

## Healthwise Medical Centre

Tweed Mall Shopping Centre  
Cnr Wharf & Bay Streets  
Tweed Heads NSW 2485  
Ph: 07 55368811

### Pfeiffer Treatment

Thank you for your enquiry about the Pfeiffer treatment. This programme is to identify chemical imbalances in the brain and correct them using a individualised compounded vitamin and mineral therapy.

### History

The treatment has been available in America for over 25 years with great success. For further information search the following websites: [www.hriptic.org](http://www.hriptic.org) or Google: methylation, histamine, Walsh and eg. Depression (substitute your own diagnosis). Dr Stuckey first began this treatment in March 2004 and was the first doctor to be trained outside America. There are now doctors through-out Australia and New Zealand trained to follow Pfeiffer protocol.

### Cost:

Your out of pocket expense will be approximately \$500.00. Please refer to total costs on page 2. On going costs for vitamin and mineral supplements, range between \$60 and \$120 per month. Some variances will occur during the treatment according to improvement. Please note, a \$100.00 deposit is required to secure your appointment. This fee will be deducted from the appointment cost.

Minimum 2 working days notice is required for cancellation, otherwise the deposit will be forfeited.

### Follow up visits:

Book for second visit 4 weeks after initial consultation. Ring the surgery to confirm this visit one week prior to check all your test results are in. This visit is bulk billed if you physically come to the practice.

The initial office consultation will last approximately 1 ½ hours. With children, we strongly advise that both parents participate in the initial consultation. It is imperative that two adults attend. We also suggest that you bring a snack and drink for your child.

At the second visit Dr Stuckey will explain the results, what treatment is required and email the vitamin and mineral compounding script to the chemist. The payment and collection of the script is then between yourself and the chemist.

If you have any problems or concerns please ring the surgery immediately, the nurse can help or a message will be given to Dr Stuckey.

Phone consultations are available at this stage if you can't physically come to the surgery.

The cost will be:     \$4.00 per minute (Doctor ) no medicare rebate  
                              \$2.00 per minute (Nurse) no medicare rebate

You will be advised about on going treatment at this point. A visit to the surgery or a phone consultation will be required at 3 - 6 month intervals from then on. A blood test prior to these appointments may be required and they generally are covered by Medicare. It is very important for you to keep taking any prescription medication. Please ring to confirm appointment no less than one week prior.

Face to face consultations are required at least once a year.

Dear.....

Your Pfeiffer Treatment appointment with Dr Stuckey and our nurse is

on.....at.....

The appointment involves a 1 hour consultation.

Total cost of the consultation \$300.00 Medicare rebate approx \$110.00 Costs are subject to change:

|             |           |                                      |
|-------------|-----------|--------------------------------------|
| Hair test   | \$ 70.00  | Nil rebate                           |
| Blood tests | \$ 300.00 | Nil rebate                           |
| Urine Test  | \$ 80.00  | Nil rebate (non pension card holder) |
|             | \$ 65.00  | Nil rebate (concession card holders) |

#### 1. Hair Test

During the consultation Dr Stuckey may ask for a sample of your hair to send to America for testing. Hair testing is mainly only for children. Please follow the pre collecting requirements.

\*Leave hair a reasonable length

\*Stop using any anti-dandruff or 2 in 1 conditioning shampoos \*Use Johnson and Johnson baby shampoo 3 weeks prior.

\*No hair rinses, colours or perms

\*no vitamin or mineral supplements for 1 day prior to visit

\*No hair spray or gel on day of visit

\*Don't swim in chlorinated pools for 4 weeks prior to visit

\*Don't take any over the counter anti histamines 3 weeks prior to blood test

The cost for hair testing is \$70.00 payable to R.H.Stuckey & Assoc on the appointment day.

#### 2. Blood Test

Following the consultation with Dr Stuckey you will be required to go to Sullivan and Nicolaides Pathology at John Flynn Medical Centre for blood and urine collection.

Cost for the blood test will be approx \$300.00 (out of pocket) Pathology will send the account to your home address.

Urine test is \$80.00 or \$65.00 for concession card holders. No rebate. Payment in the form of credit card or cheque must accompany the specimen. Dr Stuckey's staff will book the appointment with pathology to follow doctors appointment. Full directions and a map will be given at appointment. Repeat blood tests will be ordered at intervals throughout your treatment. Most of these will be covered by Medicare and bulk billed. They will not be the full original tests.

PLEASE FILL IN PATIENT DETAILS AND RETURN AT FIRST APPOINTMENT

|                                    |                         |              |               |
|------------------------------------|-------------------------|--------------|---------------|
| SURNAME                            | FIRST NAME              | TITLE        |               |
| .....                              |                         |              |               |
| STREET ADDRESS                     | SUBURB                  | POSTCODE     | STATE         |
| .....                              |                         |              |               |
| PHONE CONTACT                      | MOBILE                  | WORK CONTACT | EMAIL ADDRESS |
| .....                              |                         |              |               |
| MEDICARE NUMBER                    | NUMBER NEXT TO NAME     | EXPIRY DATE  |               |
| .....                              |                         | ...../.....  |               |
| GENDER                             | MARITAL STATUS          |              |               |
| .....                              |                         |              |               |
| DATE OF BIRTH                      | .....                   |              |               |
| PENSION OR HEALTH CARE CARD NUMBER | EXPIRY DATE             |              |               |
| .....                              |                         |              |               |
| VETERAN AFFAIRS NUMBER.....        |                         |              |               |
| EMERGENCY CONTACT                  | RELATIONSHIP TO PATIENT |              |               |
| .....                              |                         |              |               |
| PERSON RESPONSIBLE FOR PAYMENT     | THEIR CONTACT DETAILS   |              |               |
| .....                              |                         |              |               |
| PARENTS NAMES (IF MINOR)           |                         |              |               |
| .....                              |                         |              |               |
| COMMENTS                           |                         |              |               |

.....

HEALTH HISTORY:

NAME.....DATE OF BIRTH...../...../.....

1. Education;(last grade completed or degree completed)

.....

2. Sex and age of siblings.....

.....

.....

3. Significant birth events if any.....

4.Surgery.....

.....

5. Injuries, head injuries.....

.....

6. Please list your primary symptoms.....

.....

.....

7. Are you pregnant?.....

8. List prescriptions, over the counter medications and any vitamins and herbs you are now taking and why you are taking them.

| NAME  | DATE STARTED | REASON |
|-------|--------------|--------|
| ..... |              |        |
| ....  |              |        |
| ..... |              |        |
| ....  |              |        |
| ..... |              |        |
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9. Which of the following symptom do you have?

Fatigue..... Nervousness..... Anxiety..... Irritability.....Inability to concentrate.....

10. Have you had a glucose tolerance test?..... When ? .....

Were you diagnosed as being hypoglycemic?.....

11. Do you tend to tan?.....or burn..... after extended sun exposure?

12. Have you ever had white spots on your fingernails?.....

13. During the past six months, have you been a frequent user of swimming pools?.....

14. How would you describe your temper?.....

15. When very angry, how long does it take for you to cool off?.....

16. Please describe your typical reaction to stress?.....

.....

17. Please tick previous diagnoses:

Schizophrenia.....Manic depression.....Behaviour disorder.....

Learning disability.....Hyperactivity.....Attention Deficit disorder.....

Depression.....Eating disorder .....Autism..... Other.....

18. Do you have 2 or more alcoholic beverages per day?.....

19. Have you ever used illegal drugs?.....

Describe.....

20. How did you hear about the Pfeiffer treatment?.....

21. Referred by:

Name.....

Last

First

Title

Address.....

Number

Street

Suburb

Postcode

Phone numbers.....

Please provide any information you think is relevant

.....

6.

Patient Medical History    Tick if applicable

|                                     |                                 |                    |
|-------------------------------------|---------------------------------|--------------------|
| acne                                | esophagitis                     | hypothyroidism     |
| eczema                              | peptic ulcer                    | hyperthyroidism    |
| psoriasis                           | gastro esophageal reflex        | alzheimers         |
| allergic rhinitis                   | parkinsons                      |                    |
| colitis colitis                     |                                 |                    |
| chronic sinusities                  | irritable bowel syndrome        | dementia           |
| asthma                              | gall bladder dysfunction        | seizure disorder   |
| arthritis/rheumatoid/lupus          | hepatitis                       |                    |
| chronic fatigue syndrome            | liver disease                   | fibrocystic        |
| breast cancer                       | endometriosis                   | multiple sclerosis |
| collagen vascular                   | kidney problems                 | fibroid tumors     |
| fibromyalgia                        | urinary tract infection         |                    |
| polycystic ovarian disease          | multiple chemical sensitivities |                    |
| benign prostatic hypertrophy        | pms                             |                    |
| depression postpartum               | heart disease                   | menopause          |
| stroke                              | thrush                          | hypertension       |
| athletes foot                       | yeast infection                 |                    |
| high cholesterol/high triglycerides | toe nail fungus/finger nail     | glaucoma           |

|                              |                                |                     |
|------------------------------|--------------------------------|---------------------|
| diabetes                     | ring worm                      | night blindness     |
| other.....                   | .....                          | .....               |
| Psychiatric History          | Anxiety disorder               | Psychotic disorder  |
| ADD                          | ADHD                           |                     |
| Generalised anxiety disorder | Schizophrenia                  |                     |
| PDD/Autism spectrum          | Phobic disorder                |                     |
| Schizoaffective disorder     | Oppositional defiant disorder  |                     |
| 1.bipolar type               | conduct disorder               | panic disorder      |
| 2.depression type            | obsessive compulsive disorder  |                     |
| behaviour disorder           | post traumatic stress disorder | delusional disorder |
| tourette                     | acute stress disorder          |                     |
| Eating disorder              | dissociative disorder          | anorexia nervosa    |
| Mood disorder                | dissociative identity disorder | bulimia nervosa     |
| major depressive disorder    | dissociative fatigue disorder  | pica                |
| bipolar 1 disorder           | obesity                        | bipolar 11 disorder |
| dysthymic disorder           | cyclothymic disorder           |                     |

Past surgeries

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 .....

Past Hospitalisations:

.....

Other therapies/ treatments pertinent tests:

.....  
 .....

Please indicate whether relatives are maternal or paternal using the below key. Other relatives may be listed if you think the information is significant.

|                |                    |                            |
|----------------|--------------------|----------------------------|
| Family History |                    |                            |
| ADD ADHD       | bipolar            | Code                       |
| Violence       | alcohol drug abuse | M=mother F=father S=sister |
| Asthma         | suicide attempt    | B=brother                  |

early senility

thyroid

ulcers

Heart disease

stroke

hypertension

depression

schizophrenia

arthritis

diabetes

kidney disease

psoriasis

Maternal

Grandparents=MGM/MGF

Paternal Grandparents= PGM/PGF

Maternal aunt/uncle=MA/MU

Paternal aunt/uncle=PA/PU

cancer