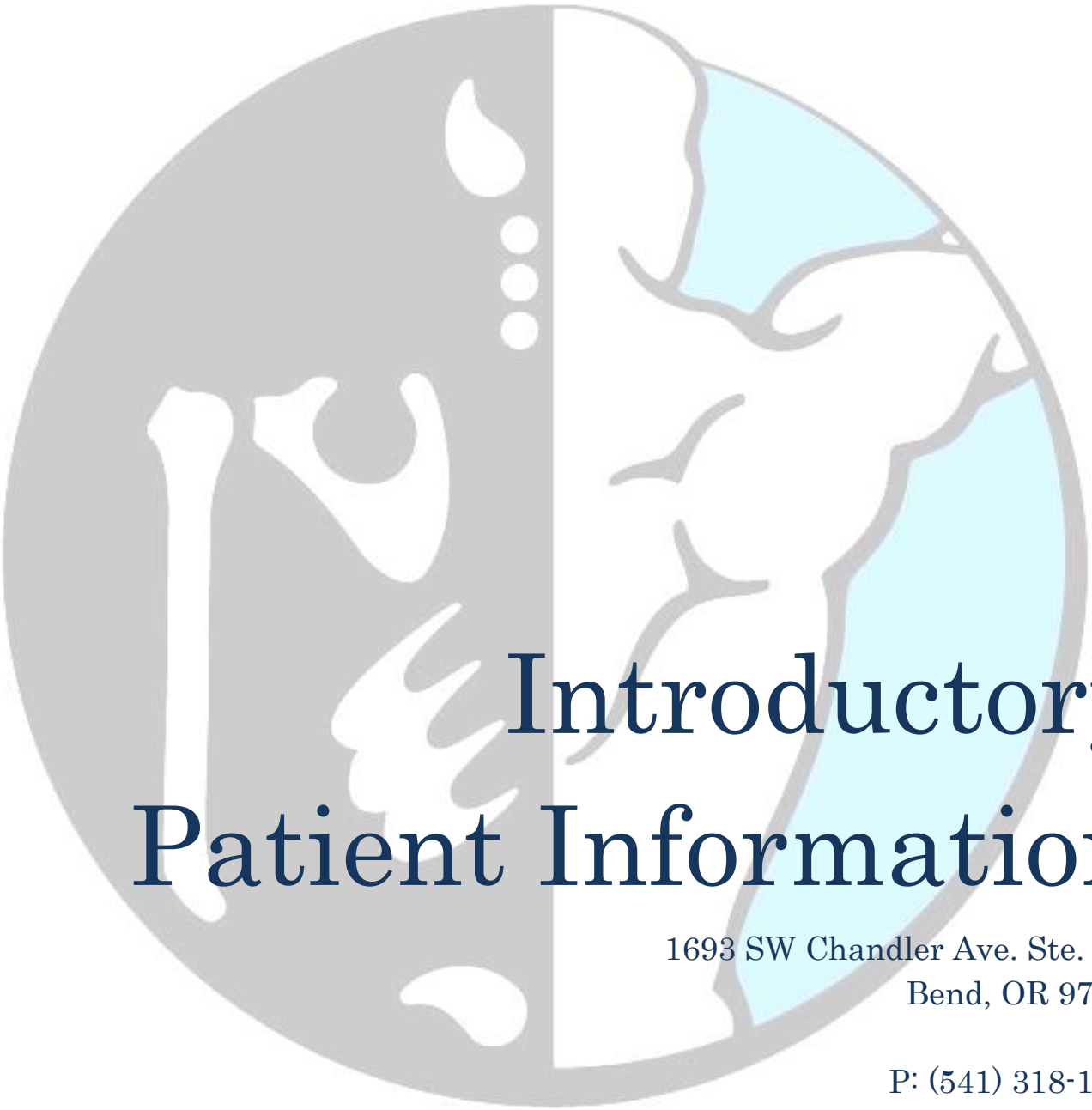
Wellness Doctor, Inc.

TREATING THE CAUSE, NOT THE SYMPTOMS



Introductory Patient Information

1693 SW Chandler Ave. Ste. 280
Bend, OR 97702

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F: (541) 318-7050
Appointments@BendWellnessDoctor.com

www.BendWellnessDoctor.com
www.HealthAroundYOU.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Facility or Person: _____
Address: _____
Telephone Number: (___) ____ - _____ Fax Number: (___) ____ - _____

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to Wellness Doctor, Inc. 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 HIV 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 related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with 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 Wellness Doctor, Inc., its employees, agents, managing members, and the attending physician(s) from legal responsibility 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. However, no such fee will be charged if these records are requested for continuing medical care.

Name: _____ DOB: _____

Signature: _____ Date: _____

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

Information Released: _____ Date: _____
Medical Records Technician Name: _____
Signature: _____

Please send records to: Wellness Doctor, Inc., 1693 SW Chandler Ave., Suite 280, Bend, OR 97702 * Fax: 541-318-7050

INFORMED CONSENT REGARDING EMAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Wellness Doctor, Inc. provides patients the opportunity to communicate with their healthcare providers, and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
    a. General e-mail risks are the following: email can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the send or the recipient has deleted his/her copy.
    b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.
2. It is the policy of Wellness Doctor, Inc. that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Wellness Doctor, Inc. will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail internet communication.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
    a. All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Wellness Doctor, Inc. physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.
    b. Wellness Doctor, Inc. may forward e-mail messages within the practice as necessary for diagnosis and treatment. Wellness Doctor, Inc. will not, however, forward the email outside the practice without the consent of the patient as required by law.
    c. Wellness Doctor, Inc. will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
    d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
    e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/ HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
    f. Wellness Doctor, Inc. cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication but Wellness Doctor, Inc. is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
    g. If consent is given for the use of e-mail, it is the responsibility of the patient's to inform Wellness Doctor, Inc. of any types of information you do not want to be sent by e-mail.
    h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from Wellness Doctor, Inc. to protect confidentiality. Wellness Doctor, Inc. is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Wellness Doctor, Inc.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name: _____ Date: _____

Signature: _____

Wellness Doctor, Inc., 1693 SW Chandler Ave., Suite 280, Bend, OR 97702 * Fax: 541-318-7050

Wellness Doctor, Inc.

TREATING THE CAUSE, NOT THE SYMPTOMS

GENERAL INFORMATION

First: _____Middle:_____Last:_____
Preferred Name: _____
Date of Birth:_____ Age:____ Gender: __ M __F Email:_____

Genetic Background: ___ African ___European ___ Native American ___Mediterranean
___Asian ___Ashkenazi ___Middle Eastern ___ _____

Highest Education Level: ___High School ___Under-Graduate ___Post-Graduate

Job Title:_____
Nature of Business: _____

Primary Address: _____
_____
Alternate Address: _____
_____
Home Phone 1: _____
Home Phone 2: _____
Work Home: _____
Cell Phone: _____
Fax: _____
Email: _____
Emergency Contact: Name: _____ Phone: _____
Address: _____
_____

Physician: Name: _____
Phone: _____Fax: _____

Referred by: ___ Book ___ Website ___Media ___Friend or Family Member
___ Other _____

MEDICAL QUESTIONNAIRE

ALLERGIES:

Medication/ Supplement/ Food _____ Reaction _____

_____ _____

_____ _____

_____ _____

COMPLAINTS/ CONCERNS

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. _____

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 current and ongoing problems in order of priority:

Describe Problem	**Mild**	**Moderate**	**Severe**	**Prior Treatment/Approach**	**Excellent**	**Good**	**Fair**
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		

DISEASES/ DIAGNOSIS/ CONDITIONS *Check appropriate box and provide date of onset*

		GASTROINTESTINAL			**GENITAL NAD URINARY SYTEMS**
		Irritable Bowel Syndrome:			Kidney Stones:
		Inflammatory Bowel Disease:			Gout:
		Crohn's:			Interstitial Cystitis:
		Ulcerative Colitis:			Frequent Urinary Tract Infections:
		Gastritis or Peptic Ulcer Disease:			Frequent Yeast Infections:
		GERD			Erectile Dysfunction or Sexual Dysfunction:
		Celiac Disease:			Other:
		Other:			**MUSCULOSKELETAL/ PAIN**
		CARDIOVASCULAR			Osteoarthritis:
		Heart Attack:			Fibromyalgia:
		Other Heart Disease:			Chronic Pain:
		Stroke:			Other:
		Elevated Cholesterol:			**INFLAMMATORY/ AUTOIMMUNE**
		Arrythmia (Irregular heart rate):			Chronic Fatigue Syndrome:
		Hypertension (High blood pressure):			Autoimmune Disease:
		Rheumatic Fever:			Rheumatoid Arthritis:
		Mitral Valve Prolapse:			Lupus SLE:
		Other:			Immune Deficiency Disease:
		METABOLIC/ ENDOCRINE			Herpes-Genital:
		Type 1 Diabetes:			Severe Infectious Disease:
		Type 2 Diabetes:			Poor Immune Function (frequent infections):
		Hypoglycemia:			Food Allergies:
		Metabolic Syndrome: (Insulin Resistance or Pre-Diabetes)			Environmental Allergies:
		Hypothyroidism (low thyroid):			Multiple Chemical Sensitivities:
		Hyperthyroidism (overactive thyroid):			Latex Allergy:
		Endocrine Problems:			Other:
		Polycystic Ovarian Syndrome (PCOS):			**RESPIRATORY DISEASE**
		Infertility:			Asthma
		Weight Gain:			Chronic Sinusitis:
		Weight Loss:			Bronchitis:
		Frequent Weight Fluctuations:			Emphysema:
		Bulimia:			Pneumonia:
		Anorexia:			Tuberculosis:
		Binge Eating Disorder:			Sleep Apnea:
		Night Eating Syndrome:			Other:
		Eating Disorder (non-specific):			**SKIN DISEASES**
		Other:			Eczema:
		CANCER			Psoriasis:
		Lung Cancer:			Acne:
		Breast Cancer:			Melanoma:
		Colon Cancer:			Skin Cancer:
		Ovarian Cancer:			Other:
		Prostate Cancer:			
		Skin Cancer:			
		Other:			

		NEUROLOGICAL/ MOOD			Autism:
		Depression:			Mild Cognitive Impairment:
		Anxiety:			Memory Problems:
		Bipolar Disorder:			Parkinson's Disease:
		Schizophrenia:			Multiple Sclerosis:
		Headaches:			ALS:
		Migraines:			Seizures:
		ADD/ADHD			Other Neurological Problems:

Check box if yes and provide date

	PREVENTIVE TESTS AND DATE OF LAST TEST
	Full Physical Exam:
	Bone Density:
	Colonoscopy:
	Cardiac Stress Test:
	EBT Heart Scan:
	EKG:
	Hemoccult Test-stool test for blood:
	MRI:
	CT Scan:
	Upper Endoscopy:
	Upper GI Series:
	Ultra Sound:

Check box if yes and provide date

	SURGERIES
	Appendectomy:
	Hysterectomy +/ - Ovaries:
	Gall Bladder:
	Hernia:
	Tonsillectomy:
	Dental Surgery:
	Joint Replacement- Knee/ Hip:
	Heart Surgery- Bypass Valve:
	Angioplasty or Stent:
	Pacemaker:
	Other:
	None

INJURIES:
Check if yes
____ Back Injury ____ Head Injury ____ Neck Injury ____ Broken Bones ____ Other: _____

BLOOD TYPE:
____ A ____ B ____ AB ____ O ____Rh+ ____ Unknown

HOSPITALIZATIONS : ____ NONE

DATE:	REASON:

COMMENTS:
_____
_____
_____
_____
_____
_____
_____

GYNECOLOGIC HISTORY *(for women only)*

OBSTETRIC HISTORY

Check if yes and provide number of

☐ Pregnancies: _____ ☐ Caesarean: _____ ☐ Vaginal Deliveries: _____
☐ Miscarriage: _____ ☐ Abortion:_____ ☐ Living Children: _____
☐ Post Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby over 18 pounds
☐ Breast Feeding For how long? _____

MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length: _____ Pain: ___YES ___NO
Clotting: ___YES ___NO
Has your period ever skipped? _____ For how long? _____
Last Menstrual Period:_____
Use of hormonal Contraception such as: ___ Birth Control Pills ___ Patch ___ Nuva Ring How long:__
Do you use contraception? ___ YES ___NO ___ Condom ___Diaphragm ___IUD ___Partner Vasectomy

WOMEN'S DISORDERS/ HORMONAL IMBALANCES

___Fibrocystic Breasts ___Endometriosis ___Fibroids ___Infertility
___Painful Periods ___Heavy Periods ___PMS
Last Mammogram: _____ Breast Biopsy/ Date: _____
Last PAP Test: _____ Normal___ Abnormal___
Last Bone Density: _____ Results: ___ High ___Low ___Within Normal Range
Are you in Menopause: ___ YES ___NO
Age at Menopause:_____
___Hot Flashes ___Mood Swings ___Concentration/ Memory Problems ___Vaginal Dryness
___Decreased Libido ___Heavy Bleeding ___Joint Pains ___Headaches ___Weight Gain
___Loss of Control of Urine ___Palpitations
___Use of hormone replacement therapy, how long? _____

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
___Difficulty Obtaining an 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

GI HISTORY

Foreign Travel? ___YES ___NO Where? _____
Wilderness Camping? ___YES ___NO Where? _____
Have you ever had severe: ___ Gastroenteritis ___Diarrhea
Do you feel like you digest your food well? ___YES ___NO
Do you feel bloated after meals? ___YES ___NO

PATIENT BIRTH HISTORY

___Term ___Premature
Pregnancy Complications: _____
Birth Complications: _____
___Breast Fed. How long? _____ Bottle-Fed
Age of introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____
Did you eat a lot of candy or sugar as a child? ___YES ___NO

DENTAL HISTORY

DENTAL SURGERY

___ Silver Mercury Fillings How many? _____
___Gold Fillings ___Root Canals ___Implants ___ Tooth Pain ___Bleeding Gums
___Gingivitis ___Problems with Chewing
Do you floss regularly? ___YES ___NO

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS: Last 10 Years

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/ MINERALS/ HERBS/ HOMEOPATHY)

Supplication and Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

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

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Etc.), Motrin, Aspirin? ___YES ___NO

Have you had prolonged or regular use of Tylenol? ___YES ___NO

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, Etc.) __YES __NO

Frequent Antibiotics >3 times/ year ___YES ___NO

Long term antibiotics ___YES ___NO

Use of steroids (prednisone, nasal allergy inhalers) in the past ___YES ___NO

Use of oral contraceptives ___YES ___NO

FAMILY HISTORY

Check family members that apply	Mother	Father	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)												
Cancers												
Lyme Disease												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis)												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/ Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Alzheimer's												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ____YES ____NO
Have you made any changes in your eating habits because of your health? ___YES ___NO Describe:
_____
Do you currently follow a special diet or nutritional program? ___YES ___NO
Check all that apply:
___Low Fat ___Low Carbohydrate ___High Protein ___Low Sodium ___Diabetic ___No Dairy ___No Wheat
___Gluten Restricted ___Vegetarian ___Vegan ___Ultrametabolism
___Specific Program for Weight Loss/ Maintenance Type: _____ ___Other:
_____

Height (feet/ inches) _____	Current Weight _____
Usual Weight Range +/- 5lbs _____	Desired Weight Range +/- 5lbs _____
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
Have you ever had your metabolism (resting metabolic rate) checked? ___YES ___NO If yes, what was it?
_____
Do you avoid any particular foods? ___YES ___NO If yes, types and reasons _____
_____
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? _____
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 meals per week
Check all the factors that apply to your current lifestyle and eating habits:

	Fast eater		Significant other or family members have special dietary needs or food preferences
	Erratic eating pattern		Love to eat
	Eat too much		Eat because I have to
	Late night eating		Have a negative relationship with food
	Dislike healthy food		Struggle with eating issues
	Time constraints		Emotional eater (eat when sad, lonely, depressed, bored)
	Eat more than 50% meals away from home		Eat too much under stress
	Travel frequently		Eat too little under stress
	Non-availability of healthy foods		Don't care to cook
	Do not plan meals or menus		Eating in the middle of the night
	Reliance on convenience items		Confused about nutrition advice
	Significant other or family members don't like healthy foods.		Poor snack choices

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

SMOKING

Currently Smoking? ___YES ___NO How many years? _____ Packs per day: _____
Attempts to quit: _____
Previous Smoking: How many years? _____ Packs per day? _____
Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink= 5 ounces wine, 12 ounces 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) ___NONE
Have you ever been told you should 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

OTHER SUBSTANCES

Caffeine Intake: ___YES ___NO Coffee cups/day: ___1 ___2-4 ___>4 Tea cups/day: ___1 ___2-4 ___>4
Caffeinated Sodas or Diet Sodas Intake: ___YES ___NO
12-ounce can/ bottle ___1 ___2-4 ___>4 per day
List favorite type (Ex. Diet Coke, Pepsi, Etc.): _____
Are you currently using any recreational drugs? ___YES ___NO Type _____
Have you ever used IV or inhaled recreational drugs? ___YES ___NO

EXERCISE

Current Exercise Program: (List type of activity, number of sessions/ week, and duration)

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/ Aerobics			
Strength			
Other (Yoga, pilates, etc.)			
Sports or Leisure Activities (golf, tennis, cycling, hiking, 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

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 ever 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

Have you ever sought counseling? ___YES ___NO
Are you currently in therapy? ___YES ___NO Describe: _____
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? ___YSE ___NO
Daily Stressors: *Rate on a scale of 1-10*
Work _____ Family _____ Social _____ Finances _____ Health _____ Other_____

SLEEP/ REST

Average number of hours you sleep per night: ___>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: _____

ROLES/ RELATIONSHIP

Marital Status ___Single ___Married ___Divorced ___Gay/Lesbian ___Long Term Partnership ___Widow/er
List Children:

Child's Name	Age	Gender

Who is living in the household? Number: _____ Names: _____
Their Employment / Occupations: _____
_____
Resources for emotional support?
Check all that apply: ___Spouse ___Family ___Friends ___Religious/ Spiritual ___Pets ___Other: _____
Are you satisfied with your sex life? ____YES ____NO

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
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?				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ___YES ___NO If yes, describe symptoms:

_____

Do you have any food allergies or sensitivities? ___YES ___NO If yes, list all:

_____

Do you have an adverse reaction to caffeine? ___YES ___NO

When you drink caffeine do you feel: ____Irritable or Wired ____Aches and Pains

Do you adversely react to (check all that apply):

___Monosodium glutamate (MSG) ___Aspartame (Nutrasweet) ___Caffeine ___Bananas ___Garlic ___Onion

___Cheese ___Citrus Foods ___Chocolate ___Alcohol ___Red Wine

___Sulfite Containing Foods (wine, dried fruit, salad bars) ___Preservatives (ex. Sodium benzoate)

___Other: _____

Which of these significantly affect you? Check all that apply:

___Cigarette Smoke ___Perfumes/ Colognes ___Auto Exhaust Fumes ___Other: _____

In your work or home environment, are you exposed to: ___Chemicals ___Electromagnetic Radiation ___Mold

Have you ever turned yellow (jaundiced)? ___YES ___NO

Have you ever been told you have Gilbert's Syndrome or a liver disorder? ___YES ___NO

Explain: _____

Do you have a known history or significant exposure to any harmful chemicals such as the following:

___Herbicides ___Insecticides (frequent visits of exterminator) ___Pesticides ___Organic Solvents

___Heavy Metals ___Other: _____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? ___YES ___NO

Do you or have you ever lived or worked in a damp or moldy environment or had other mold exposures?

___YES ___NO

Do you have any pets or farm animals? ___YES ___NO

Have you ever been bitten by a Tick or had Lyme Disease? ___YES ___NO

Were you treated? ___YES ___NO

Where have you lived in the past and approximately how long?

_____

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months

	GENERAL		Muscle Weakness		**DIGESTION**
	Cold Hands & Feet		Neck Muscle Spasm		Anal Spasms
	Cold Intolerance		Tendonitis		Bad Teeth
	Low Body Temperature		Tension Headache		Bleeding Gums
	Low Blood Pressure		TMJ Problems		Bloating of Lower Abdomen
	Daytime Sleepiness		**MOOD/ NERVES**		Bloating of Whole Abdomen
	Difficulty Falling Asleep		Agoraphobia		Bloating after Meals
	Early Waking		Anxiety		Blood in Stools
	Fatigue		Auditory Hallucinations		Burping
	Fever		Black-out		Canker Sores
	Flushing		Depression		Cold Sores
	Heat Intolerance		Difficulty Concentrating		Constipation
	Night Waking		Difficulty with Balance		Cracking at Corner of Lips
	Nightmares		Difficulty with Thinking		Cramps
	No Dream Recall		Difficulty with Judgment		Dentures w/ Poor Chewing
	HEAD, EYES & EARS		Difficulty with Speech		Diarrhea
	Conjunctivitis		Difficulty with Memory		Alternating Diarrhea and Constipation
	Distorted Sense of Smell		Dizziness (spinning)		Difficulty Swallowing
	Distorted Taste		Fainting		Dry Mouth
	Ear Fullness		Fearfulness		Excess Flatulence/ Gas
	Ear Pain		Irritability		Fissures
	Ear Ringing/ Buzzing		Light-headedness		Foods “Repeat” (Reflux)
	Lid Margin Redness		Numbness		Gas
	Eye Crusting		Other Phobias		Heartburn
	Eye Pain		Panic Attacks		Hemorrhoids
	Hearing Loss		Paranoia		Indigestion
	Hearing Problems		Seizures		Nausea
	Headache		Suicidal Thoughts		Upper Abdominal Pain
	Migraine		Tingling		Vomiting
	Sensitivity to Loud Noises		Tremor/ Trembling		Intolerance to Lactose
	Vision Problems (other than glasses)		Visual Hallucinations		Intolerance to All Dairy Products
	Macular Degeneration		**EATING**		Intolerance to Wheat
	Vitreous Detachment		Bing Eating		Intolerance to Gluten (wheat, rye, barley)
	Retinal Detachment		Bulimia		Intolerance to Corn
	MUSCULOSKELETAL		Can’t Gain Weight		Intolerance to Eggs
	Back Muscle Spasm		Can’t Lose Weight		Intolerance to Fatty Foods
	Calf Cramps		Can’t Maintain Healthy Weight		Intolerance to Yeast
	Chest Tightness		Frequent Dieting		Liver Disease/ Jaundice (yellow eyes or skin)
	Foot Cramps		Poor Appetite		Abnormal Liver Function Tests
	Joint Deformity		Salt Cravings		Lower Abdominal Pain
	Joint Pain		Carbohydrate Craving (breads, pastas)		Mucus in Stools
	Joint Redness		Sweet Cravings (candy, cookies, cakes)		Periodontal Disease
	Joint Stiffness		Chocolate Cravings		Sore Tongue
	Muscle Pain		Caffeine Dependency		Strong Stool Odor
	Muscle Spasms				Undigested Food in Stools
	Muscle Stiffness				
	Muscle Twitches __eyes __arms Or __legs				

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:	5	4	3	2	1
Significantly modify your diet					
Take several nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (e.g., work demands, sleep habits)					
Practice a relaxation technique					
Engage in regular exercise					
Have periodic lab tests to assess your progress					

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 (very unsupportive):

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 on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? **5 4 3 2 1**

Comments:

_____

_____

_____

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g, milk-what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/ diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. Craving sweet, skipped meal and why, when the meal was at a restaurant, etc.).
- Please not all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name: _____ Date: _____

DAY 1

Time	Food/ Beverage/ Amount	Comments

Bowel Movements (#, form, color) _____

Stress/ Mood/ Emotions _____

Other Comments _____

DAY 2

Time	Food/ Beverage/ Amount	Comments

Bowel Movements (#, form, color) _____

Stress/ Mood/ Emotions _____

Other Comments _____

Day 3

Time	Food/ Beverage/ Amount	Comments

Bowel Movements (#, form, color) _____

Stress/ Mood/ Emotions _____

Other Comments _____

MSQ- MEDICAL SYMPTOM/ TOXICITY QUESTIONNAIRE

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this form after your first time, then record your symptoms for the last 48 hours ONLY.

Point Scale

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT
___Nausea or Vomiting
___Diarrhea
___Constipation
___Bloated feeling
___Heartburn
___Intestinal Stomach Pain
Total _____

EARS
___Itchy ears
___Earaches, ear infections
___Drainage from ear
___Ringing in ears, hearing loss
Total _____

EMOTIONS
___Mood swings
___Anxiety, fear or nervousness
___Anger, irritability or aggressiveness
___Depression
Total _____

ENERGY/ ACTIVITY
___Fatigue, sluggishness
___Apathy, lethargy
___Hyperactivity
___Restlessness
Total _____

EYES
___Watery or itchy eyes
___Swollen, reddened or sticky eyelids
___Bags or dark circles under eyes
___Blurred or tunnel vision (does not Include near or far-sightedness)
Total _____

HEAD
___Headaches
___Faintness
___Dizziness
___Insomnia
Total _____

HEART
___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
___Chest Pain
Total _____

JOINTS/ MUSCLES
___Pain or aches in joints
___Arthritis
___Stiffness or limitation of movement
___Pain or aches in muscles
___Feeling of weakness or tiredness
Total _____

LUNGS
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficulty breathing
Total _____

MIND
___Poor memory
___Confusion, poor comprehension
___Poor concentration
___Poor physical coordination
___Difficulty in making decisions
___Stuttering or stammering
___Slurred speech
___Learning disabilities
Total _____

MOUTH/ THROAT
___Chronic Coughing
___Gagging, frequent need to clear throat
___Sore throat, hoarseness, loss of voice
___Swollen/discolored tongue, gum, lips
___Canker Sores
Total _____

NOSE
___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus formation
Total _____

SKIN
___Acne
___Hives, rashes or dry skin
___Hair loss
___Flushing or hot flushes
___Excessive sweating
Total _____

WEIGHT
___Binge eating/ drinking
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water retention
___Underweight
Total _____

OTHER
___Frequent illness
___Frequent or urgent urination
___Genital itch or discharge
Total_____

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

Optimal is less than 10 Mild Toxicity is 10-50 Moderate Toxicity is 50-100 Severe Toxicity is over 100