

CENTER FOR NATURAL MEDICINE

Introductory Patient Information

2828 S. Arlington Road
Akron, Oh 44312

Phone: 330-644-7246

Fax: 330-644-9292

Web site
www.balanceyourchemistry.com

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PATIENT CHECKLIST

DID YOU REMEMBER TO?

- Read all of our documents
- Obtain your medical records and/or test results from previously seen physicians and have them sent to **[YOUR ADDRESS]**

FILL OUT AND/OR SIGN THE FOLLOWING FORMS

- Important Patient Information
- Authorization for Release of Medical Information
- General Information
- Health Goals Form
- Functional Diagnostic Medicine Questionnaire
- Nutrition and Lifestyle Questionnaire
- Review of systems
- Environmental Influences Questionnaire
- Patient Readiness Form
- Nutritional Assessment Questionnaire
- Diet Diary

Thank you

FREQUENTLY ASKED QUESTIONS

Do you think you can help me with my health problem?

Our clinic uses an innovative approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by your doctor, having blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that all your tests are normal yet both you and your doctor know that you are anything but normal!. Unfortunately this experience is all too common.

Most physicians are trained to look only in specific places for the answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found in these places. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies and metabolic imbalances. New gene testing can uncover underlying genetic predispositions that can be modified through diet, lifestyle, supplements or medications.

We use a variety of innovative testing techniques and procedures to help our patients prevent illness and recover from many chronic and difficult to treat conditions. Our clinicians are highly skilled in evaluating, assessing and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, memory problems and other chronic, complex conditions. We also focus on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

Can all the tests I need be done at this clinic?

Most of the testing can be performed at this clinic. Some testing can be done through conventional laboratories and others are only available through specialty laboratories. During your consultation, we will determine which tests are needed and then our office assistants can review the testing recommendations, the instructions (e.g. fasting or non-fasting, etc.) and costs. Some testing can be performed at home with test kits to collect urine, saliva or stool. Others may require you to go to a local laboratory to draw the blood. In all cases, we will assist you in coordinating initial and follow-up testing.

Occasionally, we may recommend certain tests that are not performed at our facility. In those instances, we can provide you with an order that you can take to a facility near your home or we can schedule an appointment to have them done near our office.

Do you take insurance?

We do not accept insurance or Medicare and we do not file insurance paperwork on your behalf. However, we will provide a detailed receipt for services performed for you to submit to your insurance carriers. Some insurance carriers may partially cover medical services and laboratory tests performed by the physicians. Payment in full by check, cash or credit card is due at the time services are provided.

What credit cards do you accept?

We accept the following credit cards: MasterCard, Visa, Discover and American Express. If you like we can maintain an active credit card on file at the office so we can bill follow-up consultations, laboratory testing, and other services.

CENTER FOR NATURAL MEDICINE

Consent Forms

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Akron, Oh 44312

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IMPORTANT PATIENT INFORMATION

This page must be filled out. Then you must print this page and fax it to our office.

Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is the **Center for Natural Medicine's** opinion that you should be well informed on our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, the **Center for Natural Medicine** would appreciate that you read the below steps and provide your signature. This would simply imply that you have read the *Patient Acceptance Policy* and understand what is expected of you.

1. **Completion of the following forms:**

- The Health Questionnaires**
- The Nutritional Assessment Questionnaire** This 322 question questionnaire was developed to gather important information about your body. It will help the **Center for Natural Medicine** assist in helping you. The medical questionnaire will allow the **Center for Natural Medicine** to quickly “zero” in on the probable causes of your health problems.
- The Diet Diary**

It is **VERY** important for you to carefully and thoroughly complete all of these forms and questionnaires prior to your first consultation with the **Center for Natural Medicine**. Once the **Center for Natural Medicine** has received your completed forms, our office will schedule your first consultation

2. **Medical Records** from all physicians since you were **first diagnosed** with your health condition **MUST** be obtained prior to scheduling an appointment.
3. Once the **Center for Natural Medicine** has your completed questionnaires and copies of all your medical records, a one-hour appointment will be scheduled. The cost for the one-hour appointment as well as the **Center for Natural Medicine's** time for reviewing your medical questionnaire, medical records and written report is **\$225.00**
4. Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain **comprehensive blood chemistry**. The blood chemistry test will include:
- Comprehensive Executive Metabolic Panel**, which includes 24 important disease markers such as SGOT, SGPT, GGT, Bilirubin (Liver), BUN, Creatinine, Uric (Kidney), Alkaline Phosphatase (Bone)
 - Cardiovascular Panel:** Cholesterol, Triglycerides, LDL, HDL, Cholesterol/HDL Ratio, LDL/HDL Ratio,
 - Thyroid Panel:** TSH Free T3, and Free T4,
 - Magnesium**
 - CBC differential:** White Blood Cells and Red Blood Cells, Platelets

Based on your medical history, questionnaire, medical records and initial consultation, it may be necessary to order additional medical laboratory tests. You will be presented with detailed

information on the **specific tests recommended**. The cost for your initial Laboratory tests will be discussed at that time. **Payment can be made via check and/or credit card**. We accept Visa Master Card, Discover, and American Express. If you have not had a physical examination within the last year or since the start of your most recent health problem, it is required to either schedule an appointment with the **Center for Natural Medicine** or with your primary physician.

5. The results of your lab tests may take approximately **three weeks**, at which point, you will be scheduled for a follow- up appointment. This appointment usually takes approximately one to one and half hours. It is recommended that you have your spouse or a supportive family member attend this appointment.
6. Your treatment may consist of dietary and lifestyle changes as well as herbs, supplements, which must be paid at the time of purchase. The supplements must be purchased at the clinic or on the website www.balanceyourchemistry.com If you plan on purchasing your supplements from another source then I will not accept you as a client.
7. It is strongly recommended that you have access to a computer with Internet Connection. **A progress medical questionnaire** will be posted to your e-mail one week before your next scheduled appointment. Completion of the progress questionnaire is required every 6-12 weeks to monitor your progress. Correspondence by e-mail is strongly encouraged and is **Free of Charge**. If you do not have access to the internet, then a copy of the progress questionnaire will be mailed or faxed. If you would prefer to schedule an appointment to discuss any questions, you may do so either on [practice day] or [practice day].
8. Follow-up consultations will be scheduled every **week for the first month** allowing you the opportunity to discuss your progress and any concerns with the **Center for Natural Medicine**. The **Center for Natural Medicine** will at this time determine what direction to take to help you continue your progress. Your cooperation in taking **“personal responsibility”** in your health care will go a long way in getting better. Consultations can be conducted either by phone or in person (at the office). The fee for follow-up consultations is **\$4.00 per minute**.
9. **Abnormal laboratory tests** will need to be re-evaluated. The success of your treatment will not only be measured on the reduction of elimination of your physical symptoms, but on abnormal laboratory tests returning to a normal status.
For example: Many physicians will prescribe Lipitor for individuals suffering with high cholesterol. Your physician will also require periodic cholesterol blood tests to monitor the success of the medication. Laboratory fees can vary depending on what needs to be re-tested.

I,(name) have read and fully understand the **Patient Acceptance Policy**

_____ By writing yes in the previous space I have read and agree to the **Patient Acceptance Policy**

Patient Signature

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This page must be filled out. Then you must print this page and fax it to our office. This must be filled out and printed for each doctor you have seen for your condition. Fax each one to our office.

Requesting Records of Doctor:

Name of Facility or Doctor:

Address:

Telephone number:

Fax number:

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to the **Center for Natural Medicine** all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information. I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: Yes No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: Yes No

Genetic Testing Yes No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release the **Center for Natural Medicine**; its employees, agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name:

D.O.B.

Signature:

Date:

PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE ALONG WITH THE COMPLETED AND SIGNED FORM

Records Requested by:

Center for Natural Medicine Dr. Keith Ungar

Address: 2828 S. Arlington Rd. Akron, Oh 44312

Telephone number (330) 644-7246 Fax Number (330) 644-9292

Signature: _____

CENTER FOR NATURAL MEDICINE

Health Questionnaires

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Akron, Oh 44312

Phone: 330-644-7246

Fax: 330-644-9292

Web site

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Center for Natural Medicine

GENERAL INFORMATION

Name

Preferred Name

Date

Address

City

State

Zip Code

Home Phone

Work Phone

Cell Phone

Email

Age

Date of Birth

Place of birth

Gender: female male

Married Separated Divorced Widowed Single Partnership

Right Handed: Left Handed: Mixed Dominance:

Number of Sisters: (# deceased:) # of Brothers: (# deceased:) Birth Order:

Occupation Hours per week Retired

Nature of Business

How did you hear about our clinic? Book Website Media Friend/ family member

Other

Has any other family member already been a patient at the clinic?

Next of Kin or other to reach in an emergency

Relationship

Phone

Address

Genetic Background: Please check appropriate box(es):

African American Hispanic Mediterranean Asian

Native American Caucasian Northern European Other

Who is your primary medical physician?

Primary medical physician address & office phone #

PERSONAL DESCRIPTIVE INFORMATION

Marital status:

- Single
 Married
 Divorced
 Widow
 Long Term Partnership

List Children:

Child's Name	Age	Gender

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
 Example: Wendy, age 7, sister

Do you have any pets or farm animals? Yes No

If yes, where do they live? Indoors Outdoors Both indoors and outdoors

Have you ever lived or travelled outside the United States? Yes No

If so, when and where?

Have you or your family recently experienced any major life changes? Yes No

If yes, please comment:

Have you experienced any major losses in life? Yes No

If so, please comment:

How much time have you lost from work or school in the past year?

- 0-2 days
 3 –14 days
 > 15 days

Previous jobs:

Please list your highest level of education:

- High School
 College _____ Major: _____ Year: _____
 Graduate School _____ Field: _____ Year: _____
 Professional School _____ Field: _____ Year: _____
 Did you have learning problems?

Functional Diagnostic Medicine Questionnaire

Please complete the following Functional Medicine Questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help the doctor evaluate the root cause of your health concerns and determine an effective treatment program.

Note that we are interested in so-called minor symptoms as well as major problems. We know that in many doctor's offices there is some tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. The rules in our office are different. We are interested in any odd or unusual message you are getting from your body, even though it may be considered irrelevant to "making a diagnosis" or it may seem to you to be of no consequence to your health. Some such symptoms are useful clues in the kind of "medical detective work" we do. Please include as much information as you can on this form.

Please print or write legibly.

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

What diagnosis or explanation have been given to you?

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel **worse**?

What makes you feel **better**?

Please list all physicians you have seen for the above health conditions:

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Please check all the Alternative Treatments you have tried for your condition(s)

- | | | | |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Massage | <input type="checkbox"/> Yoga | <input type="checkbox"/> Environmental medicine |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Rolfing | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Nutritional Therapy |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Reiki | <input type="checkbox"/> Ayurveda | <input type="checkbox"/> Biological Dentistry |
| <input type="checkbox"/> Iridology | <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Light therapy | <input type="checkbox"/> IV (chelation) therapy |
| <input type="checkbox"/> Colonics | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Meditation | <input type="checkbox"/> Naturopathic medicine |

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES	Date	Date	Date	Comments
Chicken Pox				
German Measles				
Measles				
Mononucleosis				
Mumps				
Whooping cough				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue Syndrome				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
Hugh blood pressure				
Irritable bowel				
Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				
ILLNESSES	Date	Date	Date	Comments
Sleep apnea				

Stroke				
Thyroid disease				
Other (describe)				
INJURIES	Date	Date	Date	Comments
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES	Date	Date	Date	Comments
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan of Abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone Density Test				
Carotid Artery Ultrasound				
Blood Tests				
Other (describe)				
OPERATIONS	Date	Date	Date	Comments
Tonsillectomy				
Tubes in Ears				
Appendectomy				
Gall Bladder				
Hernia				
Hysterectomy				
Dental Surgery				
Other (describe)				
Other (describe)				

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

PATIENT BIRTH HISTORY

Question	Yes	No	Don't Know	Comment
Were you a full term baby?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
A Premie?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Forcep delivery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cesarean section?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epidural used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breast fed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bottle fed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
When your mother was pregnant with you, did she:				
Smoke tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Take estrogen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

CHILDHOOD HEALTH HISTORY

Question	Yes	No	Don't Know	Comment
Did you live in an area with soft water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hard water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
As a child, did you consume a lot of the following:				
Sugar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Candy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sweet foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Soda?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diet soda?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Question	Yes	No	Don't Know	Comment
White bread?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cookies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Ice Cream?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meat, vegetable & potato/rice/pasta diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vegetarian & grain based diet with little meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vegetarian diet with milk & eggs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vegetarian diet without milk & eggs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

As a child, were there any foods that you had to avoid because they gave you symptoms? Yes No

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

AGE OF ONSET OF ILLNESSES

Please indicate which, if any, of the following problems/conditions developed when you were a child (ages birth to age12) by indicating the approximate age of onset.

- | | |
|---|----------------------------|
| Frequent colds or flu | Tonsillitis |
| Bronchitis | Ear Infections |
| Measles | Mumps |
| Chicken Pox | Whooping Cough |
| Strep Infections | Seasonal allergies |
| Significant dental work | Behavior problems |
| ADD | Hyperactivity |
| Difficulty learning: | Frequent headaches |
| High # of absences from school | Upset stomach, indigestion |
| Jaundice | Colic |
| Ear infections | Congenital abnormalities |
| Premature at birth | Pneumonia |
| Fever blisters | Parent (s) smoked |
| Abusive or alcoholic parent (s) | Skin disorders (eczema) |
| Major illness(s) that required hospitalization. | |

If yes, please explain your illness:

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:

- | | |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Measles |

- Diphtheria
- Pertussis
- Polio (oral)
- Polio (Injection)

- Rubella (German measles)
- Typhoid
- Cholera

FEMALE MEDICAL HISTORY (for women only)

OBSTETRICS HISTORY Check box if yes and provide number of

- | | | |
|---|---|---|
| <input type="checkbox"/> Pregnancies | <input type="checkbox"/> Caesarean | <input type="checkbox"/> Vaginal deliveries |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Abortion | <input type="checkbox"/> Living Children |
| <input type="checkbox"/> Post partum depression | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Gestational diabetes |
| <input type="checkbox"/> Baby over 8 pounds | <input type="checkbox"/> Breast feeding For how long? | |

GYNECOLOGICAL HISTORY

Age at 1st period: Menses Frequency: Length: Pain: Yes No

Clotting: Yes No Has your period skipped? Yes No For how Long?

Last Menstrual Period:

Do you currently use contraception? Yes No If yes, what type do you use?

- Condom Diaphragm IUD Partner vasectomy

Have you ever used hormonal contraception? Yes No If yes, when

Use of hormonal contraception: Birth control pills Patch Nuva Ring How long?

Are you using the pill now? Yes No Did taking the pill agree with you? Yes No

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes No

Last Mammogram

Breast Biopsy/Date

Last PAP Test: Normal Abnormal

Date of last Bone Density: Results: High Low Within normal range

Are you in menopause? Yes No Age at Menopause

Do you take: Estrogen Ogen Estrace Premarin Other

Progesterone Provera Other

How long have you been on hormone replacement?

FAMILY HISTORY

(Place mark any health problem(s) your family has suffered with either now or in the past)

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	GrandmotherMaternal	Maternal Grandfather	GrandmotherPaternal	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALS or other Motor Neuron Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Diseases (such as Lupus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clotting problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies, Sensitivities, Intolerances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	GrandmotherMaternal	Maternal Grandfather	GrandmotherPaternal	Paternal Grandfather	Aunts	Uncles	Other
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous breakdown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse (such as alcoholism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other family history we should know about? Yes No

If yes, please comment:

What is the attitude of those close to you about your illness? Supportive Non-supportive

ESTABLISHING HEALTH GOALS

Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve in your visit with us?

If you had a magic wand and could erase three problems, what would they be?

- 1.
- 2.
- 3.

Have you made the decision to change? To do what it takes to get well?

Yes

No

I have read something interesting: ***“The definition of insanity is to keep doing the same thing and expecting different results”***. If you keep following the same course of treatment you have been following will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they're made the decision to change. But how many people have truly decided to change? Very few! Why? Because there is a big difference between deciding something and having “reasons” to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

List up to 5 things that you have been unable to do as a result of your present symptoms. Please be specific.

List up to 5 things that you plan to do once you are feeling better. Please be specific.

Are there any other health goals you want to achieve?



HAVE YOU COMPLETED THE LAST SECTION?

IF NOT, PLEASE GO BACK AND ANSWER ALL THE QUESTIONS!

PLEASE DO NOT SKIP THIS SECTION!!

**GIVE CAREFUL THOUGHT TO WHY YOU WANT TO GET BETTER AND
HOW IT WOULD AFFECT YOUR LIFE!**

REVIEW OF SYSTEMS

Check only those items with which you identify, **past or present**. Ignore anything that does not apply to you.

GENERAL

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Night Walker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted Vision

SKIN:

- Cuts Heal slowly
- Bruise Easily
- Rash
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Cracking skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Have bumps on the back of arms and front of thighs
- Skin Cancer
- Strong body odor

Is your skin sensitive to the:

- Sun
- Fabrics
- Detergents

HEAD:

- Poor Concentration
- Confusion
- Headaches
- After Meals
- Severe
- Migraine
- Frontal

- Afternoon
- Occipital
- Afternoon
- Daytime
- Relieved by:
- Eating Sweets
- Concussion/Whiplash
- Mental Sluggishness
- Forgetfulness
- Indecisive
- Face Twitch
- Poor Memory
- Hair Loss

EYES:

- Sand in Eyes
- Double Vision
- Blurred Vision
- Poor Night Vision
- Bright Flashes
- Halo around Lights
- Eye Pains
- Dark Circles under Eyes
- Strong Light Irritates
- Cataracts
- Floaters in Eyes
- Visual hallucinations

EARS:

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss
- Itching
- Pressure
- Wear a hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing Hallucinations

NOSE/SINUSES

- Stuffy
- Bleeding
- Running
- Discharge
- Watery Nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes No

If yes, is it worse in the:

- Spring
- Summer

- Fall
- Winter

MOUTH:

- Coated Tongue
- Sore Tongue
- Teeth Problems
- Bleeding Gums
- Canker Sores
- TMJ
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

THROAT:

- Mucus
- Difficulty Swallowing
- Frequent Hoarseness
- Tonsillitis
- Enlarged Glands
- Constant clearing of throat
- Throat closes up

NECK:

- Stiffness
- Swelling
- Lumps
- Neck glands swell

CIRCULATION/RESPIRATION:

- Swollen Ankles
- Sensitive to Hot
- Sensitive to Cold
- Extremities Cold or Clammy
- Hands/Feet go to sleep/numb
- High Blood Pressure
- Chest Pain
- Pain between shoulders
- Dizziness upon standing
- Fainting Spells
- High Cholesterol
- High Triglycerides
- Wheezing
- Irregular Heartbeat
- Palpitations
- Low exercise tolerance
- Frequent coughs
- Breathing heavily
- Frequently Sighing
- Shortness of breath
- Night Sweats
- Varicose Veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema

- Croup
- Frequent colds
- Heavy/tight chest
- Past Heart Attack ?? When
- Phlebitis
- Spider Veins

GASTROINTESTINAL/DIGESTION

- Peptic/Duodenal Ulcer
- Poor Appetite
- Excessive Appetite
- Gallstones
- Gallbladder pain
- Nervous Stomach
- Full Feeling after meal
- Indigestion
- Heartburn
- Acid Reflux
- Hiatal Hernia
- Nausea
- Vomiting
- Vomiting Blood
- Abdominal Pains/Cramps
- Gas
- Diarrhea
- Constipation
- Changes in Bowels
- Rectal Bleeding
- Tarry Stools
- Rectal Itching
- Use laxatives
- Bloating
- Belch frequently
- Anal itching
- Anal fissures
- Bloody stools
- Undigested food in stools

KIDNEY/URINARY TRACT:

- Burning
- Frequent Urination
- Blood in Urine
- Night time Urination
- Problem Passing Urine
- Kidney Pain
- Kidney Stones
- Painful Urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas

WOMEN'S HISTORY (for women only)

- Fibrocystic Breasts
- Lumps in breast
- Fibroid Tumors/Breast
- Spotting
- Heavy Periods
- Fibroid Tumors/Uterus
- Painful periods
- Change in period
- Breast soreness before period

- Endometriosis
- Non-period bleeding
- Breast soreness during period
- Vaginal Dryness
- Vaginal discharge
- Had partial/total hysterectomy
- Hot Flashes
- Mood Swings
- Concentration/Memory Problems
- Breast cancer
- Ovarian cysts
- Pregnant
- Infertility
- Decreased Libido
- Heavy Bleeding
- Joint Pains
- Headaches
- Weight Gain
- Loss of Control of Urine
- Palpitations

MEN'S HISTORY (for men only)

Have you had a PSA done?

Yes No

PSA Level:

- 0 – 2
- 2 – 4
- 4 – 10
- >10
- Prostate enlargement
- Prostate infection
- Change in libido
- Impotence
- Diminished libido
- Poor libido
- Infertility
- Lumps in testicles
- Sore on penis
- Genital pain
- Hernia
- Prostate cancer
- Low sperm count
- Difficulty Obtaining Erection
- Difficulty Maintaining an Erection
- Nocturia (urination at night)
- How many times at night?
- Urgency/Hesitancy/Change in Urinary Stream
- Loss of Control of Urine

JOINT/MUSCLES/TENDONS

- Pain wakes me up
- Weakness in Legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle Stiffness in Morning
- Damp weather bothers you

EMOTIONAL:

- Convulsions
- Dizziness
- Fainting Spells

- Blackouts
- Amnesia
- Had shock therapy
- Frequently keyed up and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Forgetful
- Listless
- Withdrawn feeling
- Feel "lost" in time
- Had nervous breakdown
- Had "burnout"
- Feel groggy
- Unable to concentrate
- Short attention span
- Vision changes
- Unable to reason
- Considered a nervous person
- Worried over little things
- Anxiety
- Unusual tension
- Frustration
- Numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Been admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Aggressive
- Misunderstood by others
- Irritable
- Easily flare in anger
- Feeling of hostility
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide

- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

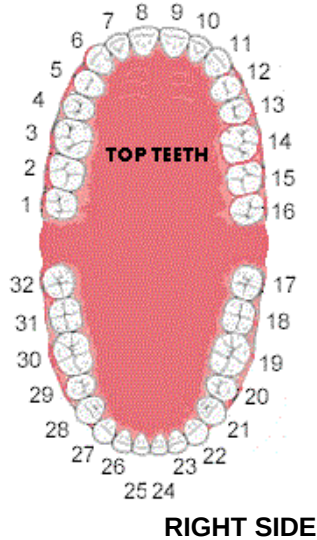
DENTAL HISTORY

- Have you had sore gums (gingivitis) often over the years? Yes No
- Has ringing in the ears (tinnitus) been present? Yes No
- Have TMJ (temporal mandibular joint) problems been a concern? Yes No
- Do you often have a 'metallic' taste in your mouth? Yes No
- Do you have a lot of bad breath (halitosis) or white tongue (thrush)? Yes No
- Have you worn or do you presently wear braces? Yes No
- Do you have problems chewing? Yes No
- Do you floss regularly? Yes No
- Did your mother have dental fillings prior to giving birth to you? Yes No
- Did you have fillings as a child? Yes No
- If yes, about how many fillings did you have up to 18 yrs?
- Did you have dental fillings as an adult? Yes No
- If yes, about how many fillings did you have after to 18 yrs?
- How many amalgam fillings do you have now?
- Did you play with mercury as a child or adult? Yes No
- Have you eaten a lot of fish in your life? Yes No

List the approximate age and the type of dental work done from childhood until present:

Age	Describe Dental Work	Health Problems following dental work? (describe)

Please check the tooth or teeth you have had or still have problems with. Add comments to type of problem you have had, for example: root canal, crown, abscessed tooth, partials, etc. and indicate which teeth have fillings.



RECORD ANSWERS:

- | | |
|--|--|
| 1. <input type="checkbox"/> Comments: | 17. <input type="checkbox"/> Comments: |
| 2. <input type="checkbox"/> Comments: | 18. <input type="checkbox"/> Comments: |
| 3. <input type="checkbox"/> Comments: | 19. <input type="checkbox"/> Comments: |
| 4. <input type="checkbox"/> Comments: | 20. <input type="checkbox"/> Comments: |
| 5. <input type="checkbox"/> Comments: | 21. <input type="checkbox"/> Comments: |
| 6. <input type="checkbox"/> Comments: | 22. <input type="checkbox"/> Comments: |
| 7. <input type="checkbox"/> Comments: | 23. <input type="checkbox"/> Comments: |
| 8. <input type="checkbox"/> Comments: | 24. <input type="checkbox"/> Comments: |
| 9. <input type="checkbox"/> Comments: | 25. <input type="checkbox"/> Comments: |
| 10. <input type="checkbox"/> Comments: | 26. <input type="checkbox"/> Comments: |
| 11. <input type="checkbox"/> Comments: | 27. <input type="checkbox"/> Comments: |
| 12. <input type="checkbox"/> Comments: | 28. <input type="checkbox"/> Comments: |
| 13. <input type="checkbox"/> Comments: | 29. <input type="checkbox"/> Comments: |
| 14. <input type="checkbox"/> Comments: | 30. <input type="checkbox"/> Comments: |
| 15. <input type="checkbox"/> Comments: | 31. <input type="checkbox"/> Comments: |
| 16. <input type="checkbox"/> Comments: | 32. <input type="checkbox"/> Comments: |

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

Oral Steroids: How often have you taken oral steroids (e.g. Prednisone, Cortisone, etc.)?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

Indicate any medications you're currently taking or have taken in the last month:

- | | |
|---|--|
| <input type="checkbox"/> Acid Blocking Drugs | <input type="checkbox"/> Diuretics |
| <input type="checkbox"/> Anti-anxiety medications | <input type="checkbox"/> Estrogen or progesterone (pharmaceutical, prescription) |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Estrogen or progesterone (natural) |
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Heart medications |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> High blood pressure medications |
| <input type="checkbox"/> Anti-fungals | |

Have your medications or supplements ever caused you unusual side effects or problems?
Yes No If yes, please describe:

ALLERGIES	
Medication/Supplement/Food	Reaction

NUTRITION & LIFESTYLE HISTORY

Have you made any changes in your eating habits because of your health? Yes No

Do you currently follow a special diet or nutritional program? Yes No

Check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Low fat | <input type="checkbox"/> Gluten restricted | <input type="checkbox"/> The Zone Diet |
| <input type="checkbox"/> Mixed food diet (animal and vegetable sources) | <input type="checkbox"/> Low sodium | <input type="checkbox"/> Total calorie restriction |
| <input type="checkbox"/> High protein | <input type="checkbox"/> Fat restriction | <input type="checkbox"/> Ovo-lacto diet |
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Low starch/carbohydrate | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> The Blood type Diet | <input type="checkbox"/> No dairy |
| <input type="checkbox"/> Specific Program for Weight Loss/Maintenance Type: | <input type="checkbox"/> Metabolic Typing Diet | <input type="checkbox"/> No wheat |

Please check any specific food restrictions you have:

- | | | |
|--------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Wheat | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Corn | <input type="checkbox"/> All gluten |
| <input type="checkbox"/> Other | | |

Is there anything special about your diet that I should know?

Height (feet/inches)

Current Weight

Usual weight range +/- 5 lbs

Desired Weight range +/- 5 lbs

Highest adult weight

Lowest adult weight

Weight fluctuations (>10lbs) Yes No

Body Fat %

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Are there any foods that you avoid because they give you symptoms? Yes No

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

If you could only eat a few foods a week, what would they be?

Do you grocery Shop? Yes No If no, who does the shopping?

When you shop do you purchase the following?

- Organic Foods Hormone free and antibiotic free meat

Do you read food labels? Yes No

Do you Cook? Yes No If no, who does the cooking?

How many meals do you eat out per week? 0-1 1-3 3-5 >5

Check all the factors that apply to our current lifestyle and eating habits:

- | | |
|--|---|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Significant other or family members have special dietary needs or food preferences |
| <input type="checkbox"/> Erratic eating habits | <input type="checkbox"/> Love to eat |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Late night eater | |

- | | |
|---|---|
| <input type="checkbox"/> Dislike health food | <input type="checkbox"/> Have a negative relationship to food |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Struggle with eating issues |
| <input type="checkbox"/> Eat more than 50% of meals away from home | <input type="checkbox"/> Emotional eater (eat when sad, lonely, depressed, bored) |
| <input type="checkbox"/> Travel frequently | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Non-availability of healthy foods | <input type="checkbox"/> Eat too little under stress |
| <input type="checkbox"/> Do not plan meals or menus | <input type="checkbox"/> Don't care to cook |
| <input type="checkbox"/> Reliance on convenience items | <input type="checkbox"/> Eating in the middle of the night |
| <input type="checkbox"/> Poor snack choices | <input type="checkbox"/> Confused about nutritional advise |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | <input type="checkbox"/> Diet often for weight control |

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Bacon/Sausage	<input type="checkbox"/> Butter	<input type="checkbox"/> Beans (legumes)
<input type="checkbox"/> Bagel	<input type="checkbox"/> Coffee	<input type="checkbox"/> Brown rice
<input type="checkbox"/> Butter	<input type="checkbox"/> Eat in a cafeteria	<input type="checkbox"/> Butter
<input type="checkbox"/> Cereal	<input type="checkbox"/> Eat in restaurant	<input type="checkbox"/> Carrots
<input type="checkbox"/> Coffee	<input type="checkbox"/> Fish sandwich	<input type="checkbox"/> Coffee
<input type="checkbox"/> Donut	<input type="checkbox"/> Fried foods	<input type="checkbox"/> Fish
<input type="checkbox"/> Eggs	<input type="checkbox"/> Hamburger	<input type="checkbox"/> Green vegetables
<input type="checkbox"/> Fruit	<input type="checkbox"/> Hot dogs	<input type="checkbox"/> Juice
<input type="checkbox"/> Juice	<input type="checkbox"/> Juice	<input type="checkbox"/> Margarine
<input type="checkbox"/> Margarine	<input type="checkbox"/> Leftovers	<input type="checkbox"/> Milk
<input type="checkbox"/> Milk	<input type="checkbox"/> Lettuce	<input type="checkbox"/> Pasta
<input type="checkbox"/> Oat bran	<input type="checkbox"/> Margarine	<input type="checkbox"/> Potato
<input type="checkbox"/> Sugar	<input type="checkbox"/> Mayo	<input type="checkbox"/> Poultry
<input type="checkbox"/> Sweet roll	<input type="checkbox"/> Meat sandwich	<input type="checkbox"/> Red meat
<input type="checkbox"/> Sweetener	<input type="checkbox"/> Milk	<input type="checkbox"/> Rice
<input type="checkbox"/> Tea	<input type="checkbox"/> Pizza	<input type="checkbox"/> Salad
<input type="checkbox"/> Toast	<input type="checkbox"/> Potato chips	<input type="checkbox"/> Salad dressing
<input type="checkbox"/> Water	<input type="checkbox"/> Salad	<input type="checkbox"/> Soda
<input type="checkbox"/> Wheat bran	<input type="checkbox"/> Salad dressing	<input type="checkbox"/> Sugar
<input type="checkbox"/> Yogurt	<input type="checkbox"/> Soda	<input type="checkbox"/> Sweetener
<input type="checkbox"/> Oat meal	<input type="checkbox"/> Soup	<input type="checkbox"/> Tea
<input type="checkbox"/> Milk protein shake	<input type="checkbox"/> Sugar	<input type="checkbox"/> Vinegar
<input type="checkbox"/> Slim fast	<input type="checkbox"/> Sweetener	<input type="checkbox"/> Water
<input type="checkbox"/> Carnation shake	<input type="checkbox"/> Tea	<input type="checkbox"/> White rice
<input type="checkbox"/> Soy protein	<input type="checkbox"/> Tomato	<input type="checkbox"/> Yellow vegetables
<input type="checkbox"/> Whey protein	<input type="checkbox"/> Vegetables	<input type="checkbox"/> Other: (List below)
<input type="checkbox"/> Rice protein	<input type="checkbox"/> Water	
<input type="checkbox"/> Other: (List below)	<input type="checkbox"/> Yogurt	
	<input type="checkbox"/> Slim fast	
	<input type="checkbox"/> Carnation shake	
	<input type="checkbox"/> Protein shake	

Check foods/drinks that you consume a minimum of 3 days or more each week.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Almonds | <input type="checkbox"/> Corn | <input type="checkbox"/> Mexican Food | <input type="checkbox"/> Sour cream |
| <input type="checkbox"/> Almond Butter | <input type="checkbox"/> Crab | <input type="checkbox"/> Malt | <input type="checkbox"/> Soybean |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cranberry | <input type="checkbox"/> Nutmeg | <input type="checkbox"/> Spinach |
| <input type="checkbox"/> Apples | <input type="checkbox"/> Cashew | <input type="checkbox"/> NutriSweet | <input type="checkbox"/> Strawberry |
| <input type="checkbox"/> Avocado | <input type="checkbox"/> Cheese | Oatmeal, Regular | <input type="checkbox"/> Sucralose |
| <input type="checkbox"/> Asparagus | <input type="checkbox"/> Cucumber | <input type="checkbox"/> Oatmeal, Instant | <input type="checkbox"/> Sugar |
| <input type="checkbox"/> Bagels | <input type="checkbox"/> Deli Meats | <input type="checkbox"/> Olive | <input type="checkbox"/> Sunflower |
| <input type="checkbox"/> Barley | <input type="checkbox"/> Desserts | <input type="checkbox"/> Onion | <input type="checkbox"/> Salad Bar |
| <input type="checkbox"/> Banana | <input type="checkbox"/> Deli Sandwich | <input type="checkbox"/> Orange Juice | <input type="checkbox"/> Sardines |
| <input type="checkbox"/> Burger King | <input type="checkbox"/> Eggplant | <input type="checkbox"/> Oregano | <input type="checkbox"/> Squash |
| <input type="checkbox"/> Bacon | <input type="checkbox"/> Ensure | <input type="checkbox"/> Oyster | <input type="checkbox"/> Taco bell food |
| <input type="checkbox"/> Bean, Lima | <input type="checkbox"/> Flounder | <input type="checkbox"/> Orange | <input type="checkbox"/> Tea, Black |
| <input type="checkbox"/> Bread, White | <input type="checkbox"/> Fried Foods | <input type="checkbox"/> Papaya | <input type="checkbox"/> Tea, |
| <input type="checkbox"/> Bread, Wheat | <input type="checkbox"/> French Fries | <input type="checkbox"/> Parsley | Decaffeinated |
| <input type="checkbox"/> Bread, Rye | <input type="checkbox"/> French Toast | <input type="checkbox"/> PopTarts | <input type="checkbox"/> Thai food |
| <input type="checkbox"/> Bagels | <input type="checkbox"/> Garlic | <input type="checkbox"/> Peanuts | <input type="checkbox"/> Tomato |
| <input type="checkbox"/> Biscuits | <input type="checkbox"/> Ginger | <input type="checkbox"/> Peanut butter | <input type="checkbox"/> Trout |
| <input type="checkbox"/> Bean, Pinto | <input type="checkbox"/> Grape | <input type="checkbox"/> Peas | <input type="checkbox"/> Tuna |
| <input type="checkbox"/> Bean, String | <input type="checkbox"/> Grits | <input type="checkbox"/> Peach | <input type="checkbox"/> Turkey |
| <input type="checkbox"/> Broccoli | <input type="checkbox"/> Greek Food | <input type="checkbox"/> Pecan | <input type="checkbox"/> Tangerine |
| <input type="checkbox"/> Brazil Nuts | <input type="checkbox"/> Grapefruit | <input type="checkbox"/> Pepper | <input type="checkbox"/> Vinegar |
| <input type="checkbox"/> Brussels | <input type="checkbox"/> Grape nuts | <input type="checkbox"/> Pepper, Green | <input type="checkbox"/> Walnut |
| Sprouts | <input type="checkbox"/> Haddock | <input type="checkbox"/> Perch | <input type="checkbox"/> Waffles |
| <input type="checkbox"/> Blueberries | <input type="checkbox"/> Ham | <input type="checkbox"/> Pineapple | <input type="checkbox"/> Whitefish |
| <input type="checkbox"/> Butter | <input type="checkbox"/> Halibut | <input type="checkbox"/> Pancakes | <input type="checkbox"/> Wheat |
| <input type="checkbox"/> Cabbage | <input type="checkbox"/> Herring | <input type="checkbox"/> Protein Shakes, | <input type="checkbox"/> Wendy's food |
| <input type="checkbox"/> Cereal, | <input type="checkbox"/> Hot Dogs, Pork | Soy | <input type="checkbox"/> Yeast, Bakers |
| Special K | <input type="checkbox"/> Hot Dogs, Beef | <input type="checkbox"/> Protein Shakes, | <input type="checkbox"/> Yeast, |
| <input type="checkbox"/> Cereal, Bran | <input type="checkbox"/> Hamburgers | Milk | Brewers |
| flakes | <input type="checkbox"/> Hardies Food | <input type="checkbox"/> Protein Shakes, | <input type="checkbox"/> Yogurt |
| <input type="checkbox"/> Cereal, | <input type="checkbox"/> Honey | Whey | <input type="checkbox"/> Yam |
| Cornflakes | <input type="checkbox"/> Italian Food | <input type="checkbox"/> Protein Shakes, | <input type="checkbox"/> Zucchini |
| <input type="checkbox"/> Cereal, | <input type="checkbox"/> Ice Cream | | |
| <input type="checkbox"/> Cereal, | <input type="checkbox"/> Indian Food | <input type="checkbox"/> Protein Shakes, | |
| <input type="checkbox"/> Celery | <input type="checkbox"/> Jack in the box | | |
| <input type="checkbox"/> Cantaloupe | food | <input type="checkbox"/> Plum | |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Japanese Food | <input type="checkbox"/> Pork | |
| <input type="checkbox"/> Chinese Food | <input type="checkbox"/> Jelly | <input type="checkbox"/> Peanut | |
| <input type="checkbox"/> Cream | <input type="checkbox"/> Ketchup | <input type="checkbox"/> Potato, sweet | |
| Cheese | <input type="checkbox"/> Lamb | <input type="checkbox"/> Potato, White | |
| <input type="checkbox"/> Carrot | <input type="checkbox"/> Lemon | <input type="checkbox"/> Pumpkin | |
| <input type="checkbox"/> Chicken | <input type="checkbox"/> Lentil | <input type="checkbox"/> Quinoa | |
| <input type="checkbox"/> Chili Pepper | <input type="checkbox"/> Lettuce | <input type="checkbox"/> Radish | |
| <input type="checkbox"/> Cinnamon | <input type="checkbox"/> Lime | <input type="checkbox"/> Rye | |
| <input type="checkbox"/> Clam | <input type="checkbox"/> Lobster | <input type="checkbox"/> Safflower | |
| <input type="checkbox"/> Cloves | <input type="checkbox"/> Mackerel | <input type="checkbox"/> Sage | |
| <input type="checkbox"/> Cocoa- | <input type="checkbox"/> Margarine | <input type="checkbox"/> Salt | |
| Chocolate | <input type="checkbox"/> McDonalds Food | <input type="checkbox"/> Salmon | |
| <input type="checkbox"/> Carnation | <input type="checkbox"/> Millet | <input type="checkbox"/> Scallops | |
| Drink | <input type="checkbox"/> Mung Bean | <input type="checkbox"/> Sausage | |
| <input type="checkbox"/> Chewing gum, | <input type="checkbox"/> Mushroom | <input type="checkbox"/> Slim Fast | |
| sweetened | <input type="checkbox"/> Mustard | <input type="checkbox"/> Sweet & Low | |
| <input type="checkbox"/> Chewing gum, | <input type="checkbox"/> Milk, Cow | <input type="checkbox"/> Sesame | |
| sugar free | <input type="checkbox"/> Milk, Goat | <input type="checkbox"/> Shrimp | |
| <input type="checkbox"/> Coconut | <input type="checkbox"/> Milk, Rice | <input type="checkbox"/> Snapper | |
| <input type="checkbox"/> Cod | <input type="checkbox"/> Milk, Almond | <input type="checkbox"/> Soft Drinks | |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Milk, Soy | <input type="checkbox"/> Sole | |

What snacks do you eat or drink between:

Breakfast & Lunch:

Lunch & Dinner:

After Dinner:

How much of the following do you consume each day/week?

ITEM	Daily	Weekly	Favorite Type
Candy			
Cheese			
Chocolate			
Cups of caffeine containing coffee			
Cups of decaffeinated coffee or tea			
Cups of hot chocolate			
Cups of caffeine containing tea			
Diet sodas (12-ounce can/bottle)			
Sodas with caffeine (12-ounce can/bottle)			
Sodas without caffeine (12-ounce can/bottle)			
Energy Drinks (12-ounce can/bottle)			
Ice cream			
Salty foods			
Slices of white bread (rolls/bagels)			

Water: Glasses/day **Type:** Tap: Distilled: Spring: Well: Reverse Osmosis:

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?

Yes No If yes, please explain:

If yes, are these symptoms associated with a particular food or supplement(s)? Yes No

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes No

Do you feel **worse** when you eat a lot of:

- | | |
|---|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods
(breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| | Other |

Do you feel **better** when you eat a lot of:

- | | |
|---|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods
(breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| | Other |

Does skipping meals greatly affect your symptoms? Yes No

Has there ever been a food that you have craved or really “pigged out” on over a period of time?

Yes No If yes, what food(s)

Do you have an aversion to certain foods? Yes No

If yes, what food(s)

The most important thing I should change about my diet to improve my health is:

TOBACCO HISTORY

Currently using tobacco? Yes No How many years? Packs per day:

If yes, what type? Cigarette Smokeless Cigar Pipe Patch/Gum

Attempts to quit:

Previous smoking: How many years? Packs per day:

Are you exposed to 2nd hand smoke? If yes, please explain:

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None 1-3 4-6 7-10 >10 *If none skip to “Other Substances”*

Previous alcohol intake? Yes (Mild Moderate High)

Have you ever been told to cut down your alcohol intake? Yes No

Do you get annoyed when people ask you about your drinking? Yes No

Do you ever feel guilty about your alcohol consumption? Yes No

Do you ever take an eye-opener? Yes No

Do you notice a tolerance to alcohol (can you “hold” more than others?) Yes No

Have you ever been unable to remember what you did during a drinking episode? Yes No

Do you get into arguments or physical fights when you have been drinking? Yes No

Have you ever been arrested or hospitalized because of drinking? Yes No

Have you ever thought about getting help to control or stop your drinking? Yes No

Was your mother an alcoholic? Yes No Father? Yes No

Other family member?

OTHER SUBSTANCES

Are you currently using recreational drugs? Yes No

If yes, what types?:

Have you ever used IV or inhaled recreational drugs? Yes No

If yes, what types?:

EXERCISE

Current Exercise program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Other (Pilates, yoga, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading etc.)			

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity:

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe:

Do you usually sweat when exercising? Yes No

SOCIAL HISTORY

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No

Do you feel your life has meaning and purpose? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No

Have you experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations?

Yes No

Would you describe your experience as a child in your family as happy and secure? Yes No

STRESS/COPING

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

Did you feel safe growing up? Yes No

Have you ever been involved in abusive relationships in your life? Yes No

Was alcoholism or substance abuse present in your childhood home? Yes No

Is alcoholism or substance abuse present in your relationships now? Yes No

Have you ever sought counseling? Yes No

Currently? Yes No Previously? Yes No If previously from _____ to _____

What kind?

Comments:

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

Daily stressors: Rate on a scale of 1 – 10 (1 not stressful - 10 very stressful)

Work Family Social Finances Health Other

Do you practice meditation or relaxation techniques? Yes No How often?

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other

Hobbies and leisure activities:

How important is religion (or spirituality) for you and your family's life?

a. not at all important b. somewhat important c. extremely important

Have you ever been abused, a victim of a crime, or experienced a significant trauma?

Yes No

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With close friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your boyfriend/girlfriend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which of the following provide you emotional support? *Check all that apply*

Spouse Family Friends Religious/Spiritual Pets Other

STRESS EVALUATION

This section of the questionnaire is an assessment of stressors and related stress symptoms and complaints. The questions have assigned scores/point values. To obtain score, multiply points (column 1) by duration (column 2). Add the scores of each section and make a note at the bottom under total score.

Symptom	Score	Duration (years)			Score
<input type="checkbox"/> Excessive Fatigue	10	½	1	2	
<input type="checkbox"/> Dry & Thin Skin	10	½	1	2	
<input type="checkbox"/> Nervous/Irritability	9	½	1	2	
<input type="checkbox"/> Low body temperature	8	½	1	2	
<input type="checkbox"/> Premenstrual tension	8	½	1	2	
<input type="checkbox"/> Inability to concentrate	8	½	1	2	
<input type="checkbox"/> Mental depression	8	½	1	2	
<input type="checkbox"/> Food allergies & sensitivities	7	½	1	2	
<input type="checkbox"/> Craving for sweets	7	½	1	2	
<input type="checkbox"/> Headaches	6	½	1	2	
<input type="checkbox"/> Alcohol intolerance	6	½	1	2	
<input type="checkbox"/> Poor memory	5	½	1	2	
<input type="checkbox"/> Heart palpitations	5	½	1	2	
TOTAL SCORE					

Do you have chronic pain? Yes No

Do you have chronic inflammation? Yes No

SOCIAL READJUSTMENT RATING SCALE*

Circle YES or NO to each life event in this list that happened in the last twelve months. For every "Yes" that applies, give yourself the points as listed. Upon completion, total the score and enter in box below.

Life Event	Answer		Points
Death of spouse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	100
Divorce	<input type="checkbox"/> Yes	<input type="checkbox"/> No	73
Marital seperation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	65
Jail term	<input type="checkbox"/> Yes	<input type="checkbox"/> No	63
Death of close family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No	63
Personal injury or illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	53
Marriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	50
Fired from work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	47
Marital reconciliation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	45
Retirement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	45
Change in family members health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	44
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	40
Sex difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Addition to family	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Business readjustment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Change in financial status	<input type="checkbox"/> Yes	<input type="checkbox"/> No	38
Death of close friend	<input type="checkbox"/> Yes	<input type="checkbox"/> No	37
Change in line of work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	36
Change in # of marital arguements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	35
Mortgage or loan over \$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	31
Foreclosure of mortgage or loan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	30
Change in work responsibilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Son or daughter leaving home	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Trouble with in-laws	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Outstanding personal achievement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	28
Spouse begins or stops work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26

Starting or finishing school	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26
Change in living conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	25
Revision of personal habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	24
Trouble with boss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	23
Change in work hours, conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in residence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in recreational habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19
Mortgage or loan under \$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18
Change in sleeping habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16
Change in eating habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15
Vacation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	13
TOTAL SCORE			

* Holmes, TH and Rahe, RH Booklet for Schedule of Recent Experience (SRE) Seattle, University of Washington, 1967

TOXIC STRESS TRIGGERS

(These refer to on-going stress that has accumulated over months or years. Please mark any of the above that you have experienced in your lifetime)

- Childhood traumas
- Perfectionism
- Divorce or change in a relationship
- Care giving: *taking care of a sick family member*
- Job or career challenges
- Illness, either short-term or chronic
- Dieting: *constantly trying a new and improved diet program*
- Menopause

DO YOU WORRY OVER?

- Home life
- Marriage
- Children
- Job
- Income

IS YOUR LIFE:

- Satisfactory
- Boring
- Demanding
- Unsatisfactory
- Money Problems

SLEEP/REST

Average number of hours you sleep >10 8 – 10 6 – 8 <6

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No

Do you use sleeping aids? Yes No Explain:

ENVIRONMENTAL INFLUENCES

There are over 70,000 chemicals commercially produced in the United States. The long-term effects of many of these chemicals have never been investigated. But many chemicals are harmful in very low doses. Unless generated by the body (formaldehyde, pentane), the body's level for chemicals should be non-detectable, and not "low level". Chemicals are widespread in our environment, and constant exposure to low levels can cause dysfunction in many systems of the body. The purpose in the following questions is to determine if any of your health problems can be a result of chemical toxicity and to measure your **TOTAL TOXIN LOAD**.

Electromagnetic Factors

Live or have you lived within 200 yards from high-voltage wires or transformers
When?

Live or have lived near an electric distribution substation

Bed is close to the main electrical current

Have a fan directly over your bed

Have an alarm clock or radio close to your bed (plugged in)

Live or have you lived near a television transmitter

Sleep with an electric blanket, heating pad

Sleep on a waterbed

Position of your head of your bed is facing:

North

South

East

West

Work on a computer for longer than six hours/day

Use a screening shield over your computer screen

Live or have you lived near a power generating station

Live near a radio tower

You use a cellular phone more than 2 hours per day

Use microwave ovens

Bed has a wooden backboard

Have fluorescent light fixtures

What is your occupation?

Toxin Exposure

Trichloroethylene/TCE

Work close to a copy machine

Worked in a printing shop

Drink decaffeinated coffee

Use typewriter correction fluid

Use rug cleaners

Use disinfectants

Use carbonless paper

Use spot removers

Use cleaning supplies

Use metal degreasers

Do recreational painting

Formaldehyde

Wear many dry-cleaned clothes

Noticed changes of your health since you moved into your home

Wear many polyester clothes and permanent press

You use Spray Starch

Have foam wall insulation

Have particleboard, chip board or interior plywood

Put up wallpaper in the last 2 years

Have foam cushions or foam mattresses

Live or lived in a trailer

Worked in a laboratory

Your home been insulated since your illness

Had new carpets.

When?

Use waxes and polishes on your floor

Been around resin glues and plastics

Have exterior grade plywood on your home

Home made of stucco, plaster or concrete

Have a wood-burning stove

Have draperies

- Have used acid-cured resin floor finishes
- Have fire-proof material in your home
- Smoke in your home
- Have a photography darkroom
- Use nail polish remover
- Use fingernail hardeners

Pesticides & Herbicides

(Organochlorines, Organophosphate, Carbamate, Chlorinated Cyclodiene, Botanical & Microbial)

- Use pesticides
- Use weed killer
- You use cleaning fluids, waxes
- Lived or worked at a dry cleaning plant
- Have been around wood preservatives
- Drink tap water
- Work with electrical equipment
- Have mothballs in your closets
- Gasoline fumes bother you
- Eat store bought meat
- Use insecticides
- Crop-surface sprays
- Aerosols
- Fumigants

Volatile Organic Compounds

(Paradichlorobenzenes, toluene, ethers, ketones, propane, polymers, tetrachloroethylene)

- Had home painted in the last 2 years
- Use cleaning solvents
- Have soft vinyl floors
- Handle propane and butane
- Get your clothes dry-cleaned
- Store dry-cleaned clothes in closets
- Barbecue more than 2 times per month
- Work in a "tightly sealed building"
- Work close to a laser printer
- Use moth balls
- Have nylon carpet
- Use air fresheners
- Have a workshop in the home

Phenols

Do you use the following?

- Household cleaners
- Nasal Sprays
- Styrofoam cups
- Cough Syrup
- Decongestants
- Hair sprays
- Scented deodorants
- Scotch tape
- Newsprint
- Lysol
- Epoxy
- Listerine
- Chloraseptic throat sprays
- Noxema
- Mildew cleaners
- Perfumes
- Air Fresheners
- Disinfectants
- Polishes
- Glues
- Waxes
- Mouthwash
- Hard saucepan handles
- Smoke in the house
- Have you been exposed to chemicals?
When?
- Have you had your home treated for termites
When?
- Wash own vehicle by hand.
What type of cleaners do you use?

Carbon Monoxide/Nitrogen Oxide/Sulfur Dioxide

- Have oil or gas stove
- Have water heaters
- Chimney is damaged
- Live near a busy street
- Garage attached to your home
- Smoke at home
- Have an open fireplace

Ozone

- Use an electrical sewing machine
- Use power tools

- Use ion generators
- Work close to a photocopier

Carbon Dioxide

- Work in a crowded work place
- Have poor ventilation at work

Asbestos

- Live in an old home
- Have old ceiling tiles, plaster, insulation board and heating duct tape
- Lived in a large city with many trucks, buses etc.
- Lived near a building which was torn down
- Mother exposed to any unusual chemicals or drugs during pregnancy (DES)
- Do you have your nails treated? Acrylic Adhesives

Please note the "brand" of product you use

For example: Toothpaste: Crest

Shampoo:

Toothpaste:

Hair Conditioner:

Makeup:

Lipstick:

Make-up Foundation:

Deodorant:

Perfume:

Hairspray:

Shaving Cream:

Cologne:

Facial Creams:

Body Creams:

Do you have hair permanents? Yes No
If yes, how often?

Do you have hair colorings? Yes No
If yes, was it permanent temporary?

Do you use Latex products?

- Baby bottle nipples
- Balloons
- Bandages
- Diaphragms
- Hot water bottles
- Latex gloves
- Dishwashing gloves

- Rubber dams for dental work
- Tires
- Worked in a rubber industry

General Miscellaneous

- Have basement Molds
- Home is damp
- Use a humidifier? If yes, when the last time you cleaned it?
- Use black hair dye (Nitrosamines)
- Worked in beauty shop.
When?
- Take any illicit drugs as an adolescent/young adult?
What type?
- Open your windows at home
- Work in a machine shop
- Work in a garden?
- Work or have you worked on a farm
When?
- Have mercury fillings
- Had mercury fillings removed? When?
- Been exposed to radiation
When?
- Have a hot tub
- Use chlorine or bromine
- Have a well
- Work around PVC pipe (Vinyl chloride)
- Home well ventilated
- Moved to a new office in the last two years
- Live in an apartment?
How old?
- Eat at salad bars
- Eat raw fish (Sushi)
- Buy food from street vendors
- For Women:** Have breast implants. The implant was made of saline silicone
- Has any type of metal been used in implants or joint replacements in your body?
What type?
Where
- Notice more symptoms at work than at home or vice versa?
- Symptoms worse going into a mall
- Have you ever worked in a mall?
When?

- Have live plants in your home
- Have pets in your home
- Owned a new vehicle since your symptoms began
- Furniture been put in storage or possibly fumigated
- Stained furniture in the last 2 years
- Have a tool shop in your garage
- Live on or near a golf course
- Live in or near an industrial area
- Lived or traveled outside the US.

Where?

- Bought new furniture?

What type of material?

- Installed drop ceilings
- Painted indoors
- Sided your home
- Changed your heating system, stove, clothes dryer or water heater
- Lived in a brand new home
- Lived in a new office
- Noticed changes of your health since you moved into your home?
- Have a water purification system?
- Live near a landfill?
- Have a water filter on your shower?

Describe the contents of your bedroom

- What type of mattress?
- Have hardwood floors
- Have carpeting
- Have blinds
- Have draperies
- Use a foam pillow
- Use a feather pillow
- Use a Dacron pillow
- Use wool blankets
- Use cotton blankets
- Use quilts
- Use synthetic blankets

- Use an electric blanket
- Have a ceiling fan
- Have material under your bed
- Have real plants in your bedroom
- Have artificial plants in your bedroom
- Use aromatherapy in your bedroom
- Burn scented candles in your bedroom
- Have central heat
- Have a fireplace in your room
- Have an electric baseboard

- Use gas heat

- Use an air filter in your bedroom

What type?

- When was the last time you changed your filter in your room?

- Have central air conditioning
- Sleep with your windows open
- Live close to a high traffic road

Smoke in bed

- Allow any pets in your room

What type?

- Have plugged in air fresheners

Art and Leisure Activities

- Silk-screening
- Make stained glass
- Make pottery & ceramic products
- Make jewelry
- Buy art and craft supplies
- Use airbrush and spray paints
- Do quilting and weaving
- Gardening
- Make soapstone carvings
- Use acrylic paint

What hobbies do you have? Please list:

- 1.
- 2.
- 3.

Please indicate the occupation of your parents during your childhood:

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet – 5 4 3 2 1

Take several nutritional supplements each day– 5 4 3 2 1

Keep a record of everything you eat each day – 5 4 3 2 1

Modify your lifestyle (e.g. work demands, sleep habits) – 5 4 3 2 1

Practice relaxation techniques 5 4 3 2 1

Engage in regular exercise – 5 4 3 2 1

Have periodic lab tests to assess progress – 5 4 3 2 1

Comments

Rate on a scale of: 5 (very confident) to 1 (not confident at all).

How confident are you of your ability to organize and follow through on the above health related activities?

5 4 3 2 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?

Rate on a scale of: 5 (very supportive) to 1 (not supportive at all).

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? – 5 4 3 2 1

Comments

Rate on a scale of: 5 (very frequent contact) to 1 (very infrequent contact).

How much ongoing support and contact (e.g. telephone consults, e-mail correspondence) from your professional staff would be helpful to you as you implement your personal health program?

5 4 3 2 1 Comments

Thank you for taking the time to complete this health history medical questionnaire.

The information derived from all of these medical forms will provide invaluable data.

Each section builds upon the other, allowing me and other physicians the opportunity to discover the “**missing key**” that will solve your health problem.

Once all the sections of this form and the questionnaires have been filled out please return them to our office and we'll make an appointment for our initial consultation.

I thank you once again and look forward to helping you achieve a “**return to health and well being.**”

Sincerely,

(Your Name)