknights (hrs)

Sleep weekends (hrs)

Occupation

Living situation

If others, how many

Is anyone else in the home unwell?

Details

MEDICAL HISTORY

Other conditions

Past surgeries and procedures

Surgery or procedure	Year

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Past hospitalizations

Reason	Date

Relevant scans or tests

Study or scan	Date	Finding

Family history of digestive disease, cancer, or autoimmune conditions. If yes, please give details.

MEDICATION AND SUPPLEMENTS

Please list prescription and over the counter medicines, vitamins, minerals, herbs, and any acid reducing medicines such as PPIs or antacids.

Medication or supplement	Reason	Dose and frequency

HEIDELBERG PH TEST SCREENING

If diagnostic testing with the Heidelberg pH capsule is recommended, this helps us confirm it is suitable and safe for you. We will discuss anything you flag here before any test takes place.

Are you pregnant, or could you be? We do not offer the test during pregnancy.	Yes	No
Do you have difficulty swallowing pills or food?	Yes	No
Have you had surgery on your stomach, esophagus, or intestines?	Yes	No

Details:

Have you been told you have Crohn's disease, a stricture, narrowing, or blockage in the gut?	Yes	No
Do you have an implanted electronic device, such as a pacemaker?	Yes	No
Do you take acid reducing medicine (PPI, H2 blocker, or antacid)?	Yes	No

If yes, which and how often

Some medicines need to be paused before the test. We will advise you on this.

A FEW LAST THINGS

How did you hear about us?

Referral source, if any

Is there anything else you would like us to know?

Thank you for completing this. Please save the file and email it, along with any results or reports, to hello@gutrest.com.