**Carucci Chiropractic Center**

**&**

**The CT Wellness Institute**

**Introductory, Consent, and**

**Patient Information Forms**

**53 New Britain Avenue**

**Rocky Hill, CT 06067**

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| --- | --- |
| **TABLE OF CONTENTS** |  |

|  |  |
| --- | --- |
| **INTRODUCTORY INFORMATION**  Frequently Asked Questions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Do you think you can help with my problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Can all the tests I need be done in the clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Do you take insurance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * What credit cards do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1  1  1  1  1 |
| **CONSENT FORMS**  Important Patient Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Patient Acceptance Form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Authorization for Release of Medical Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1  1-2  3 |
| **HEALTH QUESTIONNAIRES**  General Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Personal Descriptive Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Functional Diagnostic Medicine Questionnaire\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Health Goals Form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Review of systems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nutrition and Lifestyle Questionnaire\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Social Questionnaire\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Environmental Influences Questionnaire\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient Readiness Questionnaire\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient Checklist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1  2  3  11  14  21  26  31  36  43 |

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| **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 many effects of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders. Here at our clinic we focus on the body that has the condition and not the condition itself!

**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 come in to our office to have blood drawn, or 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. On some qualified Insurance Companies, we will file insurance paperwork on your behalf. For the non-qualified Insurance Companies, 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.

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| **IMPORTANT PATIENT INFORMATION** |  |

**Patient Acceptance Policy**

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is Dr. Carucci’s opinion that you should be well informed on our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, Dr. Carucci 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 Dr. Carucci assist in helping you. The medical questionnaire will allow Dr. Caruccito 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 Dr. Carucci. Once Dr. Carucci has received your completed forms, our office will schedule your first consultation

1. **Medical Records** from all physicians since you were **first diagnosed** with your health condition **MUST** be obtained prior to scheduling an appointment.
2. Once Dr. Carucci has your completed questionnaires and copies of all your medical records, a one-hour appointment will be scheduled to review your case. The cost for the one-hour appointment as well as Dr. Caruccis’time for reviewing your medical questionnaire, medical records and written reports is **$200.00**
3. 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 AST, ALT, GGT, Bilirubin (Liver), BUN, Creatinine, Uric Acid (Kidney), Alkaline Phosphatase (Bone)
* **Cardiovascular Panel:** Cholesterol, Triglycerides, LDL, HDL, Cholesterol/HDL Ratio, LDL/HDL Ratio, C Reactive Protein (hs-CRP), Homocysteine, Fibrinogen, Ferratin
* **Thyroid Panel:** Total T3, Total T4, Free T3, Free T4, TSH
* **Magnesium, Vitamin D 3**
* **CBC differential:** White Blood Cells and Red Blood Cells, Platelets
* **Inflammatory markers:** Sedimentation Rate

1. 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 MasterCard, Visa, Discover and American Express.
2. If you have not had a physical examination within the last two years or since the start of your most recent health problem, it is required to either schedule an appointment with Dr. Carucci or with your primary physician, for that physical examination.
3. The results of your lab tests may take approximately **three weeks,** at which point, you will be scheduled for an appointment. This appointment usually takes approximately one to one and half hours. You will be presented with a written report **detailing the results of your tests, the possible causes of your health problem and the recommended treatment protocol**. It is recommended that you have your spouse or a supportive family member attend this appointment.
4. Your treatment may consist of dietary and lifestyle changes as well as prescribed **Natural Pharmaceuticals,** which must be paid at the time of purchase.
5. Follow-up consultations will be scheduled every **3, 6 or 12 weeks** allowing you the opportunity to discuss your progress and any concerns with Dr. Carucci. Dr. Carucci 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 YOU getting better. Consultations can be conducted either by phone or in person (at the office). The fee for follow-up consultations is **$80.00 for up to 20 minutes.** Any examination performed at follow-up appointments are subject to separate charges, i.e. BP monitoring, ABI monitoring, CasPro evaluation, spirometry, UA, etc.
6. **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, *(Patient’s Name)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the **Patient Acceptance Policy.**

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**Patient’s Signature Date**

**Patient accepted for evaluation and treatment consideration by:**

­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dr. Carucci - Signature Date**

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| **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS** |  |

**I am Requesting Records of Doctor:**

Name of Facility or Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE PURPOSE FOR THIS RELEASE**

You are hereby authorized to furnish and release to Dr. Gina M. Carucci 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: O Yes O No

Communicable disease related information, including AIDS or

ARC diagnosis and/or HIT or HTLA-III test results or treatment: O Yes O No

Genetic Testing O Yes O 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 Dr. Gina M. Carucci; any and all of his employees, agents managing members, and any of the attending physician(s) that I am requesting records of and/or from; from any and all 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 that there may be a fee for this service depending on the number of pages photocopied. If such a fee is to be paid, it shall be paid by me, the requestor, and not Dr. Carucci. However; no such fee is usually charged if these records are requested for continuing medical care.

*Please Print:*

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Please send copy of all records to:**

Dr. Gina M. Carucci

53 New Britain Avenue

Rocky Hill, CT 06067

Phone: 860-257-8445

***The CT Wellness Institute***

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| **GENERAL PATIENT INFORMATION** |  |

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Preferred Name*

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_ Place of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: female \_\_ male\_\_\_

Right Handed: \_\_\_\_ Left Handed: \_\_\_\_ Mixed Dominance: \_\_\_\_\_

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

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours per week \_\_\_\_\_\_\_\_\_ Retired \_\_\_\_\_\_\_\_

Nature of job/Business \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic? Article\_\_\_\_ 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 & Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL DESCRIPTIVE INFORMATION** |  |

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| --- | --- | --- | --- | --- |
| **Marital status:** | | | | |
| * Single | * Married | | * Widowed | |
| * Separated | * Divorced | | * Long Term Partnership | |
| **Please List All Children’s Names** | | **Age** | | **Gender** |
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With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)  
Example: Wendy, age 7, sister

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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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If yes, please comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you experienced any major losses in life? Yes\_\_\_\_ No\_\_\_\_

If so, please comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| a. \_\_\_\_\_ 0-2 days | b. \_\_\_\_\_ 3 –14 days | c. \_\_\_\_\_ > 15 days |

Previous jobs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list your highest level of education:

* Some or all of High School
* College \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Graduate School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Field: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_
* Professional School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Field: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_
* Did you have learning problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Functional Diagnostic Medical Health Questionnaire**

Please complete the following Functional Medical Health 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 Dr. Carucci evaluate the root cause of your health concerns and determine an effective treatment program.

**Note:** We are also interested in the so-called minor symptoms as well as the 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. If you need additional space, please use an extra sheet of paper and include it with these forms.

**Please print or write legibly.**

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| **CONCERNS / COMPLAINTS** |  |

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

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| **Problem** | **Onset** | **Frequency** | **Severity** |
| e.g. Headaches | June 2007 | 4 times per week | Mild / moderate / severe |
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What diagnosis or explanations have been given to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When was the last time you felt well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did something trigger your change in health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What makes you feel **worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What makes you feel **better**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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):

|  |  |  |  |
| --- | --- | --- | --- |
| * None * Chiropractic * Acupuncture * Iridology * Colonics | * Massage * Rolfing * Reiki * Homeopathy * Biofeedback | * Yoga * Hypnosis * Ayurvedic * Light therapy * Meditation | * Environmental medicine * Nutritional Therapy * Biological Dentistry * IV (chelation) therapy * Naturopathic medicine |

Other treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PAST MEDICAL & SURGICAL HISTORY** |  |

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| --- | --- | --- |
| **ILLNESSES** | **WHEN / ONSET** | **COMMENTS** |
| Anemia |  |  |
| Arthritis |  |  |
| Asthma |  |  |
| Bronchitis |  |  |
| Cancer |  |  |
| Chicken Pox |  |  |
| Chronic Fatigue Syndrome |  |  |
| Crohn’s Disease or Ulcerative Colitis |  |  |
| Diabetes |  |  |
| Emphysema |  |  |
| Epilepsy, convulsions, or seizures |  |  |
| Gallstones |  |  |
| German Measles |  |  |
| Gout |  |  |
| Heart Attack, Angina |  |  |
| Heart Failure |  |  |
| Hepatitis |  |  |
| Herpes Lesions / Shingles |  |  |
| High blood fats (cholesterol, triglycerides) |  |  |
| High blood pressure (hypertension) |  |  |
| Irritable bowel (or chronic diarrhea) |  |  |
| Kidney stones |  |  |
| Measles |  |  |
| **ILLNESSES** | **WHEN / ONSET** | **COMMENTS** |
| Mononucleosis |  |  |
| Mumps |  |  |
| Pneumonia |  |  |
| Rheumatic Fever |  |  |
| Sinusitis |  |  |
| Sleep Apnea |  |  |
| Stroke |  |  |
| Thyroid disease |  |  |
| Whooping Cough |  |  |
| Other (describe) |  |  |
| Other (describe) |  |  |
| **INJURIES** | **WHEN** | **COMMENTS** |
| Back injury |  |  |
| Broken bones or fractures (describe) |  |  |
| Head injury |  |  |
| Neck injury |  |  |
| Other (describe) |  |  |
| Other (describe) |  |  |
| Other (describe) |  |  |
| **DIAGNOSTIC STUDIES** | **WHEN** | **COMMENTS** |
| Barium Enema |  |  |
| Blood Tests |  |  |
| Bone Density Test |  |  |
| Bone Scan |  |  |
| Carotid Artery Ultrasound |  |  |
| CAT Scan *(Please indicate type: Brain, Spine, Abdomen, etc.* |  |  |
| Colonoscopy |  |  |
| EKG |  |  |
| Liver Scan |  |  |
| Sigmoidoscopy |  |  |
| Mammogram |  |  |
| MRI |  |  |
| Upper GI Series |  |  |
| X-Ray *(Please indicate type: Head, Neck, Back, Pelvis, Chest, Joint, etc.* |  |  |
| Other (describe) |  |  |
| Other (describe) |  |  |
| **SURGERIES** | **WHEN** | **COMMENTS** |
| Appendectomy |  |  |
| Dental Surgery |  |  |
| Gall Bladder |  |  |
| Hernia |  |  |
| Hysterectomy |  |  |
| Tonsillectomy |  |  |
| Tubes in Ears |  |  |
| Other (describe) |  |  |
| Other (describe) |  |  |
| Other (describe) |  |  |

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| --- | --- |
| **HOSPITALIZATIONS** |  |

|  |  |  |
| --- | --- | --- |
| **Where Hospitalized** | **When** | **For What Reason** |
|  |  |  |
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| **PATIENT BIRTH HISTORY** |  |

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| --- | --- | --- | --- | --- | --- |
| **Question** | **Yes** | **No** | | **Don’t Know** | **Comment** |
| Were you a full term baby? |  |  | |  |  |
| A Preemie? |  |  | |  |  |
| Forcep delivery? |  |  | |  |  |
| Cesarean section? |  |  | |  |  |
| Epidural used? |  |  | |  |  |
| Breast fed? |  |  | |  |  |
| Bottle fed? |  |  | |  |  |
| When your mother was pregnant with you, did she: | | | | | |
| Smoke tobacco? |  |  | |  |  |
| Drink alcohol? |  |  | |  |  |
| Take estrogen? |  |  | |  |  |
| Use recreational drugs? |  |  | |  |  |
| On prescription meds? |  |  | |  |  |
| **IMMUNIZATION HISTORY** | | |  | | |

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

|  |  |
| --- | --- |
| * Smallpox * Tetanus * Diphtheria * Pertussis * Polio (oral) * Polio (Injection) | * Mumps * Measles * Rubella (German measles) * Typhoid * Cholera |

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| **CHILDHOOD HEALTH HISTORY** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Question** | | **Yes** | **No** | **Don’t Know** | **Comment** | |
| Did you live in an area with soft water? | |  |  |  |  | |
| Hard water? | |  |  |  |  | |
| **As a child, did you consume a lot of the following:** | | | | | | |
| Sugar? | |  |  |  |  | |
| Candy? | |  |  |  |  | |
| Sweet foods? | |  |  |  |  | |
| Soda? | |  |  |  |  | |
| Diet soda? | |  |  |  |  | |
| White bread? | |  |  |  |  | |
| Cookies? | |  |  |  |  | |
| Ice Cream? | |  |  |  |  | |
| Meat, vegetable & potato/rice/pasta diet? | |  |  |  |  | |
| Vegetarian & grain based diet with little meat? | |  |  |  |  | |
| Vegetarian diet with milk & eggs? | |  |  |  |  | |
| Vegetarian diet without milk & eggs? | |  |  |  |  | |
| 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** |
|  |  | | | | |  |
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**AGE OF ONSET OF ANY 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) |

\_\_\_\_\_ Any major illness(s) that required hospitalization? If yes, please explain your illness:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FEMALE MEDICAL HISTORY** *(For Women Only)* |  |

**OBSTETRICS HISTORY** ***Check box if yes and provide number of:***

|  |  |  |
| --- | --- | --- |
| * Pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_ | * Caesarean \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Vaginal deliveries \_\_\_\_\_\_\_\_\_ |
| * Miscarriage \_\_\_\_\_\_\_\_\_\_\_\_\_ | * Abortion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Living Children \_\_\_\_\_\_\_\_\_\_\_ |
| * Post partum depression | * Toxemia | * Gestational diabetes |
| * Baby over 8 pounds | * Breast feeding For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**GYNECOLOGICAL HISTORY**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Age at 1st period:\_\_\_\_\_\_ | | Menses Frequency: \_\_\_\_\_\_ | | | | | | | | Length: \_\_\_\_\_\_\_\_\_ | | | | | | | | Pain: Yes\_\_\_\_ No \_\_\_\_ | | |
| Clotting: Yes \_\_\_\_\_ No \_\_\_\_\_ | | | Has your period skipped? \_\_\_\_\_\_\_ 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |

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| **FAMILY HISTORY** |  |

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Check Family Members that Apply** | **Father** | **Mother** | **Brother(s)** | **Sister(s)** | **Children** | **Maternal**  **Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** | **Aunts** | **Uncles** | **Other** |
| **Age (if still alive)** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Age at death (if deceased)** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Heart Attack** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Uterine Cancer** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Colon Cancer** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Breast Cancer** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Ovarian Cancer** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Prostate Cancer** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Skin Cancer** |  |  |  |  |  |  |  |  |  |  |  |  |
| **ADD/ADHD** |  |  |  |  |  |  |  |  |  |  |  |  |
| **ALS or other Motor Neuron Diseases** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Alzheimer’s** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Anemia** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Anxiety** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Autism** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Autoimmune Diseases** (Such as Lupus etc.) |  |  |  |  |  |  |  |  |  |  |  |  |
| **Bipolar Disease** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Bladder disease** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Blood clotting problems** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Celiac disease** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Dementia** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Depression** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Eczema** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Emphysema** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Environmental Sensitivities** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Epilepsy** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Check Family Members that Apply** | **Father** | **Mother** | **Brother(s)** | **Sister(s)** | **Children** | **Maternal**  **Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** | **Aunts** | **Uncles** | **Other** |
| **Flu** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Food Allergies, Sensitivities, Intolerances** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Genetic disorders** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Glaucoma** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Headache** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Heart Disease** |  |  |  |  |  |  |  |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |  |  |  |  |  |  |  |
| **High Cholesterol** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Inflammatory Arthritis** (Rheumatoid, Psoriatic, Ankylosing spondylitis) |  |  |  |  |  |  |  |  |  |  |  |  |
| **Inflammatory Bowel Disease** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Insomnia** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Irritable Bowel Syndrome** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Kidney disease** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Multiple Sclerosis** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Nervous breakdown** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Obesity** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Osteoporosis** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Parkinson’s** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Pneumonia/Bronchitis** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Psoriasis** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Psychiatric disorders** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Schizophrenia** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Sleep Apnea** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Smoking addiction** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Substance abuse** (such as alcoholism) |  |  |  |  |  |  |  |  |  |  |  |  |
| **Ulcers** |  |  |  |  |  |  |  |  |  |  |  |  |

Is there 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 |

Any additional diseases or health concerns:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**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 yet 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 to do something and having the “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. (Use extra pages if necessary)**

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**List up to 5 things that you plan to do once you are feeling better.**

**Please be specific. (Use extra pages if necessary)**

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**Are there any other health goals you want to achieve?**

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**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!**

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| **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 you skin sensitive to the:**

* Sun
* Fabrics \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Detergents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Lotions/Creams\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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:***

* Feeling of Sand in the 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
* Does 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?
* Loss of Bladder Control?

## 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

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| **DENTAL HISTORY** |  |

Please answer the following questions:

* Have you had sore gums (gingivitis) often over the years? 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 \_\_\_\_\_
* Has ringing in the ears (tinnitus) been present? 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)** | |
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| **Bottom**  **Teeth**  **LEFT SIDE RIGHT SIDE** | | Please circle the tooth or teeth you have had or still have problems with. Please state what type of problem you have had, for example: root canal, crown, abscessed tooth, partials, etc. and indicate which teeth have fillings.  **Please record tooth number and problem:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **MEDICATIONS & SUPPLEMENTS** |  |

**Antibiotics: How often have you taken antibiotics?**

|  |  |  |
| --- | --- | --- |
|  | **Less than 5 times** | **More than 5 times** |
| Infancy/Childhood |  |  |
| Teen |  |  |
| Adulthood |  |  |

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

|  |  |  |
| --- | --- | --- |
|  | **Less than 5 times** | **More than 5 times** |
| Infancy/Childhood |  |  |
| Teen |  |  |
| Adulthood |  |  |

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

|  |  |
| --- | --- |
| * Acid Blocking Drugs * Anti-anxiety medications * Antibiotics * Anticonvulsants * Antidepressants * Anti-fungals * Aspirin/Ibuprofen * Asthma inhalers * Beta blockers * Birth control pills/implant contraceptives * Chemotherapy * Cholesterol lowering medications * Cortisone/steroids * Diabetic medications/insulin | * Diuretics * Estrogen or progesterone (pharmaceutical, prescription) * Estrogen or progesterone (natural) * Heart medications * High blood pressure medications * Laxatives * Relaxants/Sleeping pills * Testosterone (natural or prescription) * Thyroid medication * Acetaminophen (Tylenol) * Ulcer medications * Sildenafil citrate (Viagra or similar) * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**MEDICATION LOG**

**Please indicate the type of medications you are taking now. Please include non-prescription drugs.**

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| **Medication Name** | **Date started** | **Dated Stopped** | **Dosage** | **# per day** |
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**SUPPLEMENT LOG**

**Supplements: List all vitamins, minerals and other nutritional supplements**

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| --- | --- | --- | --- | --- |
| **Supplement Name/Brand** | **Dose** | **Frequency** | **Dated Started** | **Reason for use** |
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Have any medications or nutritional supplements ever caused you any unusual side effects or problems?

Yes \_\_\_\_ No \_\_\_\_\_ If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ALLERGIES** |  |

**Medications You Are Allergic To: Reaction**

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**Foods You Are Allergic To: Reaction**

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**Supplements You Are Allergic To: Reaction**

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**Other Comments:**

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| **PAIN ASSESSMENT** |  |

Are you currently in any pain? Yes \_\_\_ No\_\_\_ Is the source of your pain due to an injury? Yes\_\_\_ No\_\_\_

***If yes***, please describe your injury and the date in which it occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If no***, please describe how long you have experienced this pain and what you believe it is attributed to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please use the area(s) and illustration below to describe the severity of your pain.

**(0= no pain, 10= severe pain)**

Example:  ***Back Pain***

1. 1 2 3 4 5 6 7 8 9 10

Area 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Area 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

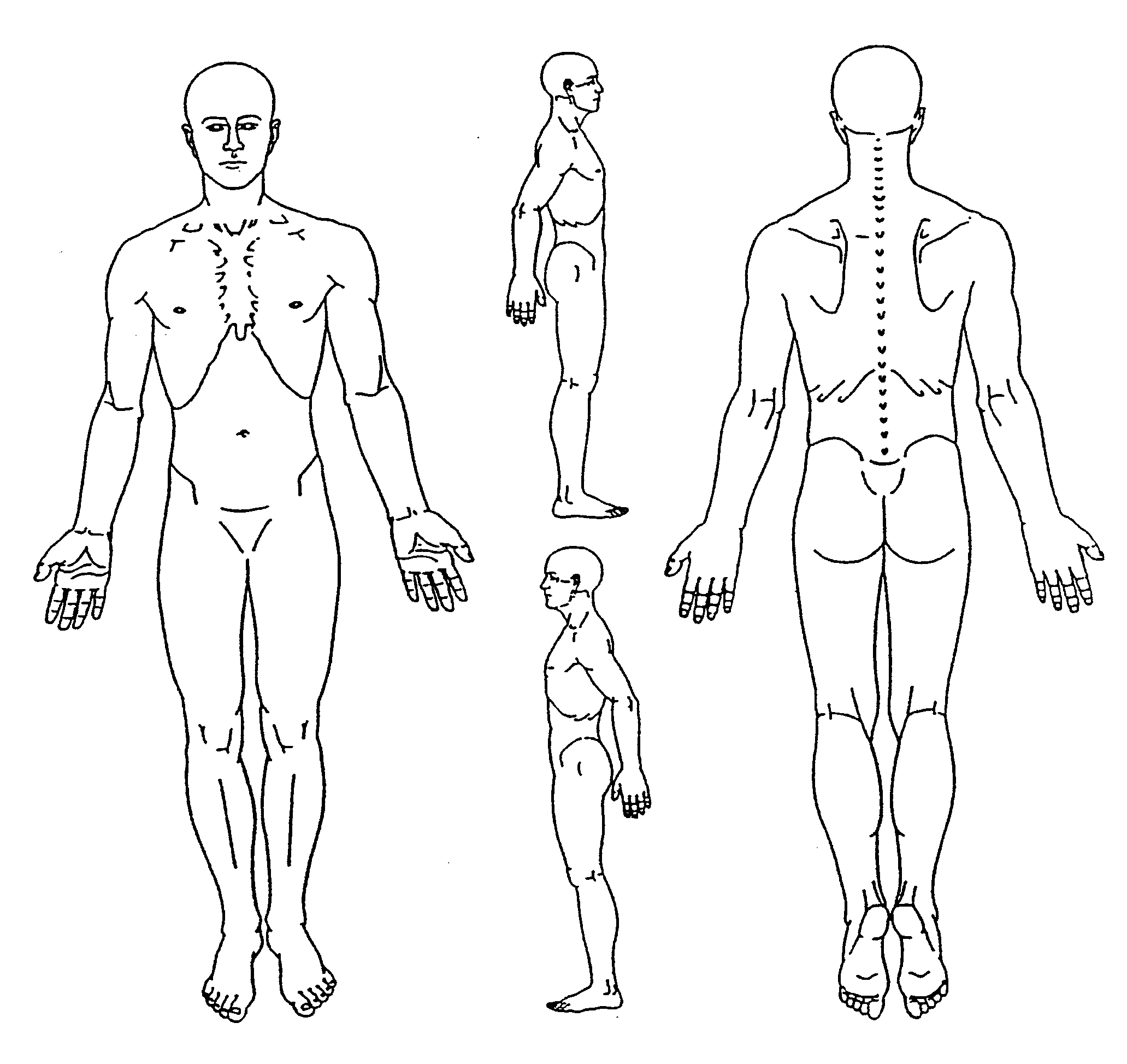
1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10

Area 3:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Area 4:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10

Use the letters provided to mark your area(s) of pain on the illustration.

**A** = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting



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| --- | --- |
| **NUTRITION & LIFESTYLE HISTORY** |  |

|  |  |
| --- | --- |
| 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 \_\_\_\_\_

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:*

* Low fat
* Mixed food diet (Animal/vegetable sources)
* High protein
* Vegetarian
* Vegan
* Gluten restricted
* Low sodium
* Fat restriction
* Low starch/carbohydrate
* The Blood type Diet
* Metabolic Typing Diet
* The Zone Diet
* Total calorie restriction
* Ovo-lacto diet
* Diabetic
* No dairy
* No wheat
* Specific Program for Weight Loss/Maintenance Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any specific food restrictions you have:**

* Dairy
* Soy
* Wheat
* Corn
* Eggs
* All gluten
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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** |
|  |  |  |
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If you could only eat a few foods a week, what would they be? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 your current lifestyle and eating habits:**

|  |  |
| --- | --- |
| * Fast eater * Erratic eating habits * Eat too much * Late night eater * Dislike health food * Time constraints * Eat more than 50% of meals away from home * Travel frequently * Non-availability of healthy foods * Do not plan meals or menus * Reliance on convenience items * Poor snack choices * Significant other or family members don’t like healthy foods | * Significant other or family members have special dietary needs of food preferences * Love to eat * Eat because I have to * Have a negative relationship to food * Struggle with eating issues * Emotional eater (eat when sad, lonely, depressed, bored) * Eat too much under stress * Eat too little under stress * Don’t care to cook * Eating in the middle of the night * Confused about nutritional advise * 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 |
| * None * Bacon/Sausage * Bagel * Butter * Cereal * Coffee * Donut * Eggs * Fruit * Juice * Margarine * Milk * Oat bran * Sugar * Sweet roll * Sweetener * Tea * Toast * Water * Wheat bran * Yogurt * Oat meal * Milk protein shake * Slim fast * Carnation shake * Soy protein * Whey protein * Rice protein * Other: (List below)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * None * Butter * Coffee * Eat in a cafeteria * Eat in restaurant * Fish sandwich * Fried foods * Hamburger * Hot dogs * Juice * Leftovers * Lettuce * Margarine * Mayo * Meat sandwich * Milk * Pizza * Potato chips * Salad * Salad dressing * Soda * Soup * Sugar * Sweetener * Tea * Tomato * Vegetables * Water * Yogurt * Slim fast * Carnation shake * Protein shake | * None * Beans (legumes) * Brown rice * Butter * Carrots * Coffee * Fish * Green vegetables * Juice * Margarine * Milk * Pasta * Potato * Poultry * Red meat * Rice * Salad * Salad dressing * Soda * Sugar * Sweetener * Tea * Vinegar * Water * White rice * Yellow vegetables * Other: (List below)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

* Almonds
* Almond Butter
* Alcohol
* Apples
* Avocado
* Asparagus
* Bagels
* Barley
* Banana
* Burger King
* Bacon
* Bean, Lima
* Bread, White
* Bread, Wheat
* Bread, Rye
* Bagels
* Biscuits
* Bean, Pinto
* Bean, String
* Broccoli
* Brazil Nuts
* Brussels Sprouts
* Blueberries
* Butter
* Cabbage
* Cereal: Special K
* Cereal:

Bran flakes

* Cereal: Cornflakes
* Cereal:

\_\_\_\_\_\_\_\_\_\_\_

* Cereal: \_\_\_\_\_\_\_\_\_\_\_
* Celery
* Cantaloupe
* Candy
* Chinese Food
* Cream Cheese
* Carrot
* Chicken
* Chili Pepper
* Cinnamon
* Clam
* Cloves
* Cocoa-Chocolate
* Carnation Drink
* Chewing gum, sweetened
* Chewing gum, sugar free
* Coconut
* Cod
* Coffee
* Corn
* Crab
* Cranberry
* Cashew
* Cheese
* Cucumber
* Deli Meats
* Desserts
* Deli Sandwich
* Eggplant
* Ensure
* Flounder
* Fried Foods
* French Fries
* French Toast
* Garlic
* Ginger
* Grape
* Grits
* Greek Food
* Grapefruit
* Grape nuts
* Haddock
* Ham
* Halibut
* Herring
* Hot Dogs, Pork
* Hot Dogs, Beef
* Hamburgers
* Hardies Food
* Honey
* Italian Food
* Ice Cream
* Indian Food
* Jack in the box food
* Japanese Food
* Jelly
* Ketchup
* Lamb
* Lemon
* Lentil
* Lettuce
* Lime
* Lobster
* Mackerel
* Margarine
* McDonalds Food
* Millet
* Mung Bean
* Mushroom
* Mustard
* Milk, Cow
* Milk, Goat
* Milk, Rice
* Milk, Almond
* Milk, Soy
* Mexican Food
* Malt
* Nutmeg
* NutriSweet
* Oatmeal, Regular
* Oatmeal, Instant
* Olive
* Onion
* Orange Juice
* Oregano
* Oyster
* Orange
* Papaya
* Parsley
* PopTarts
* Peanuts
* Peanut butter
* Peas
* Peach
* Pecan
* Pepper
* Pepper, Green
* Perch
* Pineapple
* Pancakes
* Protein Shakes:

Soy

* Protein Shakes:

Milk

* Protein Shakes:

Whey

* Protein Shakes: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Protein Shakes: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Plum
* Pork
* Peanut
* Potato, sweet
* Potato, White
* Pumpkin
* Quinoa
* Radish
* Rye
* Safflower
* Sage
* Salt
* Salmon
* Scallops
* Sausage
* Slim Fast
* Sweet & Low
* Sesame
* Shrimp
* Snapper
* Soft Drinks
* Sole
* Sour cream
* Soybean
* Spinach
* Strawberry
* Sucralose
* Sugar
* Sunflower
* Salad Bar
* Sardines
* Squash
* Taco bell food
* Tea, Black
* Tea: Decaffeinated
* Thai food
* Tomato
* Trout
* Tuna
* Turkey
* Tangerine
* Vinegar
* Walnut
* Waffles
* Whitefish
* Wheat
* Wendy’s food
* Yeast, Bakers
* Yeast Brewers
* Yogurt
* Yam
* Zucchini

**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:

|  |  |
| --- | --- |
| * High fat foods * High protein foods * High carbohydrate foods (breads, pasta, potatoes) | * Refined sugar (junk food) * Fried foods * 1 or 2 alcoholic drinks * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

|  |  |
| --- | --- |
| * High fat foods * High protein foods * High carbohydrate foods (breads, pasta, potatoes) | * Refined sugar (junk food) * Fried foods * 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 you feel that you should change about your diet and to improve your health is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOBACCO HISTORY**

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

If yes, what type? Cigarette \_\_\_\_\_ Smokeless/Chew \_\_\_\_\_ 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”

Any 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? \_\_\_\_\_\_\_\_\_\_ Father? \_\_\_\_\_\_\_\_\_ 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 |  |  | | |  | |
| Walking/Running |  |  | | |  | |
| Other 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 |
| Do you feel unusually fatigued after exercise? Yes \_\_\_\_\_ No \_\_\_\_\_ | | | | | | |
| If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Do you usually sweat when exercising? Yes \_\_\_ No \_\_\_ | | | | | | |

**Please complete the following chart as it relates to your bowel movements:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Frequency** | **√** | **Consistency** | **√** |
| More than 3x/day |  | Soft and well formed |  |
| 1-3x/ day |  | Often floats |  |
| 4-6x/week |  | Difficult to pass |  |
| 2-3x/week |  | Diarrhea |  |
| 1 or fewer x/week |  | Thin, long or narrow |  |
| **Color** | **√** | Small and hard |  |
| Medium brown consistently |  | Loose but not watery |  |
| Very dark or black |  | Alternating between hard and loose/watery |  |
| Greenish color |  | **Other *(Please describe)*:** | |
| Blood is visible |  |  | |
| Varies a lot |  |  | |
| Dark brown consistently |  |  | |
| Yellow, light brown |  |  | |
| Greasy, shiny appearance |  |  | |

Intestinal (Bowel) gas:

\_\_ Daily \_\_ Occasionally \_\_ Excessive

\_\_ Present with pain \_\_ Foul smelling \_\_ Little odor

|  |  |
| --- | --- |
| **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 immunes 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: | | | | | | | | | | | | | | | | | | | | | | | | |
| * Prayer | | * Breathing | | | * Meditation | | | | | | * Tai Chi | | | * Yoga | | | | | | * Imagery | | | * Other | |
| Hobbies ands 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 | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| In your job | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| In your social life | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| With close friends | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| With sex | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| With your attitude | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| With your boyfriend/girlfriend | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| With your children | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| With your parents | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| With your spouse | | | | | | | | | |  | | |  | | |  | | | | |  | | |  |
| 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** |
| * Excessive Fatigue | 10 | ½ | 1 | 2 |  |
| * Dry & Thin Skin | 10 | ½ | 1 | 2 |  |
| * Nervous/Irritability | 9 | ½ | 1 | 2 |  |
| * Low body temperature | 8 | ½ | 1 | 2 |  |
| * Premenstrual tension | 8 | ½ | 1 | 2 |  |
| * Inability to concentrate | 8 | ½ | 1 | 2 |  |
| * Mental depression | 8 | ½ | 1 | 2 |  |
| * Food allergies & sensitivities | 7 | ½ | 1 | 2 |  |
| * Craving for sweets | 7 | ½ | 1 | 2 |  |
| * Headaches | 6 | ½ | 1 | 2 |  |
| * Alcohol intolerance | 6 | ½ | 1 | 2 |  |
| * Poor memory | 5 | ½ | 1 | 2 |  |
| * 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 | Yes | No | 100 |
| Divorce | Yes | No | 73 |
| Marital separation | Yes | No | 65 |
| Jail term | Yes | No | 63 |
| Death of close family member | Yes | No | 63 |
| Personal injury or illness | Yes | No | 53 |
| Marriage | Yes | No | 50 |
| Fired from work | Yes | No | 47 |
| Marital reconciliation | Yes | No | 45 |
| Retirement | Yes | No | 45 |
| Change in family members health | Yes | No | 44 |
| Pregnancy | Yes | No | 40 |
| Sex difficulties | Yes | No | 39 |
| Addition to family | Yes | No | 39 |
| Business readjustment | Yes | No | 39 |
| Change in financial status | Yes | No | 38 |
| Death of close friend | Yes | No | 37 |
| Change in line of work | Yes | No | 36 |
| Change in # of marital arguments | Yes | No | 35 |
| Mortgage or loan over $10,000 | Yes | No | 31 |
| Foreclosure of mortgage or loan | Yes | No | 30 |
| Change in work responsibilities | Yes | No | 29 |
| Son or daughter leaving home | Yes | No | 29 |
| Trouble with in-laws | Yes | No | 29 |
| Outstanding personal achievement | Yes | No | 28 |
| Spouse begins or stops work | Yes | No | 26 |
| Starting or finishing school | Yes | No | 26 |
| Change in living conditions | Yes | No | 25 |
| Revision of personal habits | Yes | No | 24 |
| Trouble with boss | Yes | No | 23 |
| Change in work hours, conditions | Yes | No | 20 |
| Change in residence | Yes | No | 20 |
| Change in schools | Yes | No | 20 |
| Change in recreational habits | Yes | No | 19 |
| Mortgage or loan under $10,000 | Yes | No | 18 |
| Change in sleeping habits | Yes | No | 16 |
| Change in eating habits | Yes | No | 15 |
| Vacation | Yes | 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 below that you have experienced in your lifetime)

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

***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 that 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? O Yes O No  
 If yes, how often? \_\_\_\_\_

Do you have hair colorings? O Yes O No  
 If yes, was it permanent or 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:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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.”**

Please see the next page and go over the Patient Checklist.

Sincerely,

*Gina M. Carucci, DC, MS, DICCP, DABCI*

|  |  |
| --- | --- |
| **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:

**Dr. Gina M. Carucci, 53 New Britain Avenue, Rocky Hill, CT 06067**

**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*