Carucci Chiropractic Center

&

The CT Wellness Institute

Introductory, Consent, and Patient Information Forms

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INTRODUCTORY INFORMATION

CONSENT FORMS

HEALTH QUESTIONNAIRES

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.

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. Carucci to quickly **"zero"** in on the probable causes of your health problems.
   - ❑ **The Diet Diary**

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

2. **Medical Records** from all physicians since you were **first diagnosed** with your health condition **MUST** be obtained prior to scheduling an appointment.

3. Once 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**

4. Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain comprehensive **blood chemistry.** The blood chemistry test will include:

   - ❑ **Comprehensive Executive Metabolic Panel,** which includes 24 important disease markers such as 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

5. 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.

6. 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.

7. 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.

8. Your treatment may consist of dietary and lifestyle changes as well as prescribed **Natural Pharmaceuticals,** which must be paid at the time of purchase.

9. 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.

10. 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.**

_____ _____

Patient's Signature **Date**

Patient accepted for evaluation and treatment consideration by:

_____ _____

Dr. Carucci - Signature **Date**

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

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 _____

_____

PERSONAL DESCRIPTIVE INFORMATION

Marital status:

- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Separated
- ❑ Divorced
- ❑ Long Term Partnership

Please List All Children's Names	Age	Gender

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

_____

_____

Do you have any pets or farm animals? Yes____ No____

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

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

If so, when and where? _____

_____

Have you or your family recently experienced any major life changes? Yes____ No____

If yes, please comment: _____

_____

Have you experienced any major losses in life? Yes____ No____

If so, please comment: _____

_____

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

a. _____ 0-2 days b. _____ 3 –14 days c. _____ > 15 days

Previous jobs: _____

_____

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.

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.

Problem	Onset	Frequency	Severity
e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

What diagnosis or explanations have been given to you? _____

_____

_____

_____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

What makes you feel **worse**? _____

_____

What makes you feel **better**? _____

_____

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

1.	4.
2.	5.
3.	6.

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

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

Other treatments: _____

PAST MEDICAL & SURGICAL HISTORY

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)		

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

PATIENT BIRTH HISTORY

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

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

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
_____ Bronchitis
_____ Measles
_____ Chicken Pox
_____ Strep Infections
_____ Significant dental work
_____ ADD
_____ Difficulty learning:
_____ High # of absences from school
_____ Jaundice
_____ Ear infections
_____ Premature at birth
_____ Fever blisters
_____ Abusive or alcoholic parent (s)

_____Tonsillitis
_____ Ear Infections
_____ Mumps
_____ Whooping Cough
_____ Seasonal allergies
_____ Behavior problems
_____ Hyperactivity
_____ Frequent headaches
_____ Upset stomach, indigestion
_____ Colic
_____ Congenital abnormalities
_____ Pneumonia
_____ Parent (s) smoked
_____ Skin disorders (eczema)

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

_____
_____
_____
_____
_____

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? _____

FAMILY HISTORY

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

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	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:

_____

_____

_____

_____

ESTABLISHING HEALTH GOALS

Personal Message

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

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

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

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

_____

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

1. _____
2. _____
3. _____

Have you made the decision to change? To do what it takes to get well? Yes _____ No _____

I have read something interesting: ***"The definition of insanity is to keep doing the same thing and 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 *<u>been unable</u>* to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)

_____

_____

_____

_____

_____

_____

_____

List up to 5 things that you plan to do once you are feeling better.
Please be specific. (Use extra pages if necessary)

Are there any other health goals you want to achieve?

HAVE YOU COMPLETED THE LAST SECTION?

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

PLEASE DO NOT SKIP THIS SECTION!!

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

REVIEW OF SYSTEMS

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

GENERAL

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

SKIN:

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

Is 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

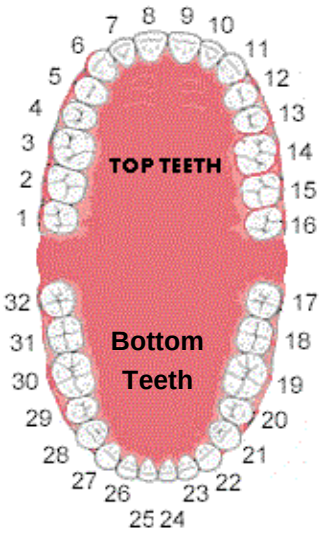
DENTAL HISTORY

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)



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:

_____

_____

_____

_____

_____

_____

_____

_____

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.

Medication Name	Date started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for use

Have any medications or nutritional supplements ever caused you any unusual side effects or problems?

Yes ____ No _____ If yes, please describe: _____

_____

_____

ALLERGIES

Medications You Are Allergic To: **Reaction**

Foods You Are Allergic To: **Reaction**

Supplements You Are Allergic To: **Reaction**

Other Comments:

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***

0 1 2 3 4 5 6 7 8 9 10

Area 1:_____
1 2 3 4 5 6 7 8 9 10

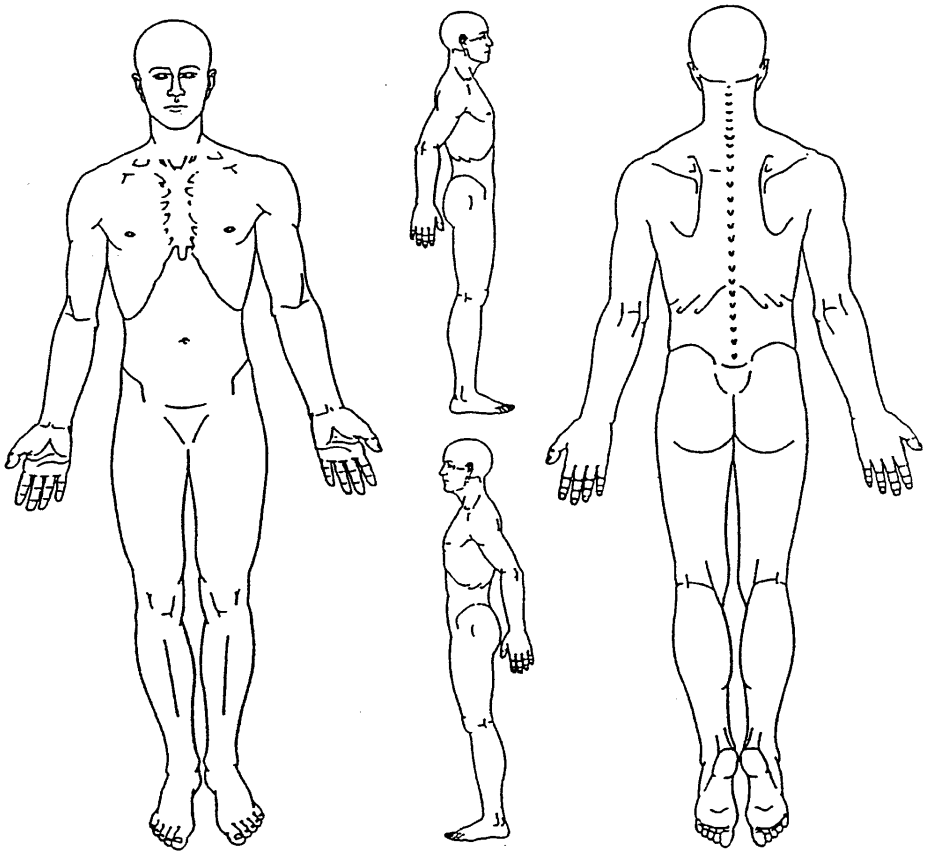
Area 2:_____
1 2 3 4 5 6 7 8 9 10

Area 3:_____
1 2 3 4 5 6 7 8 9 10

Area 4:_____
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



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
- ❑ Other_____
- ❑ Wheat
- ❑ Corn
- ❑ Eggs
- ❑ All gluten

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

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

_____

_____

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

When you shop do you purchase the following?

❑ Organic Foods ❑ Hormone free and antibiotic free meat

Do you read food labels? Yes _____ No _____

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

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

Check all the factors that apply to 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	❑ None	❑ None
❑ Bacon/Sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Coffee	❑ Brown rice
❑ Butter	❑ Eat in a cafeteria	❑ Butter

❑ Cereal	❑ Eat in restaurant	❑ Carrots
❑ Coffee	❑ Fish sandwich	❑ Coffee
❑ Donut	❑ Fried foods	❑ Fish
❑ Eggs	❑ Hamburger	❑ Green vegetables
❑ Fruit	❑ Hot dogs	❑ Juice
❑ Juice	❑ Juice	❑ Margarine
❑ Margarine	❑ Leftovers	❑ Milk
❑ Milk	❑ Lettuce	❑ Pasta
❑ Oat bran	❑ Margarine	❑ Potato
❑ Sugar	❑ Mayo	❑ Poultry
❑ Sweet roll	❑ Meat sandwich	❑ Red meat
❑ Sweetener	❑ Milk	❑ Rice
❑ Tea	❑ Pizza	❑ Salad
❑ Toast	❑ Potato chips	❑ Salad dressing
❑ Water	❑ Salad	❑ Soda
❑ Wheat bran	❑ Salad dressing	❑ Sugar
❑ Yogurt	❑ Soda	❑ Sweetener
❑ Oat meal	❑ Soup	❑ Tea
❑ Milk protein shake	❑ Sugar	❑ Vinegar
❑ Slim fast	❑ Sweetener	❑ Water
❑ Carnation shake	❑ Tea	❑ White rice
❑ Soy protein	❑ Tomato	❑ Yellow vegetables
❑ Whey protein	❑ Vegetables	❑ Other: (List below)
❑ Rice protein	❑ Water	_____
❑ Other: (List below)	❑ Yogurt	_____
_____	❑ Slim fast	_____
_____	❑ Carnation shake	_____
_____	❑ Protein shake	_____

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

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:

_____

_____

_____

_____

_____

_____

READINESS ASSESSMENT

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

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

Significantly modify your diet: 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Take several nutritional supplements each day: 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

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

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

Practice relaxation techniques: 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Engage in regular exercise: 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

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

Comments: _____

_____

_____

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

How confident are you of your ability to organize and follow through on the above health related activities?
5 _____ 4 _____ 3 _____ 2 _____ 1 _____

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

_____

_____

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

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

Comments: _____

_____

_____

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

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

5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments: _____

_____

_____

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

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

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

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

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

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