

Darien Center for
Integrative Medicine

COMFORT. CLARITY. SATISFACTION.



Introductory Patient Information

870 Post Road
Darien, CT 06820

203-655-4494

Fax 203-655-7577

www.darienim.com

info@darienim.com

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PATIENT CHECKLIST

DID YOU REMEMBER TO?

- Read all of our documents
- Obtain your medical records and/or test results from previously seen physicians and have them sent to the DCIM, 870 Post Road, Darien CT 06820 or fax 203-655-7577

FILL OUT AND/OR SIGN THE FOLLOWING FORMS:

- Important Patient Information
- Authorization for Release of Medical Information
- General Information
- Personal Descriptive Information
- Functional Diagnosis Questionnaire
- Establishing Health Goals
- Review Of Systems
- Dental History
- Medications & Supplements
- Allergies
- Nutrition & Lifestyle History
- Social History
- Environmental Influences
- Readiness Assessment

Thank you

FREQUENTLY ASKED QUESTIONS

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

Our clinic uses an innovative approach to assessing and treating your health-care concerns. Perhaps you have experienced being examined by your doctor, having blood tests done, x-rays or other diagnostic tests taken, only to have your doctor report that all your tests are normal. Usually, that is good news. But how would you feel getting those results when you know something is wrong, when you're not feeling well and know that you're not normal? Unfortunately that experience is all too common.

Most physicians are trained to look only in specific places for answers, using the same familiar diagnostic tests processed by the same labs. Yet, many causes of illness cannot be found in routine tests. Diagnosing food allergies, environmental toxins, mold exposure, Hidden infections, nutritional deficiencies and metabolic imbalances often requires specialized testing.

We use a variety of innovative testing techniques and procedures to help our patients recover from many chronic and difficult-to-treat conditions, and to prevent future illness. Dr. Zembroski is 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, "age-related" and complex conditions. He also focuses on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders. New gene testing can uncover underlying genetic predispositions that can be modified through diet, lifestyle, supplements or medications.

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

Some testing is done at our clinic; some tests are handled by conventional laboratories, and others are available only through specialized laboratories. During your consultation, Dr. Zembroski will determine which tests are needed; our office assistants then review testing instructions (*i.e.*, fasting or non-fasting, etc.), recommendations, and costs. Some tests can be started with at-home kits to collect urine, saliva or stool. Others may require you to go to a local laboratory to have blood drawn. 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 accept insurance?

We do not participate in any insurance networks, including Medicare, but we will provide a detailed receipt for services for you to submit to your insurance carrier. Some insurance carriers may partially cover medical services and laboratory tests. 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, American Express and Discover. As an added convenience, you may choose to maintain an active credit card on file at the office to facilitate billing.

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Consent Forms

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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. Zembroski's opinion that you should be well informed about our expectations and clinical procedures. To prevent any misunderstandings or confusion, please read the steps below and provide your signature as an acknowledgement 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 form was developed to gather important information about your body. It will assist Dr. Zembroski in helping you. The medical questionnaire will help to quickly "zero" in on the probable causes of your health problems.
 - The Food Diary

It is VERY important for you to complete carefully and thoroughly all the forms and questionnaires prior to your first consultation with Dr. Zembroski. Once the clinic 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 we have your completed questionnaires and copies of all your medical records, a 45-minute appointment will be scheduled to review your case. The cost for this appointment, as well as Dr. Zembroski's time spent reviewing your medical questionnaire, medical records and written report, is \$350. This fee covers the evaluation and interpretation of all the data you have provided. You will also receive recommendations at this time.
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 Metabolic Panel, which includes 24 important disease markers such as SGOT, SGPT, GGT, Bilirubin (Liver), BUN, Creatinine, Uric (Kidney), Alkaline Phosphatase (Bone)
 - Cardiovascular Panel: Cholesterol, Triglycerides, LDL, HDL, Cholesterol/HDL Ratio, LDL/HDL Ratio, C Reactive Protein (hs-CRP), Homocysteine, Fibrinogen
 - Thyroid Panel: Total T3, Total T4, Free T3, Free T4, TSH
 - Magnesium
 - CBC differential: White Blood Cells and Red Blood Cells, Platelets
 - Inflammatory markers: Sedimentation Rate
 - Fasting glucose and Hemoglobin A1C
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. If you have insurance, we will verify your coverage for the tests needed and let you know what you are covered for. If you have insurance benefits we will provide you the necessary forms to submit and get reimbursed. If not, payment can

be made via check and/or credit card to the clinic. We also have an in-house medical credit card called Care Credit, which can be used to cover the expense of any of your medical fees. Information on Care Credit can be obtained at my office and is subject to credit approval.

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. Zembroski or with your primary physician.
7. The results of your lab tests may take approximately two days to two weeks, at which point you will be scheduled for an appointment. This appointment usually takes approximately one hour. You will be presented with a 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 compounds, which must be paid at the time of purchase.
9. It is strongly recommended that you have access to a computer with Internet Connection. A progress medical questionnaire will be posted to your e-mail one week before your next scheduled appointment. Completion of the progress questionnaire is required every 6-12 weeks to monitor your progress. Correspondence by e-mail is strongly encouraged and is Free of Charge. If you do not have access to the internet, then a copy of the progress questionnaire will be mailed or faxed. If you would prefer to schedule an appointment to discuss any questions, you may do so by calling to schedule that visit.
10. Follow-up consultations will be scheduled every two to three weeks allowing you the opportunity to discuss your progress and any concerns. Dr. Zembroski will at this time determine what direction to take to help you continue your progress. Your cooperation in taking "personal responsibility" in your health care will go a long way in getting better. Consultations can be conducted either by phone or in person (at the office). The fee for follow-up consultations is \$200 for 30 minutes.
11. 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, _____ have read and fully understand the Patient Acceptance Policy.

Patient Signature

Please Print Your Name]

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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. Robert Zembroski and the Darien Center for Integrative Medicine all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

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

Alcohol or Drug Abuse: Yes No

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

Genetic Testing Yes No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure without the specific written consent of the person to whom 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. Robert Zembroski, the Darien Center for Integrative Medicine, its employees, agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

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

Patient's Name: _____ D.O.B. _____

Please Print

Signature: _____ Date _____

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

Records Requested by:

Doctor's Name: _____

Address: _____ Telephone number () ____-____

Signature: _____

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Health Questionnaires

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Darien Center for Integrative Medicine

GENERAL INFORMATION

Name _____

Preferred Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Age _____ Date of Birth _____ Place of Birth _____ Gender: Female _____ Male _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnership _____

Right-handed: _____ Left-handed: _____ Mixed Dominance: _____

No. of Sisters (# deceased) _____ No. of Brothers (# deceased) _____ Birth Order: _____

Occupation _____ Hours per week _____ Retired _____

Nature of Business _____

How did you hear about our clinic? Book _____ Website _____ Media _____ Friend/Family _____

Other (please specify) _____

Has any member of your family been a patient at our clinic? _____

Next of Kin/Emergency Contact: _____

Relationship _____ Phone _____

Address _____

Genetic Background: Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

Who is your primary medical physician? _____

Physician office address & phone: _____

PERSONAL DESCRIPTIVE INFORMATION

Marital status:

- Single Married Divorced
 Separated Widow Partnership

List Children:

Child's Name	Age	Gender

With whom do you live? Include spouse, 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 traveled 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 describe:

Have you experienced any major losses in life? Yes No

If so, please describe:

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

- 0-2 days 3-14 days more than 15 days

Previous jobs (describe):

Please list your highest level of education:

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

Functional Diagnosis Questionnaire

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

Note that we are interested in so-called minor symptoms as well as major problems. We know that in many doctors' offices there is some tendency not to mention minor symptoms for fear of being labeled 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. Such symptoms are often useful clues in the kind of "medical detective work" we do. Please include as much information as you can on this form.

Please print or write legibly.

COMPLAINTS/CONCERNS

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

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

What diagnosis or explanation has 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 conditions you listed above:

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

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

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

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES	Date	Date	Date	Comments
Chicken Pox				
German Measles				
Measles				
Mononucleosis				
Mumps				
Whooping cough				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				

Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	Date	Date	Date	Comments
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES	Date	Date	Date	Comments
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan of Abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone Density Test				
Carotid Artery Ultrasound				
Blood Tests				
Other (describe)				

OPERATIONS	Date	Date	Date	Comments
Tonsillectomy				
Tubes in Ears				
Appendectomy				
Gall Bladder				
Hernia				
Hysterectomy				
Dental Surgery				
Other (describe)				
Other (describe)				

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

PATIENT BIRTH HISTORY

Question	Yes	No	Don't Know	Comment
Were you a full term baby?				
A Premie?				
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?				

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 ILLNESSES

Please indicate which, if any, of the following problems/conditions developed when you were a child (birth to age 12) by indicating the approximate age of onset.

- | | |
|---|---|
| <input type="checkbox"/> Frequent colds or flu
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Measles
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Strep Infections
<input type="checkbox"/> Significant dental work
<input type="checkbox"/> ADD
<input type="checkbox"/> Difficulty learning
<input type="checkbox"/> Frequent absence from school | <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Mumps
<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Behavior problems
<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Upset stomach, indigestion |
|---|---|

- Jaundice
- Ear infections
- Premature at birth
- Fever blisters
- Abusive or alcoholic parent(s)
- Major illness(es) that required hospitalization
- Colic
- Congenital abnormalities
- Pneumonia
- Parent(s) smoked
- Skin disorders (eczema)

If yes, please explain your illness:

IMMUNIZATION HISTORY

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

- | | |
|--|---|
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Pertussis | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Polio (oral) | <input type="checkbox"/> Cholera |
| <input type="checkbox"/> Polio (Injection) | |

FEMALE MEDICAL HISTORY (for women only)

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

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

GYNECOLOGICAL HISTORY

Menstrual: Age at first period: _____ Menses Frequency: _____ Length: _____

Pain: Yes No Clotting: Yes No Last Menstrual Period: _____

Has your period skipped? Yes No For how long? _____

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? _____

Type of hormonal contraception: Birth-control pills Patch Nuva Ring How long? _____

Are you using birth-control pills now? Yes No Did taking the pills agree with you? Yes No

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

Date of last mammogram: _____ Breast biopsy? Date: _____

Date of last PAP test: _____ Normal Abnormal

Date of last bone-density test: _____ Results: High Low Normal

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 therapy? _____

FAMILY HISTORY

(Place mark any health problem(s) your family has suffered 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												

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												
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												

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
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

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 treatment 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, and 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 but to expect different results"***. If you keep following the same course of treatment you have been following, will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

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

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness?

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)

**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 your skin sensitive to:

- Sun
- Fabrics: _____
- Detergents: _____

HEAD:

- Poor Concentration
- Confusion
- Headaches:
- After Meals
- Severe
- Migraine
- Frontal
- Afternoon
- Occipital
- Afternoon
- Daytime
- Relieved by:
- Eating Sweets
- Concussion/Whiplash
- Mental Sluggishness
- Forgetfulness
- Indecisive
- Face Twitch
- Poor Memory
- Hair Loss

EYES:

- Sand in Eyes
- Double Vision
- Blurred Vision
- Poor Night Vision
- Bright Flashes
- Halo around Lights

- Eye Pains
- Dark Circles under Eyes
- Strong Light Irritates
- Cataracts
- Floaters in Eyes
- Visual hallucinations

EARS:

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

NOSE/SINUSES

- Stuffy
- Bleeding
- Running
- Discharge
- Watery Nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Change of season makes symptoms worse?

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? _____
- Urinary urgency/hesitancy/change
- Loss of Control of Urine

JOINT/MUSCLES/TENDONS

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

EMOTIONAL

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts
- Amnesia
- Had shock therapy
- Frequently keyed up and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Forgetful

- Listless
- Withdrawn feeling
- Feel "lost" in time
- Had nervous breakdown
- Had "burnout"
- Feel groggy
- Unable to concentrate
- Short attention span
- Vision changes
- Unable to reason
- Considered a nervous person
- Worried over little things
- Anxiety
- Unusual tension
- Frustration
- Numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Been admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Aggressive
- Misunderstood by others
- Irritable
- Easily flare in anger
- Feeling of hostility
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Have been addicted to drugs
- Extremely shy

DENTAL HISTORY

Have you had sore gums (gingivitis) often over the years? Yes No

Has ringing in the ears (tinnitus) been present? Yes No

Have TMJ (temporal mandibular joint) problems been a concern? Yes No

Do you often have a 'metallic' taste in your mouth? Yes No

Do you have a lot of bad breath (halitosis) or white tongue (thrush)? Yes No

Have you worn or do you presently wear braces? Yes No

Do you have problems chewing? Yes No

Do you floss regularly? Yes No

Did your mother have dental fillings prior to giving birth to you? Yes No

Did you have fillings as a child? Yes No

If yes, about how many fillings did you have up to 18 yrs? _____

Did you have dental fillings as an adult? Yes No

If yes, about how many fillings did you have after age 18 yrs? _____

How many amalgam fillings do you have now? _____

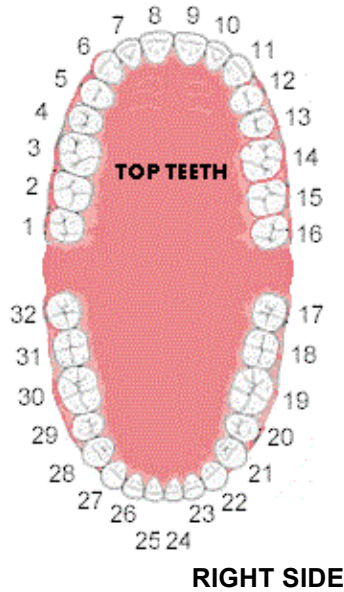
Did you play with mercury as a child or adult? Yes No

Have you eaten a lot of fish in your life? Yes No

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

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

Please 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 (if you know).



RECORD ANSWERS:

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	Less than 5 times	More than 5 times
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

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:

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

- Anti-fungals
- Aspirin/Ibuprofen
- Asthma inhalers
- Beta blockers
- Birth control pills/implant contraceptives
- Chemotherapy
- Cholesterol lowering medications
- Cortisone/steroids
- Diabetic medications/insulin
- High blood pressure medications
- Laxatives
- Relaxants/Sleeping pills
- Testosterone (natural or prescription)
- Thyroid medication
- Acetaminophen (Tylenol)
- Ulcer medications
- Sildenafil citrate (Viagra or similar)

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 your medications or supplements ever caused you unusual side effects or problems?

Yes No

If yes, please describe:

ALLERGIES

Medication / Supplement / Food	Reaction

NUTRITION & LIFESTYLE HISTORY

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

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

Check all that apply:

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

Please check any specific food restrictions you have:

- Dairy Wheat Eggs
 Soy Corn All gluten
 Other: _____

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

Height (feet/inches): _____ Current weight: _____

Usual weight range +/- 5 lbs: _____ Desired weight range (+/- 5 lbs): _____

Highest adult weight: _____ Lowest adult weight: _____

Weight fluctuations (>10 lbs)? Yes No Body Fat %: _____

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

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

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

Food	Symptom	Other comments

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

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

When you shop do you purchase the following?

Organic Foods Hormone-free/antibiotic-free meat

Do you read food labels? Yes No

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

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

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

- 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 healthful foods
- Do not plan meals or menus
- Reliance on convenience items
- Poor snack choices
- Significant other or family members don't like healthful foods
- Significant other or family members have special dietary needs or 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 advice
- Diet often for weight control

FOOD DIARY

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

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

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

- | | |
|--|--|
| <input type="checkbox"/> Almonds | <input type="checkbox"/> Chewing gum, sweetened |
| <input type="checkbox"/> Almond Butter | <input type="checkbox"/> Chewing gum, sugar free |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Coconut |
| <input type="checkbox"/> Apples | <input type="checkbox"/> Cod |
| <input type="checkbox"/> Avocado | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Asparagus | <input type="checkbox"/> Corn |
| <input type="checkbox"/> Bagels | <input type="checkbox"/> Crab |
| <input type="checkbox"/> Barley | <input type="checkbox"/> Cranberry |
| <input type="checkbox"/> Banana | <input type="checkbox"/> Cashew |
| <input type="checkbox"/> Burger King | <input type="checkbox"/> Cheese |
| <input type="checkbox"/> Bacon | <input type="checkbox"/> Cucumber |
| <input type="checkbox"/> Bean, Lima | <input type="checkbox"/> Deli Meats |
| <input type="checkbox"/> Bread, White | <input type="checkbox"/> Desserts |
| <input type="checkbox"/> Bread, Wheat | <input type="checkbox"/> Deli Sandwich |
| <input type="checkbox"/> Bread, Rye | <input type="checkbox"/> Eggplant |
| <input type="checkbox"/> Bagels | <input type="checkbox"/> Ensure |
| <input type="checkbox"/> Biscuits | <input type="checkbox"/> Flounder |
| <input type="checkbox"/> Bean, Pinto | <input type="checkbox"/> Fried Foods |
| <input type="checkbox"/> Bean, String | <input type="checkbox"/> French Fries |
| <input type="checkbox"/> Broccoli | <input type="checkbox"/> French Toast |
| <input type="checkbox"/> Brazil Nuts | <input type="checkbox"/> Garlic |
| <input type="checkbox"/> Brussels Sprouts | <input type="checkbox"/> Ginger |
| <input type="checkbox"/> Blueberries | <input type="checkbox"/> Grape |
| <input type="checkbox"/> Butter | <input type="checkbox"/> Grits |
| <input type="checkbox"/> Cabbage | <input type="checkbox"/> Greek Food |
| <input type="checkbox"/> Cereal, Special K | <input type="checkbox"/> Grapefruit |
| <input type="checkbox"/> Cereal, Bran | <input type="checkbox"/> Grape nuts |
| <input type="checkbox"/> Cereal, Corn | <input type="checkbox"/> Haddock |
| <input type="checkbox"/> Cereal, _____ | <input type="checkbox"/> Ham |
| <input type="checkbox"/> Cereal, _____ | <input type="checkbox"/> Halibut |
| <input type="checkbox"/> Celery | <input type="checkbox"/> Herring |
| <input type="checkbox"/> Cantaloupe | <input type="checkbox"/> Hot Dogs, Pork |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Hot Dogs, Beef |
| <input type="checkbox"/> Chinese Food | <input type="checkbox"/> Hamburgers |
| <input type="checkbox"/> Cream Cheese | <input type="checkbox"/> Hardies Food |
| <input type="checkbox"/> Carrot | <input type="checkbox"/> Honey |
| <input type="checkbox"/> Chicken | <input type="checkbox"/> Italian Food |
| <input type="checkbox"/> Chili Pepper | <input type="checkbox"/> Ice Cream |
| <input type="checkbox"/> Cinnamon | <input type="checkbox"/> Indian Food |
| <input type="checkbox"/> Clam | <input type="checkbox"/> Jack in the box food |
| <input type="checkbox"/> Cloves | <input type="checkbox"/> Japanese Food |
| <input type="checkbox"/> Cocoa-Chocolate | <input type="checkbox"/> Jelly |
| <input type="checkbox"/> Carnation Drink | <input type="checkbox"/> 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

- 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 per day ____ **Type:** Tap Distilled Spring Well Reverse Osmosis

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

Yes No If yes, please explain: _____

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

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

Food	Symptom	Other Comments

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

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

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

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

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

Does skipping meals greatly affect your symptoms? Yes No

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

Yes No If yes, what food(s):

Do you have an aversion to certain foods? Yes No If yes, what food(s):

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

TOBACCO HISTORY

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

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

Attempts to quit: _____

Previous smoking: How many years? _____ Packs per day: _____ Date you quit: _____

Are you exposed to second-hand smoke? If yes, please explain:

ALCOHOL INTAKE

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

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

Previous alcohol intake? Yes — Mild Moderate High No

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

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

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

Do you ever take an eye-opener? Yes No

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

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

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

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

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

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

Other family member? Yes No

OTHER SUBSTANCES

Are you currently using recreational drugs? Yes No

If yes, what types?: _____

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

If yes, what types?: _____

EXERCISE

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

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

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

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe: _____

Do you usually sweat when exercising? Yes No

SOCIAL HISTORY

PSYCHOSOCIAL

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

Are you happy? Yes No

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

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

Do you like the work you do? Yes No

Have you experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? Yes No

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

STRESS/COPING

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

Please do your best to answer the following questions:

Did you feel safe growing up? Yes No

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

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

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

Have you ever sought counseling? Yes No

Currently? Yes No Previously? Yes No

If previously, from _____ to _____

What kind of counseling? _____

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 if not stressful, 10 if very stressful)*

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? Yes No If yes, how often? _____

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other: _____

Hobbies and leisure activities: _____

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

Not at all important Somewhat important 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
<input type="checkbox"/> Excessive Fatigue	10	½	1	2	
<input type="checkbox"/> Dry & Thin Skin	10	½	1	2	
<input type="checkbox"/> Nervous/Irritability	9	½	1	2	
<input type="checkbox"/> Low body temperature	8	½	1	2	
<input type="checkbox"/> Premenstrual tension	8	½	1	2	
<input type="checkbox"/> Inability to concentrate	8	½	1	2	
<input type="checkbox"/> Mental depression	8	½	1	2	
<input type="checkbox"/> Food allergies & sensitivities	7	½	1	2	
<input type="checkbox"/> Craving for sweets	7	½	1	2	
<input type="checkbox"/> Headaches	6	½	1	2	
<input type="checkbox"/> Alcohol intolerance	6	½	1	2	
<input type="checkbox"/> Poor memory	5	½	1	2	
<input type="checkbox"/> Heart palpitations	5	½	1	2	
TOTAL SCORE					

Do you have chronic pain? Yes No

Do you have chronic inflammation? Yes No

SOCIAL READJUSTMENT RATING SCALE*

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

Life Event	Answer		Points
Death of spouse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	100
Divorce	<input type="checkbox"/> Yes	<input type="checkbox"/> No	73
Marital separation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	65
Jail term	<input type="checkbox"/> Yes	<input type="checkbox"/> No	63
Death of close family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No	63
Personal injury or illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	53
Marriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	50
Fired from work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	47
Marital reconciliation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	45
Retirement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	45
Change in family members health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	44
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	40
Sex difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Addition to family	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Business readjustment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Change in financial status	<input type="checkbox"/> Yes	<input type="checkbox"/> No	38
Death of close friend	<input type="checkbox"/> Yes	<input type="checkbox"/> No	37
Change in line of work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	36
Change in # of marital arguments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	35
Mortgage or loan over \$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	31
Foreclosure of mortgage or loan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	30
Change in work responsibilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Son or daughter leaving home	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Trouble with in-laws	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Outstanding personal achievement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	28
Spouse begins or stops work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26
Starting or finishing school	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26
Change in living conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	25
Revision of personal habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	24
Trouble with boss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	23
Change in work hours, conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in residence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20

Life Event	Answer		Points
Change in schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in recreational habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19
Mortgage or loan under \$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18
Change in sleeping habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16
Change in eating habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15
Vacation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	13
TOTAL SCORE			

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

TOXIC STRESS TRIGGERS

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

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

DO YOU WORRY OVER?

- Home life
- Marriage
- Children
- Job
- Income

IS YOUR LIFE:

- Satisfactory
- Boring
- Demanding
- Unsatisfactory
- Affected by Money Problems

SLEEP/REST

Average number of hours you sleep: >10 8-10 6-8 <6

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No

Do you use sleeping aids? Yes No Explain: _____

ENVIRONMENTAL INFLUENCES

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

Electromagnetic Factors

- Live or have you lived within 200 yards from high-voltage wires or transformers
When? _____
- Live or have lived near an electric distribution substation
- Bed is close to the main electrical current
- Have a fan directly over your bed
- Have an alarm clock or radio close to your bed (plugged in)
- Live or have you lived near a television transmitter
- Sleep with an electric blanket, heating pad
- Sleep on a waterbed

Position of your head of your bed is facing:

- North
- South
- East
- West
- Work on a computer for longer than six hours/day
- Use a screening shield over your computer screen
- Live or have you lived near a power generating station
- Live near a radio tower
- You use a cellular phone more than 2 hours per day
- Use microwave ovens
- Bed has a wooden backboard
- Have fluorescent light fixtures

What is your occupation?

Toxin Exposure

Trichloroethylene/TCE

- Work close to a copy machine
- Worked in a printing shop
- Drink decaffeinated coffee
- Use typewriter correction fluid
- Use rug cleaners
- Use disinfectants
- Use carbonless paper
- Use spot removers
- Use cleaning supplies
- Use metal degreasers
- Do recreational painting

Formaldehyde

- Wear many dry-cleaned clothes
- Noticed changes of your health since you moved into your home
- Wear many polyester clothes and permanent press
- 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 has been insulated since your illness
- Have new carpets When? _____
- Use waxes and polishes on your floor
- Have been around resin glues and plastics
- Have exterior-grade plywood on your home
- Home is 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
- 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
- Use crop-surface sprays
- Use aerosols
- Use fumigants

Volatile Organic Compounds

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

- Home has been 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
- Use waxes
- Use mouthwash
- Have saucepans with hard 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 heater
- Chimney is damaged
- Live near a busy street
- Garage is 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 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)
- Have fingernails treated with acrylic adhesives

**Please note the "brand" of product you use
For example: Toothpaste: Crest**

- Shampoo: _____
- Toothpaste: _____
- Hair Conditioner: _____
- Makeup: _____
- Lipstick: _____
- Make-up Foundation: _____
- Deodorant: _____
- Perfume: _____
- Hairspray: _____
- Shaving Cream: _____
- Cologne: _____
- Facial Creams: _____
- Body Creams: _____

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

Do you have hair colorings? Yes No
If yes, is 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 is 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
Implant 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
 Bought new vehicle since symptoms began
 Furniture 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
 Have siding on your home
 Changed your heating system, stove, clothes dryer or water heater
 Lived in a brand-new home
 Worked 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?

 Hardwood floors
 Laminate floors
 Carpeting
 Window blinds
 Draperies

- Foam pillow
- Feather pillow
- Dacron pillow
- Wool blankets
- Cotton blankets
- Quilts
- Synthetic blankets
- Electric blanket
- Ceiling fan
- Material stored under the bed
- Real plants
- Artificial plants
- Aromatherapy
- Scented candles
- Central heating
- Fireplace
- Electric baseboard
- Gas heat
- Air filter
What type?

- When was the last time you changed the air filter?

- Central air conditioning

- Sleep with windows open
- Live close to a high-traffic road
- Smoke in bed
- Allow any pets in your room
What type?

- Plugged-in air fresheners

Art and Leisure Activities

- Silk-screening
- Stained glass
- Pottery & ceramics
- Make jewelry
- Use art and craft supplies
- Use airbrush and spray paints
- 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 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 people in your household will be to your implementing 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 questionnaire. The information derived from all of these forms will provide invaluable data. Each section builds upon the other, allowing me the opportunity to discover the “**missing key**” that will solve your health problem. Once all the sections of this form have been filled out, please return them to our office. We will then make an appointment for your initial consultation.

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

Sincerely,

Dr. Z