Greetings! Please let me know ASAP by e-mail whether you were able to download the attachments contained within this document. Please reply to DrMGennaro@yahoo.com

I am looking forward to seeing you at our first appointment.

Please fill out the attached history form and the informed consent form and bring them with you. MAKE SURE YOU BRING ANY DRUGS OR SUPPLEMENTS YOU ARE TAKING OR THINKING OF TAKING. If you have any lab tests and can get access to them, please bring them as well.

I often use products that are sold only through health professionals. You may pay for the office visit and supplements (if needed) by cash, check (made payable to Margaret Gennaro, M.D.) or credit card (MasterCard, Visa and Discover).

PLEASE DO NOT WEAR FRAGRANCES OR ANY PERSONAL ITEMS THAT ARE PERFUMED. We have staff and patients at the office who are chemically sensitive. Thank you.

My practice is in Mosby Tower, 10560 Main Street, Suite 301 (3rd Floor), Fairfax, VA 22030. Leave extra time at peak hours of travel. Directions by car are attached. If you need directions if you are lost or late, please call 703-865-5692.

CANCELLATION POLICY:
If you need to cancel, please give me 48 hours notice.
If I do not find a replacement for you, my policy is to charge a fee for the missed appointment.

Date_____ **MARGARET GENNARO, M.D.** **Adult Intake Form**

**Patient's Name** _____ **Email** _____
Last First Middle

**Address** _____
Street City State Zip

**Home Phone (  )** _____ **Work Phone (  )**_____**Cell Phone (  )**_____

**Date of Birth** _____ **Marital Status** _____ **# of Children** _____ **Social Security #** _____

**If patient is a minor, give parent's or guardian's name** _____

**Name of nearest relative not living with you** _____

**Address**_____ **Phone** _____
Street City State Zip

**How did you hear about our office?** _____

## Responsible Party Information – Patient is responsible for bill, your insurance may reimburse you.

**Patient's Name** _____
**(or parent, if minor)** Last First Middle

**Address** _____
Street City State Zip

**Home Phone** _____ **Work Phone** _____ **Email** _____

**Birthdate**_____ **Social Security #** _____ **Relationship to Patient** _____

**Employer Name / Address** _____

**Spouse's Name** _____
Last First Middle

**Employer Name / Address** _____

## CONSENT

**I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1- ½ % finance charge (18% APR) may be added to my account.**

**Patient Signature** _____ **Date** _____

**Parent or Responsible Party Signature** _____ **Relationship** _____

**INTAKE FORM FOR ADULT** **NAME: _____**

Chief health complaint: (what is your main reason for coming in today? When did you notice your condition?) _____

_____

_____

_____

What kind of treatment have you received and from whom? _____

_____

_____

What have **you** done to relieve your condition? (Herbs, vitamins, diet, etc. Has it helped?) _____

_____

_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist, homeopath or other non-traditional health-care provider for your main complaint? [ ] No [ ] Yes

Or for any other problem? [ ] No [ ] Yes

What was the therapy and what were the results? _____

_____

What is the general state of your health? [ ] Excellent [ ] Good [ ] Average [ ] Fair [ ] Poor

On average, describe your energy level 1 – 10 ( 1= lowest & 10 = highest): _____

When during the day is your energy best? _____ Worst? _____

What is your current approximate weight? _____ Height? _____ Weight 1 year ago? _____

As an adult what has been your maximum _____ and minimum weight _____ (Not Pregnant)

Please list the 4 most significant, stressful events in your life, from the most recent to the most distant.

Are any of these continuing to impact your life? (circle: yes or no)

1. _____ Date:_____ Yes or No
2. _____ Date:_____ Yes or No
3. _____ Date:_____ Yes or No
4. _____ Date:_____ Yes or No

What childhood disease have you had?

| | | | |
|---|---|---|---|
| ____ measles | ____ mumps | ____ chickenpox | |
| ____ whooping cough | ____ polio | ____ diphtheria | ____ rheumatic fever |
| ____ scarlet fever | ____ smallpox | ____ typhoid fever | ____ tuberculosis |
| ____ mono, how long? _____ | | | |

Please list all surgeries and hospitalizations including approximate dates. (Do not include normal deliveries.)

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____
5. _____ Date:_____

_____ Check here if you have had more than 5 hospitalizations

_____ Check here if you have received a blood transfusion, when? _____

Which of the following have you had and indicate "now or past" & also when/how often.

| | | |
|---|---|---|
| ____ pneumonia _____ | ____ diabetes _____ | ____ chronic infections _____ |
| ____ tonsillitis _____ | ____ asthma _____ | ____ migraines/headaches _____ |
| ____ eczema _____ | ____ ear infection_____ | ____ venereal disease _____ |
| ____ gonorrhea _____ | ____ heart disease _____ | ____ thyroid problems _____ |
| ____ syphilis _____ | ____ herpes _____ | ____ high blood pressure _____ |
| ____ allergies _____ | ____ hepatitis _____ | ____ manic/depression _____ |
| ____ seizures _____ | ____ anemia _____ | ____ weight problems _____ |
| ____ mono _____ | ____ depression _____ | ____ schizophrenia _____ |
| ____ stroke _____ | ____ arthritis _____ | ____ hypoglycemia _____ |
| ____ concussion _____ | ____ other, list _____ | |

Do you have any allergies to drugs, herbs, foods, animals or others? [ ] No [ ] Yes, what? _____

_____

Date of last menstrual period? _____ [ ] Normal [ ] Abnormal

How many "silver" fillings do you have? _____ How many root canals? _____

Test and Immunizations (check those you have had. Enter the year when last taken/given and results if known)

____ chest x-ray _____

____ kidney tests _____

____ G.I. series _____

____ colon x-ray _____

____ gallbladder test _____

____ E.K.G./E.C.G. _____

____ T.B. test _____

____ sigmoidoscopy _____

____ mammogram _____

____ pap smear _____

____ E.E.G. (brain wave test) _____

____ C.T. scan (of what?) _____

____ Thyroid blood tests _____

____ Rectal exam (<u>for men over 40</u>) _____ PSA (prostate blood test) _____

____ CBC/SMAC _____

____ Urinalysis _____

____ tetanus shot _____

____ polio series _____

____ flu shots _____

____ hepatitis shot _____

____ measles _____

____ mumps _____

Which of the following do you currently use? (amount, how often and how long)

| | |
|---|---|
| ____ alcohol _____ | ____ tobacco _____ |
| ____ hormones _____ | ____ coffee/tea _____ |
| ____ cortisone _____ | ____ laxatives _____ |
| ____ sedatives _____ | ____ antacids _____ |
| ____ pain killers _____ | ____ diet pills _____ |

Other medications (give full name and dosage and how long have you been taking):

1. _____ Length:_____
2. _____ Length:_____
3. _____ Length:_____
4. _____ Length:_____
5. _____ Length:_____

Vitamins/herbs:

1. _____ Length:_____
2. _____ Length:_____
3. _____ Length:_____
4. _____ Length:_____
5. _____ Length:_____

## Family History

Please list ages, health problems and if deceased, cause of death:

| | Living (age?) | Health problems | Died (age?) | Cause |
|---|---|---|---|---|
| Your mother | _____ | _____ | _____ | _____ |
| Your father | _____ | _____ | _____ | _____ |
| Your brothers | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Your sisters | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Mother's Mom | _____ | _____ | _____ | _____ |
| Mother's Dad | _____ | _____ | _____ | _____ |
| Father's Mom | _____ | _____ | _____ | _____ |
| Father's Dad | _____ | _____ | _____ | _____ |

What is your nationality? (please list all background and give approximate %) _____

_____

Who do you currently live with? [ ] spouse [ ] partner [ ] parent(s) [ ] friends [ ] children [ ] alone

Are you? [ ] married [ ] divorced [ ] widowed [ ] single [ ] in a supportive relationship

What is your current level of education? _____ Are you satisfied with this? [ ] Yes [ ] No

Do you have children? [ ] No [ ] Yes, how many _____alive _____deceased

For women – how many? ____ miscarriages ____ abortions ____ stillbirths
Did you ever have? ____ toxemia ____ excessive nausea/vomiting

Do you have any blood relative (aunt, uncle, grandparent) who has had the following?

[ ] allergies [ ] arthritis [ ] asthma [ ] cancer [ ] diabetes [ ] anemia [ ] depression
[ ] skin disease [ ] heart attack [ ] high B. P. [ ] stroke [ ] sickle cell [ ] cataracts [ ] genetic problems
[ ] seizures [ ] ulcers [ ] venereal disease [ ] hypoglycemia [ ] schizophrenia
[ ] manic-depression [ ] other, _____

## Occupation/household

How long have you lived at your present address? _____

Where have you lived previously? _____

Please describe location, if old or new place, i.e., new construction, damp or moldy. _____

_____

Do you have specialized air filtration at home? [ ] No [ ] Yes Do you live in a city? [ ] No [ ] Yes

Do you work in a building ? [ ] No [ ] Yes Do the windows open? [ ] No [ ] Yes

Do you have specialized air filtration at work? [ ] No [ ] Yes

Do you work in the presence of toxic fumes or chemical? [ ] No [ ] Yes, what _____

Do any of your hobbies involve toxic materials? [ ] No [ ] Yes

If you are a non-smoker, are you exposed to second hand smoke currently? [ ] No [ ] Yes In the past? [ ] No [ ] Yes

What do you use for your drinking water? [ ] bottled [ ] filtered [ ] tap water

## Personal Habits

What do you enjoy the most in your life? _____

_____

What are your main interests or hobbies? _____

_____

What do you worry about most? _____

Do you currently exercise? [ ] No [ ] Yes, what kind, how much & how often? _____

_____

Do you have a spiritual affiliation or practice? [ ] No [ ] Yes, what? _____

How important is your spiritual life to you? (1 = not important 10 = very important) _____

Do you have problems falling or staying asleep? [ ] No [ ] Yes How many hours do you sleep a night? _____

How many times a week, on average, do you wake up refreshed? _____

Do you nap or rest horizontally during the day? [ ] No [ ] Yes, for how long? _____

If you work, do you enjoy your work? [ ] No [ ] Yes If no, explain _____

_____

Do you take vacations? [ ] No [ ] Yes

Do you meditate or do relaxation exercises regularly? [ ] No [ ] Yes, what _____

Have you traveled to many countries (for work, pleasure or military) Which? (give approximate dates) _____

_____

Diet: Is your diet primarily American food? [ ] No [ ] Yes If no, list anything unusual about your diet _____

_____

Please add anything else you feel is important:

# Symptom Survey Form

**INSTRUCTIONS:** Number the boxes, which apply to you. Use **(1) for MILD** symptoms (occur once or twice a year), **(2) for MODERATE** symptoms (occur several times a year), and **(3) for SEVERE** symptoms (you are aware of it almost constantly).

## Group One

1 [ ] Acid foods upset
2 [ ] Get chilled, often
3 [ ] "Lump" in throat
4 [ ] Dry mouth-eyes-nose
5 [ ] Pulse speeds after meal
6 [ ] Keyed up – fail to calm
7 [ ] Cuts heal slowly
8 [ ] Gag easily
9 [ ] Unable to relax; startles easily
10 [ ] Extremities cold, clammy
11 [ ] Strong light irritates
12 [ ] Urine amount reduced
13 [ ] Heart pounds after retiring
14 [ ] "Nervous" stomach
15 [ ] Appetite reduced
16 [ ] Cold sweats often
17 [ ] Fever easily raised
18 [ ] Neuralgia-like pains
19 [ ] Staring, blinks little
20 [ ] Sour stomach frequent

## Group Two

21 [ ] Joint stiffness after arising
22 [ ] Muscle-leg-toe cramps at night
23 [ ] "Butterfly" stomach, cramps
24 [ ] Eyes or nose watery
25 [ ] Eyes blink often
26 [ ] Eyelids swollen, puffy
27 [ ] Indigestion soon after meals
28 [ ] Always seems hungry; feels "lightheaded" often
29 [ ] Digestion rapid
30 [ ] Vomiting frequent
31 [ ] Hoarseness frequent
32 [ ] Breathing irregular
33 [ ] Pulse slow; feels "irregular"
34 [ ] Gagging reflex slow
35 [ ] Difficulty swallowing
36 [ ] Constipation, diarrhea alternating
37 [ ] "slow starter"
38 [ ] Get "chilled" infreqeuntly
39 [ ] Perspire easily
40 [ ] Circulation poor, sensitive to cold
41 [ ] Subject to colds, asthma and bronchitis

## Group Three

42 [ ] Eat when nervous
43 [ ] Excessive appetite
44 [ ] Hungry between meals
45 [ ] Irritable before meals
46 [ ] Get "shaky" if hungry
47 [ ] Fatigue, eating relieves
48 [ ] "Lightheaded" if meals are delayed
49 [ ] Heart palpitates if meals are missed or delayed
50 [ ] Afternoon headaches
51 [ ] Overeating sweets upsets
52 [ ] Awaken after few hours of sleep - hard to get back to sleep
53 [ ] Crave candy or coffee in the afternoons
54 [ ] Moods of depression – "blues" or melancholy
55 [ ] Abnormal craving for sweets or snacks

## Group Four

56 [ ] Hands and feet go to sleep easily, numbness
57 [ ] Sigh frequently, "air hunger"
58 [ ] Aware of "breathing heavily"
59 [ ] High altitude discomfort
60 [ ] Opens windows in closed room
61 [ ] Susceptible to cold and fevers
62 [ ] Afternoon "yawner"
63 [ ] Get "drowsy" often
64 [ ] Swollen ankles worse at night
65 [ ] Muscle cramps, worse during exercise; get "charley horses"
66 [ ] Shortness of breath on exertion
67 [ ] Dull pain in chest or radiating into left arm, worse on exertion
68 [ ] Bruise easily, "black and blue" spots
69 [ ] Tendency to anemia
70 [ ] "Nose bleeds" frequent
71 [ ] Noises in head or "ringing in ears"
72 [ ] Tension under the breastbone, or feeling of "tightness", worse on exertion

## Group Five

73 [ ] Dizziness
74 [ ] Dry skin
75 [ ] Burning feet
76 [ ] Blurred vision
77 [ ] Itching skin and feet
78 [ ] Excessive falling hair
79 [ ] Frequent skin rashes
80 [ ] Bitter, metallic taste in mouth in mornings
81 [ ] Bowel movements painful/difficult
82 [ ] Worries, feels insecure
83 [ ] Feeling queasy, headache over eyes
84 [ ] Greasy foods upset
85 [ ] Stools light-colored
86 [ ] Skin peels on foot soles
87 [ ] Pain between shoulder blades
88 [ ] Use laxatives
89 [ ] Stools alternate from soft to watery
90 [ ] History of gallbladders attacks of gallstones
91 [ ] Sneezing attacks
92 [ ] Dreaming, nightmare type - bad dreams
93 [ ] Bad breath (halitosis)
94 [ ] Milk products cause distress
95 [ ] Sensitive to hot weather
96 [ ] Burning or itching anus
97 [ ] Crave sweets

## Group Six

98 [ ] Loss of taste for meat
99 [ ] Lower bowel gas several hours after eating
100 [ ] Burning stomach sensations, eating relieves
101 [ ] Coated tongue
102 [ ] Pass large amounts of foul-smelling gas
103 [ ] Indigestion ½ - 1 hour after eating; may be up to 3 – 4 hours
104 [ ] Mucous colitis or irritable bowel
105 [ ] Gas shortly after eating
106 [ ] Stomach "bloating" after eating

## Group Seven

**(A)**

107 [ ] Insomnia
108 [ ] Nervousness
109 [ ] Can't gain weight
110 [ ] Intolerance to heat
111 [ ] Highly emotional
112 [ ] Flush easily
113 [ ] Night sweats
114 [ ] Thin, moist skin
115 [ ] Inward trembling
116 [ ] Heart palpitations
117 [ ] Increased appetite without weight gain
118 [ ] Pulse fast at rest
119 [ ] Eyelids and face twitch
120 [ ] Irritable and restless
121 [ ] Can't work under pressure

**(B)**

122 [ ] Increase in weight
123 [ ] Decrease in appetite
124 [ ] Fatigue easily
125 [ ] Ringing in ears
126 [ ] Sleepy during the day
127 [ ] Sensitive to cold
128 [ ] Dry or scaly skin
129 [ ] Constipation
130 [ ] Mental sluggishness
131 [ ] Hair coarse, falls out
132 [ ] Headaches upon arising wear off during the day
133 [ ] Slow pulse
134 [ ] Frequency in urination
135 [ ] Impaired hearing

**(C)**

137 [ ] Failing memory
138 [ ] Low blood pressure
139 [ ] Increased sex drive
140 [ ] Headaches, "splitting or rending" type
141 [ ] Decreased sugar tolerance

**(D)**

142 [ ] Abnormal thirst
143 [ ] Bloating of abdomen
144 [ ] Weight gain around hips or waist
145 [ ] Sex drive reduced or lacking
146 [ ] Tendency to ulcers, colitis
147 [ ] Increased sugar tolerance
148 [ ] Women: menstrual disorders
149 [ ] Young girls: lack of menstrual function

**(E)**

150 [ ] Dizziness
151 [ ] Headaches
152 [ ] Hot flashes
153 [ ] Increased blood pressure
154 [ ] Hair growth on face or on body (female)
155 [ ] Sugar in urine (not diabetes)
156 [ ] Masculine tendencies (female)

**(F)**

157 [ ] Weakness, dizziness
158 [ ] Chronic fatigue
159 [ ] Low blood pressure
160 [ ] Nails weak, ridged
161 [ ] Tendency to get hives
162 [ ] Arthritic tendencies
163 [ ] Perspiration increase
164 [ ] Bowel disorders
165 [ ] Poor circulation
166 [ ] Swollen ankles
167 [ ] Crave salt
168 [ ] Brown spots or bronzing of skin
169 [ ] Allergies – tendency to asthma
170 [ ] Weakness after colds, influenza
171 [ ] Exhaustion - muscular and nervous
172 [ ] Respiratory disorders

## Female Only

173 [ ] Very easily fatigued
174 [ ] Premenstrual tension
175 [ ] Painful menses
176 [ ] Depressed feelings before menstruation
177 [ ] Menstruation excessive and prolonged
178 [ ] Painful breasts
179 [ ] Menstruate too frequently
180 [ ] Vaginal discharge
181 [ ] Hysterectomy/ovaries removed
182 [ ] Menopausal hot flashes
183 [ ] Menses scanty or missed
184 [ ] Acne, worse at menses
185 [ ] Depression of long standing

## Male Only

186 [ ] Prostate trouble
187 [ ] Urination difficult or dribbling
188 [ ] Night urination frequent
189 [ ] Depression
190 [ ] Pain on inside of legs or heels
191 [ ] Feeling of incomplete bowel evacuation
192 [ ] Lack of energy
193 [ ] Migrating aches and pains
194 [ ] Tire too easily
195 [ ] Avoids activity
196 [ ] Leg nervousness at night
197 [ ] Diminished sex drive

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## Important

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

I certify the information on this form is correct to the best of my knowledge. I will not hold Dr. Gennaro or any members of her staff responsible for nay errors or omissions that I may have made.

_____ _____
Patient or Guardian Signature Date

_____ _____
Reviewed by Date

# Margaret Gennaro, M.D.

## New Patient Informed Consent

Some of the characteristic qualities of complementary medicine that are used in this practice include the following:

1. A person's lifestyle including his or her diet, exercise patterns, sleep habits and stresses are believed to be directly related to the development and maintenance of illness. Complementary medicine evaluates these factors and seeks to help the patient give up negative lifestyle patterns and establish more positive ones regardless of age or type of medical program.

2. Although prescription and over-the counter medications are used when the physician believes it is necessary, an attempt is first made to use products that are natural to the body. These include nutritional supplements such as vitamins, minerals, enzymes, amino acids, essential fatty acids and herbs.

3. In addition to recommending that a patient take nutritional supplements by mouth, we frequently recommend that a patient receive a series of injections either intravenously or by intramuscular injection. Some of the reasons for recommending this procedure include the assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorption problems) and achieving high concentration of the substances in the bloodstream, which may be difficult if the substance is taken by mouth.

4. I look for imbalances in the body and for trends that may result in an illness if not addressed. I sometimes order tests that may be considered by mainstream medicine to be either unnecessary or of no value. These may include tests for nutritional status, such as blood levels of vitamins and minerals, hormone levels or blood tests for allergies.

5. I believe that environmental factors may play a major role in health and disease. Some of the diseases of unknown cause may be triggered or perpetuated by common environmental substances, many of which are manmade. Individuals may vary greatly in their susceptibility to various substances, so that one individual may be made deathly ill by an exposure to a substance while another is not at all affected. I attempt to identify offending substances and help patients to detoxify from past exposures that are affecting them.

6. I very much believe in persons being involved in their own health care and encourage questions, exploration and participation in decisions surrounding diagnostic and treatment procedures. I encourage consultations with consensus mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues.

7. Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.

**The above represents some of the ways our practice may differ from other physicians' offices that you have visited. You should also be aware of the following points:**

8. My practice is exclusively office based. I do not work in a hospital. Additionally, some patients come long distances to receive care at my office. Consequently, I STRONGLY RECOMMEND that in addition to our care you maintain a relationship with one or more physicians appropriate to your condition and situation. For example, most of you may want to have a relationship with a family physician or pediatrician in the case of children. Cardiac patients should have either a cardiologist or an internist or both. I am happy to cooperate with any physician who is willing to work with me.

9. I make no representations, claims or guarantees that you will be helped with your medical problems or conditions by undergoing treatment here. However, I will do my best to help you accomplish your health care and wellness goals.

10. In my office, I make available nutritional supplements and other recommended products. Many of these products are not available through retail outlets or the quality is superior to retail brands. These are provided for the convenience of our patients. You are in no way obligated to purchase these products from this office. You are free to purchase any recommended supplements or other products from any source that you chose.

11. Most health insurance plans today have clauses which limit coverage to "usual and customary fees for reasonable and necessary services." Because many of the treatments used in complementary medicine are not recognized by consensus mainstream medicine, I cannot guarantee the amount or availability of coverage for my services and treatments under your health care insurance policy. You are responsible for the payments of my invoices without regard to insurance

coverage. You are entitled to know the cost of all service and procedures in advance. Please ask if they are not told to you.

I have read, understand and agree to the foregoing. I understand that I have the right to review this Consent with a lawyer if I choose before accepting any medical services from Margaret Gennaro, M.D. I have executed this Consent freely and willingly understand its provisions. I recognize that Margaret Gennaro, M.D. will rely upon my signing of this document in accepting me as a patient.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian (if patient is minor): _____

**Statement of Understanding**

I do hereby acknowledge that by signing this Statement of Understanding that I understand that some and perhaps all of the medical, preventive, nutritional and diagnostic services provided by Margaret Gennaro, M.D. on or after the date of my signing this statement may be innovative, nontraditional or unconventional. (Definition: services that are not necessarily recognized by traditional medicine, some physicians, some 3rd party purveyors of the AMA, as acceptable testing/evaluation techniques and/or medical and nutritional recommendations or therapies.)*

I also understand that these unconventional services may be viewed by 3rd party insurance purveyors as non-covered services, in that they might be considered unreasonable or unnecessary under the Medicare program or any other medical insurance program.

I also realize that my insurance coverage may not pay for such uncovered services and that I will be personally responsible for payment to Margaret Gennaro, M.D. for all such non-covered services.

Should it be necessary for Margaret Gennaro, M.D. to take action for the purpose of recovering any sum of money owed for services rendered, I understand that I will pay all costs including responsible attorney fees, should that become necessary. I understand that all outstanding balances bear interest at the maximum rate allowable by law.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian (if patient is minor): _____

*Definition of innovative, non-traditional or unconventional: Services: preventive nutritional, homeopathic and naturopathic evaluation and therapies, acupuncture & traditional Chinese medicine; health risk assessment; immune stimulating therapy; magnetic and electromagnetic evaluation and therapy; specialized food and immune antibody assessments; body composition analysis; hyperbaric oxygen therapy; hair analysis; gastrogram; blood analysis for vitamins, minerals, amino acids and other specialized studies; oral and intravenous therapies, including chelating or metabolic techniques; counseling; massage and colon irrigation therapies and electro-stimulating therapies.

Please initial (acknowledgement of above): _____

DIRECTIONS TO MARGARET GENNARO, M.D.
The Mosby Tower
10560 Main Street, Suite 301, Fairfax, VA
703-865-5692

**Coming from the Beltway (495) north and from D.C.:**

Take 66 West to exit 60 which is Route 123 South (Chain Bridge Rd).
Once you get off the exit, you will come to a light. Go through the light and proceed 0.9 miles and make a right onto North Street (236 West).
Stay in the right lane as North Street immediately becomes Main Street.
In 0.1 miles, make a right into The Mosby Tower parking lot.
Take the elevator to the 3rd Floor. Make a right off of the elevator and walk down the corridor to Suite 301 which is the last door on your right.

**Coming from Route 50 West of Office:**

Take Route 236 Eastbound (Main Street).
Pass Judicial Drive on your right and make a left after Railroad Avenue into The Mosby Tower parking lot.
Take the elevator to the 3rd Floor. Make a right off of the elevator and walk down the corridor to Suite 301 which is the last door on your right.

**Coming from Route 50 East of Office:**

Take Route 50 Westbound and make a left onto Route 123 South (Follow directions above).

**Coming from Richmond:**

Take 95 North to 495 West (toward Tyson's Corner).
Take 66 West to Exit 60 (123 South, Chain Bridge Road).
(Follow directions above).