

DR. ANTHONY G. BECK

EDUCATE • MOTIVATE • INSPIRE
EDUCATE • MOTIVATE • INSPIRE



Introductory Patient Information

951 Nola Drive
Ocoee, FL 34761

Phone # 407.435.1083

Fax # 407.347.7672

www.dranthonybeck.com
dranthonybeck@gmail.com

TABLE OF CONTENTS

INTRODUCTORY INFORMATION

Patient Checklist_____	1
Frequently Asked Questions_____	2
<input type="checkbox"/> Do you think you can help with my problem?_____	2
<input type="checkbox"/> Can all the tests I need to be done in the clinic?_____	2
<input type="checkbox"/> Do you take insurance?_____	2
<input type="checkbox"/> What credit cards do you take?_____	2
	2

CONSENT FORMS

Important Patient Information_____	
<input type="checkbox"/> Patient Acceptance Form_____	1
Authorization of Treatment_____	3
Authorization for Release of Medical Information_____	8

HEALTH QUESTIONNAIRES

General Information_____	1
Functional Diagnostic Medicine Questionnaire_____	3
Health Goals Form_____	11
Review of systems_____	14
Nutrition and Lifestyle Questionnaire_____	21
Environmental Influences Questionnaire_____	31
Patient Readiness Form_____	35

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 FAX: () _____ - _____

FILL OUT AND/OR SIGN THE FOLLOWING FORMS

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

Thank you

FREQUENTLY ASKED QUESTIONS

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

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

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

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

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

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

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

Do you take insurance?

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

What credit cards do you accept?

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

DR. ANTHONY G. BECK
EDUCATE & MOTIVATE & INSPIRE
EDUCATE & MOTIVATE & INSPIRE



Consent Forms

951 Nola Drive
Ocoee, FL 34761

Phone # 407.435.1083
Fax # 407.347.7672

www.Dranthonygbeck.com
dranthonygbeck@gmail.com

IMPORTANT PATIENT INFORMATION

Patient Acceptance Policy

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

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

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

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

2. **Medical Records** from all physicians since you were **first diagnosed** with your health condition **MUST** be obtained prior to scheduling an appointment.
3. Once Dr. Beck has your completed questionnaires and copies of all your medical records, a one-hour appointment will be scheduled either on a _____ or _____ to review your case. Dr. Beck will provide a **Initial Detailed Written Medical Report** at the time of your scheduled appointment. The cost for the one-hour appointment as well as Dr. Beck's time for reviewing your medical questionnaire, medical records, setting up your case file and authoring a written report is **\$385.00**.
4. Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain **comprehensive blood chemistry**. The blood chemistry test will include:
- Comprehensive Executive Metabolic Panel**, which includes 24 important disease markers such as SGOT, SGPT, GGT, Bilirubin (Liver), BUN, Creatinine, Uric (Kidney), Alkaline Phosphatase (Bone)
 - Cardiovascular Panel:** Cholesterol, Triglycerides, LDL, HDL, Cholesterol/HDL Ratio, LDL/HDL Ratio, C Reactive Protein (hs-CRP), Homocysteine, Fibrinogen
 - Thyroid Panel:** Total T3, Total T4, Free T3, Free T4, TSH, TPO
 - Magnesium**
 - CBC differential:** White Blood Cells and Red Blood Cells, Platelets
 - Inflammatory markers:** Sedimentation Rate

5. Based on your medical history, questionnaire, medical records and initial consultation, it may be necessary to order **additional medical laboratory tests**. You will be presented with detailed information on the **specific tests recommended**. The cost payment options for your initial Laboratory tests will be discussed at that time. **Payment can be made via check and/or credit card**. We accept MC/Visa/Discover/American Express. 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 this office and is subject to credit approval.
6. If you have not had a physical examination within the last year or since the start of your most recent health problem, it is required to either schedule an appointment with one of the physicians in this office or with your primary physician.
7. The results of your lab tests may take approximately **three weeks**, at which point, you will be scheduled for an appointment. This appointment usually takes approximately one to one and half hours. You will be presented with a written report **detailing the results of your tests, the possible causes of your health problem and the recommended treatment protocol**. It is recommended that you have your spouse or a supportive family member attend this appointment. The fee for this **Review of Findings appointment is \$165.00**.
8. Your treatment may consist of dietary and lifestyle changes as well as prescribed **Nutraceuticals**, 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 either on _____ or _____.
10. Follow-up consultations will be scheduled every **3, 6 or 12 weeks** allowing you the opportunity to discuss your progress and any concerns with Dr. Beck. Dr. Beck 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 **\$95.00 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 Cortef for individuals suffering with Adrenal Dysfunction. Your physician will also require periodic salivary 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

Date

AUTHORIZATION OF TREATMENT:

I, _____, hereby authorize health and nutritional consultation for myself or my minor child by Dr. Anthony G Beck, and/or physicians, medical assistants and staff at A Woman’s Place here forward referred to as (AGB/WP).

NOTICE AS TO NATURE OF SERVICES: I seek the medical and health care consultation services of (AGB/WP) employees and staff. I understand that (AGB/WP) uses some diagnostic and treatment methods that some may be considered holistic, complementary or alternative. Some of these methods have not been accepted by “mainstream” medicine. I understand that the principles of this practice are based on Functional Diagnostic Medicine, a health system, in which we believe that the body has an inherent ability to heal itself given the right tools. Treatment modalities provided by (AGB/WP) are based on functional and science based evidence.

Some of the characteristic qualities of therapies that are used by (AGB/WP) include the following:

1. A person’s lifestyle including his or her diet, exercise patterns, sleep habits and stresses are believed to be directly related to the development and maintenance of illness. (AGB/WP) will evaluate these factors and seek to help the patient give up negative life style patterns and establish more positive ones regardless of age or type of medical problem.
2. Although prescription and over-the-counter medications are used when a physician believes it is necessary, an attempt is first made to use products that are natural to the body. These include nutritional supplements such as vitamins, minerals, enzymes, amino acids, essential fatty acids and herbs.
3. In addition to recommending that a patient take nutritional supplements by mouth, it is sometimes recommend that a patient receive a series of injections either intravenously or by intramuscular injection. Some of the reasons for recommending this procedure include the assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorption problems), and achieving high concentration of the substances in the bloodstream, which may be difficult if the substance is taken by mouth.

()
Initials

4. For some patients, we recommend homeopathy, based on appropriate history. It is based on the principle of “like cures like,” and uses extremely tiny concentrations of animal, vegetable or mineral substances to stimulate the body’s healing mechanisms. Although homeopathy is fairly well established in some European countries, India and other countries worldwide, it is generally not at all accepted by consensus mainstream medicine in the United States.

5. Because (AGB/WP) looks for imbalances in the body and for trends that may result in illness if not addressed, tests are sometimes ordered that may be considered by consensus mainstream medicine to be either unnecessary or of no value. These may include tests for nutritional status,

such as blood levels of vitamins and minerals, hormone levels, test for heavy metals or tests for allergies.

6. (AGB/WP) feels that environmental factors may play a major role in health and disease. Some of the diseases of unknown cause maybe triggered or perpetuated by common environmental substances, many of which are man-made. Individuals may vary greatly in their susceptibility to various substances, so that one individual may be made deathly ill by an exposure to a substance while another is not at all affected. (AGB/WP) will attempt to identify offending substances and help patients to detoxify from past exposures that are affecting them.

7. (AGB/WP) very much believes in persons being involved in their own health care and encourage questions, exploration and participation in decisions surrounding diagnostic and treatment procedures. Consultations are encouraged with consensus mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues.

8. Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.

9. Sometimes medications are used that are approved by the FDA to treat one condition; however, that same medication may be used for treatment that has not been FDA approved. Perhaps the best example is the use of EDTA chelation therapy to treat all forms of atherosclerotic cardiovascular disease and other degenerative diseases.

NOTICE THAT SERVICES ARE NOT PRIMARY CARE: I understand that no physician or any other practitioner that I see at (AGB/WP) is acting as my primary care physician. As such, emergency services are not offered. I understand that even though my physician(s) and (AGB/WP) may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions that I may have.

()
Initials

This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility to inform (AGB/WP) of who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at (AGB/WP) in order to properly and safely coordinate my care.

NO GUARANTEES: I understand that (AGB/WP) does not make any representations, claims or

guarantees that I will be helped with my medical problems or conditions by undergoing treatment at (AGB/WP). However, (AGB/WP) will do their best to help me accomplish my healthcare and wellness goals.

REVOCATION OF AUTHORIZATIONS: These authorizations will remain active unless revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

NUTRITIONAL SUPPLEMENTS: I understand that (AGB/WP) makes nutritional supplements and other recommended products available. Many of these products are not available through retail outlets or the quality is superior to retail brands. These are provided for the convenience of patients. I am in no way obligated to purchase these products from this office. I am free to purchase any recommended supplements or other products from any source that I choose.

NOTICE TO MEDICARE PATIENTS: (AGB/WP) have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at (AGB/WP). I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said service(s).

INSURANCE CLAIM MANAGEMENT: (AGB/WP) does not participate with any insurance company. A receipt and an encounter form will be provided to me at the time of visit to submit to my insurance company on my own. (AGB/WP) does not prepare or submit insurance claim forms. My treating practitioner(s) will not respond to insurance requests for information, and are not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim.

()

Initials

I understand I may be charged for responding to requests for information. (AGB/WP) does not typically send information directly to insurance carriers. I am responsible for the payment of services provided by (AGB/WP) in full at the time of service without regard to insurance coverage. I am entitled to know the cost of all services and procedures in advance and I will ask if they are not told to me.

FINANCIAL INSURANCE RESPONSIBILITY FOR ALL SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required in full at each visit; (AGB/WP) does not accept assignment. I am responsible for charges incurred for all treatment rendered. Differences between integrative and conventional medicine can lead to differences in views about medical necessity. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory and/or other clinical diagnostic testing and/or services requested by my treatment practitioner(s). (AGB/WP) will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for

(AGB/WP) to take action to secure payment of an outstanding balance owed. Charges are based on time spent in consultation with the physician and appropriate services rendered. The initial office cost is \$385.00. Follow-up visits cost between \$95.00 and \$1650.00 based upon the complexity of the visit and the time spent.

Full payment is expected at the time of services rendered. Any and all past due patient balances will be collected before my appointment. In addition to the fee for the office visit, the cost for lab work or other specialized testing deemed appropriate to my case will be applied to my balance.

Questions are always welcome. Most of the labs and testing done at the (AGB/WP) office are more specialized. The discussion of these labs and test results are usually in-depth and lengthy. Therefore a follow-up appointment is always scheduled. If an office visit is not possible, a telephone consultation may be scheduled, which will be billed in a manner similar to a follow-up visit – according to complexity and time spent.

(AGB/WP) is committed to providing the best treatment for patients. All appointments are considered confirmed at the time they are made. At the time my initial consultation is scheduled I will prepay a \$150.00 non-refundable deposit to make the appointment which will be credited toward the cost of my initial consultation. I will receive one courtesy call as a reminder of the appointment. Because a substantial amount of time has been set-aside for me, I will forfeit any deposit or be charged a \$150.00 fee for a missed new appointment and \$50.00 for follow-up appointments. I understand that I need to call the office 48 hours in advance if I cannot keep the appointment in order to avoid this charge.

()
Initials

PATIENT ACKNOWLEDGEMENT: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive nutritional consultation and/or medical care depending on which practitioner I see and for no other purpose. I do not represent any third party. I have read, understood and agree to the foregoing. I understand that I have the right to review this consent with a lawyer if I choose before accepting any consultation or medical services from (AGB/WP). I have executed this consent freely and willingly understand its provisions. I recognize that (AGB/WP) will rely upon my signing of this document in accepting me as a patient. I acknowledge receipt of a copy of this consent if I have requested it.

I do hereby acknowledge that by signing this statement of understanding that I acknowledge and understand that some, and perhaps all, of the consulting, medical, preventative, nutritional, and diagnostic services provided by (AGB/WP) on or after the date of my signing this statement may be innovative, non-traditional or unconventional. I further acknowledge that due to the nature of services that (AGB/WP) offer may not be licensed or regulated in the State of Nevada and these services are offered solely as consultations and recommendations and I have been advised to such fact. (Definition: services that are not necessarily recognized by traditional medicine, some physicians, some 3rd party purveyors of the AMA, as acceptable testing/evaluation techniques and/or medical and nutritional recommendations or therapies).* I also understand that these unconventional services may be viewed by 3rd party insurance purveyors as non-covered services, in that they might be considered unreasonable or unnecessary under any medical

insurance program. I also realize that my insurance coverage may not pay for such uncovered services and that I will be personally responsible for payment to (AGB/WP). I understand that I will pay all costs including reasonable attorney fees, should that become necessary. I understand that all outstanding balances bear interest at the maximum rate allowed by law.

I understand that my signature is consent for any and all treatments offered and given to me or my minor child at (AGB/WP) and that I will not be required to sign individual consent forms for any treatments received at (AGB/WP).

Signature of Patient or Responsible Party: _____

Patient Name: _____

Date: _____

Witness: _____

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. Anthony G Beck all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

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

Alcohol or Drug Abuse: Yes No

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

Genetic Testing Yes No

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

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

I hereby release Dr. Anthony G Beck; 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: _____

DR. ANTHONY G. BECK

EDUCATE ♣ **MOTIVATE** ♣ **INSPIRE**
EDUCATE ♣ MOTIVATE ♣ INSPIRE



Health Questionnaires

951 Nola Drive
Ocoee, FL 34761

Phone # 407.435.1083

Fax # 407.347.7672

www.dranthonygbeck.com
dranthonygbeck@gmail.com

DR. ANTHONY G. BECK

EDUCATE MOTIVATE INSPIRE
EDUCATE MOTIVATE INSPIRE

GENERAL INFORMATION

Name _____

Preferred Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Age _____ Date of Birth _____ Place of birth _____ Gender: female ___ male ___

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

Right Handed: ___ Left Handed: ___ Mixed Dominance: _____

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

Occupation _____ Hours per week _____ Retired _____

Nature of Business _____

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

Other _____

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

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

Address _____

Genetic Background: Please check appropriate box(es):

- African American Hispanic Mediterranean Asian
 Native American Caucasian Northern European Other

Who is your primary medical physician? _____

Primary medical physician address & office phone # _____

PERSONAL DESCRIPTIVE INFORMATION

Marital status:

- Single Married Divorced
 Widow Long Term Partnership

List Children:

Child's Name	Age	Gender

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

Do you have any pets or farm animals? Yes ___ No ___

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

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

If so, when and where? _____

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

If yes, please comment: _____

Have you experienced any major losses in life? Yes ___ No ___

If so, please comment: _____

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

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

Previous jobs: _____

your highest level of education:

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

Functional Diagnostic Medicine Questionnaire

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

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

Please print or write legibly.

COMPLAINTS/CONCERNS

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

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

What diagnosis or explanation have been given to you? _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel **worse**? _____

What makes you feel **better**? _____

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

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

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

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

PAST MEDICAL & SURGICAL HISTORY

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

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

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

PATIENT BIRTH HISTORY

Question	Yes	No	Don't Know	Comment
Were you a full term baby?				
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?				
Question	Yes	No	Don't Know	Comment
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 (ages birth to age12) by indicating the approximate age of onset.

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

If yes, please explain your illness:

IMMUNIZATION HISTORY

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

- | | |
|--|---|
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Measles |
| <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"/> Post partum depression | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Gestational diabetes |
| <input type="checkbox"/> Baby over 8 pounds | <input type="checkbox"/> Breast feeding For how long? _____ | |

GYNECOLOGICAL HISTORY

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

Clotting: Yes ___ No ___ Has your period skipped? _____ For how long? _____

Last Menstrual Period: _____

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

- | | | | |
|---------------------------------|------------------------------------|------------------------------|--|
| <input type="checkbox"/> Condom | <input type="checkbox"/> Diaphragm | <input type="checkbox"/> IUD | <input type="checkbox"/> Partner vasectomy |
|---------------------------------|------------------------------------|------------------------------|--|

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

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

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

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

Last Mammogram _____ Breast Biopsy/Date _____

Last PAP Test: _____ Normal _____ Abnormal _____

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

Are you in menopause? Yes ___ No ___ Age at Menopause _____

Do you take: Estrogen Ogen Estrace Premarin Other _____

Progesterone Provera Other _____

How long have you been on hormone replacement? _____

FAMILY HISTORY

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

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	GrandmotherMaternal	Maternal Grandfather	GrandmotherPaternal	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Heart Attack												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus)												
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												

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

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



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!**

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

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

Sincerely,
Dr. Anthony G Beck

REVIEW OF SYSTEMS

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

GENERAL

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

SKIN:

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

HEAD:

- Poor Concentration
- Confusion
- Headaches:
- After Meals

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

EYES:

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

EARS:

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

NOSE/SINUSES

- Stuffy
- Bleeding
- Running
- Discharge
- Watery Nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip

- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

If yes, is it worse in the:

- Spring
- Summer
- Fall
- Winter

MOUTH:

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

THROAT:

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

NECK:

- Stiffness
- Swelling
- Lumps
- Neck glands swell

CIRCULATION/RESPIRATION:

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

- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Past Heart Attack ?? When _____
- Phlebitis
- Spider Veins

GASTROINTESTINAL/DIGESTION

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

KIDNEY/URINARY TRACT:

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

WOMEN'S HISTORY (for women only)

- Fibrocystic Breasts
- Lumps in breast
- Fibroid Tumors/Breast

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

MEN'S HISTORY (for men only)

Have you had a PSA done?

Yes _____ No _____

PSA Level:

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

 - Urgency/Hesitancy/Change in
Urinary Stream
 - Loss of Control of Urine

JOINT/MUSCLES/TENDONS

- Pain wakes me up
- Weakness in Legs and arms
- Balance problems
- Muscle cramping

- Head injury
- Muscle Stiffness in Morning
- Damp weather bothers you

EMOTIONAL:

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts
- Amnesia
- Had shock therapy
- Frequently keyed up and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Forgetful
- Listless
- Withdrawn feeling
- Feel "lost" in time
- Had nervous breakdown
- Cry often
- Feel groggy
- Unable to concentrate
- Short attention span
- Vision changes
- Have overused drugs
- Considered a nervous person
- Worried over little things
- Anxiety
- Been addicted to drugs
- 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 considered suicide

DENTAL HISTORY

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

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

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

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

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

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

Do you have problems chewing? Yes ____ No ____

Do you floss regularly? Yes ____ No ____

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

Did you have fillings as a child? Yes ____ No ____

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

Did you have dental fillings as an adult? Yes ____ No ____

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

How many amalgam fillings do you have now? _____

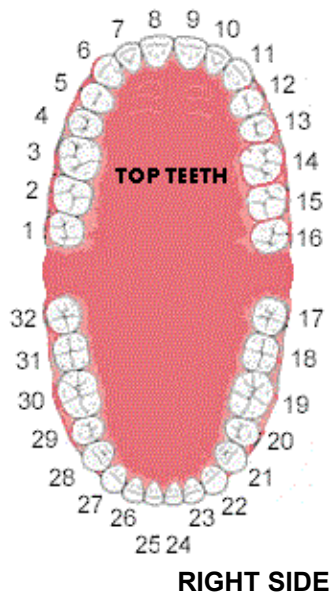
Did you play with mercury as a child or adult? Yes ____ No ____

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

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

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

Please 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.



RECORD ANSWERS:

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

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

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

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

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Acid Blocking Drugs <input type="checkbox"/> Anti-anxiety medications <input type="checkbox"/> Antibiotics <input type="checkbox"/> Anticonvulsants <input type="checkbox"/> Antidepressants <input type="checkbox"/> Anti-fungals <input type="checkbox"/> Aspirin/Ibuprofen <input type="checkbox"/> Asthma inhalers <input type="checkbox"/> Beta blockers <input type="checkbox"/> Birth control pills/implant contraceptives <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Cholesterol lowering medications <input type="checkbox"/> Cortisone/steroids | <ul style="list-style-type: none"> <input type="checkbox"/> Diuretics <input type="checkbox"/> Estrogen or progesterone (pharmaceutical, prescription) <input type="checkbox"/> Estrogen or progesterone (natural) <input type="checkbox"/> Heart medications <input type="checkbox"/> High blood pressure medications <input type="checkbox"/> Laxatives <input type="checkbox"/> Relaxants/Sleeping pills <input type="checkbox"/> Testosterone (natural or prescription) <input type="checkbox"/> Thyroid medication <input type="checkbox"/> Acetaminophen (Tylenol) <input type="checkbox"/> Ulcer medications <input type="checkbox"/> Sildenafil citrate (Viagra or similar) |
|--|---|

ALLERGIES	
Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

NUTRITION & LIFESTYLE HISTORY

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

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

Check all that apply:

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

Please check any specific food restrictions you have:

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

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

Height (feet/inches) _____ Current Weight _____

Usual weight range +/- 5 lbs _____ Desired Weight range +/- 5 lbs _____

Highest adult weight _____ Lowest adult weight _____

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

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

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

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

Food	Symptom	Other comments

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

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

When you shop do you purchase the following?

- Organic Foods Hormone free and antibiotic free meat

Do you read food labels? Yes _____ No _____

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

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

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

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

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"/> Bagels | <input type="checkbox"/> Cereal, _____ | <input type="checkbox"/> Chewing gum, sugar free |
| <input type="checkbox"/> Almond Butter | <input type="checkbox"/> Biscuits | <input type="checkbox"/> Celery | <input type="checkbox"/> Coconut |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Bean, Pinto | <input type="checkbox"/> Cantaloupe | <input type="checkbox"/> Cod |
| <input type="checkbox"/> Apples | <input type="checkbox"/> Bean, String | <input type="checkbox"/> Candy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Avocado | <input type="checkbox"/> Broccoli | <input type="checkbox"/> Chinese Food | <input type="checkbox"/> Corn |
| <input type="checkbox"/> Asparagus | <input type="checkbox"/> Brazil Nuts | <input type="checkbox"/> Cream Cheese | <input type="checkbox"/> Crab |
| <input type="checkbox"/> Bagels | <input type="checkbox"/> Brussels Sprouts | <input type="checkbox"/> Carrot | <input type="checkbox"/> Cranberry |
| <input type="checkbox"/> Barley | <input type="checkbox"/> Blueberries | <input type="checkbox"/> Chicken | <input type="checkbox"/> Cashew |
| <input type="checkbox"/> Banana | <input type="checkbox"/> Butter | <input type="checkbox"/> Chili Pepper | <input type="checkbox"/> Cheese |
| <input type="checkbox"/> Burger King | <input type="checkbox"/> Cabbage | <input type="checkbox"/> Cinnamon | <input type="checkbox"/> Cucumber |
| <input type="checkbox"/> Bacon | <input type="checkbox"/> Cereal, Special K | <input type="checkbox"/> Clam | <input type="checkbox"/> Deli Meats |
| <input type="checkbox"/> Bean, Lima | <input type="checkbox"/> Cereal, Bran flakes | <input type="checkbox"/> Cloves | <input type="checkbox"/> Desserts |
| <input type="checkbox"/> Bread, White | <input type="checkbox"/> Cereal, Cornflakes | <input type="checkbox"/> Cocoa-Chocolate | <input type="checkbox"/> Deli Sandwich |
| <input type="checkbox"/> Bread, Wheat | <input type="checkbox"/> Cereal, _____ | <input type="checkbox"/> Carnation Drink | <input type="checkbox"/> Eggplant |
| <input type="checkbox"/> Bread, Rye | | <input type="checkbox"/> Chewing gum, sweetened | |

- Ensure
- Flounder
- Fried Foods
- French Fries
- French Toast
- Garlic
- Ginger
- Grape
- Grits
- Greek Food
- Grapefruit
- Grape nuts
- Haddock
- Ham
- Halibut
- Herring
- Hot Dogs, Pork
- Hot Dogs, Beef
- Hamburgers
- Hardies Food
- Honey
- Italian Food
- Ice Cream
- Indian Food
- Jack in the box food
- Japanese Food
- Jelly
- Ketchup
- Lamb
- Lemon
- Lentil
- Lettuce
- Lime
- Lobster
- Mackerel
- Margarine
- McDonalds Food
- Millet
- Mung Bean
- Mushroom
- Mustard
- Milk, Cow
- Milk, Goat
- Milk, Rice
- Milk, Almond
- Milk, Soy
- Mexican Food
- Malt
- Nutmeg
- NutriSweet
- Oatmeal, Regular
- Oatmeal, Instant
- Olive
- Onion
- Orange Juice
- Oregano
- Oyster
- Orange
- Papaya
- Parsley
- PopTarts
- Peanuts
- Peanut butter
- Peas
- Peach
- Pecan
- Pepper
- Pepper, Green
- Perch
- Pineapple
- Pancakes
- Protein Shakes, Soy
- Protein Shakes, Milk
- Protein Shakes, Whey
- Protein Shakes,
-
- Plum
- Pork
- Peanut
- Potato, sweet
- Potato, White
- Pumpkin
- Quinoa
- Radish
- Rye
- Safflower
- Sage
- Salt
- Salmon
- Scallops
- Sausage
- Slim Fast
- Sweet & Low
- Sesame
- Shrimp
- Snapper
- Soft Drinks
- Sole
- Sour cream
- Soybean
- Spinach
- Strawberry
- Sucralose
- Sugar
- Sunflower
- Salad Bar
- Sardines
- Squash
- Taco bell food
- Tea, Black
- Tea, Decaffeinated
- Thai food
- Tomato
- Trout
- Tuna
- Turkey
- Tangerine
- Vinegar
- Walnut
- Waffles
- Whitefish
- Wheat
- Wendy's food
- Yeast, Bakers
- Yeast, Brewers
- Yogurt
- Yam
- Zucchini

What snacks do you eat or drink between:

Breakfast & Lunch: _____

Lunch & Dinner: _____

After Dinner: _____

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

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

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

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

Yes _____ No _____ If yes, please

explain: _____

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

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

Food	Symptom	Other comments

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

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

- | | |
|--|--|
| <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: _____

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

ALCOHOL INTAKE

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

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

Previous alcohol intake? Yes _____ (Mild _____ Moderate _____ High _____)

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

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

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

Do you ever take an eye-opener? Yes _____ No _____

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

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

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

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

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

Was your mother an alcoholic? _____ Father? _____ Other family member? _____

OTHER SUBSTANCES

Are you currently using recreational drugs? Yes _____ No _____

If yes, what types?: _____

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

If yes, what types?: _____

EXERCISE

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

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

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

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? Yes _____ No _____

If yes, please describe: _____

Do you usually sweat when exercising? Yes ___ No ___

SOCIAL HISTORY

PSYCHOSOCIAL

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

Are you happy? Yes _____ No _____

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

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

Do you like the work you do? Yes _____ No _____

Have you experienced major losses in your life? Yes _____ No _____

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

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

STRESS/COPING

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

Please do your best to answer the following questions:

Did you feel safe growing up? Yes _____ No _____

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

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

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

Have you ever sought counseling? Yes _____ No _____

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

What kind? _____

Comments: _____

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

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

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

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

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

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other

Hobbies and leisure activities: _____

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

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

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

Yes _____ No _____

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
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
		½	1	2	
<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
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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
Change in schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in recreational habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19
Mortgage or loan under \$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18
Change in sleeping habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16

Change in eating habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15
Vacation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	13
TOTAL SCORE			_____

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

TOXIC STRESS TRIGGERS

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

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

DO YOU WORRY OVER?

- Home life
- Marriage
- Children
- Job
- Income

IS YOUR LIFE:

- Satisfactory
- Boring
- Demanding
- Unsatisfactory
- Money Problems

SLEEP/REST

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

Do you have trouble falling asleep? Yes _____ No _____

Do you feel rested upon awakening? Yes _____ No _____

Do you have problems with insomnia? Yes _____ No _____

Do you snore? Yes _____ No _____

Do you use sleeping aids? Yes _____ No _____ Explain: _____

ENVIRONMENTAL INFLUENCES

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

Electromagnetic Factors

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

- Live or have lived near an electric distribution substation
- Bed is close to the main electrical current

- Have a fan directly over your bed
- Have an alarm clock or radio close to your bed (plugged in)
- Live or have you lived near a television transmitter
- Sleep with an electric blanket, heating pad
- Sleep on a waterbed

Position of your head of your bed is facing:

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

What is your occupation?

Toxin Exposure

Trichloroethylene/TCE

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

Formaldehyde

- Wear many dry-cleaned clothes
- Noticed changes of your health since you moved into your home
- Wear many polyester clothes and permanent press
- You use Spray Starch

- Have foam wall insulation
- Have particleboard, chip board or interior plywood
- Put up wallpaper in the last 2 years
- Have foam cushions or foam mattresses
- Live or lived in a trailer
- Worked in a laboratory
- Your home been insulated since your illness
- Had new carpets. When? _____
- Use waxes and polishes on your floor
- Been around resin glues and plastics
- Have exterior grade plywood on your home
- Home made of stucco, plaster or concrete
- Have a wood-burning stove
- Have draperies
- Have used acid-cured resin floor finishes
- Have fire-proof material in your home
- Smoke in your home
- Have a photography darkroom
- Use nail polish remover
- Use fingernail hardeners

Pesticides & Herbicides

(Organochlorines, Organophosphate, Carbamate, Chlorinated Cyclo-diene, Botanical & Microbial)

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

Volatile Organic Compounds

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

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

Phenols

Do you use the following?

- Household cleaners
- Nasal Sprays
- Styrofoam cups
- Cough Syrup
- Decongestants
- Hair sprays
- Scented deodorants
- Scotch tape
- Newsprint
- Lysol
- Epoxy
- Listerine
- Chloraseptic throat sprays
- Noxema
- Mildew cleaners
- Perfumes
- Air Fresheners
- Disinfectants
- Polishes
- Glues
- Waxes
- Mouthwash
- Hard saucepan handles
- Smoke in the house

- Have you been exposed to chemicals?
When? _____
- Have you had your home treated for termites
When? _____
- Wash own vehicle by hand.
What type of cleaners do you use? _____

Carbon Monoxide/Nitrogen Oxide/Sulfur Dioxide

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

Ozone

- Use an electrical sewing machine
- Use power tools
- Use ion generators
- Work close to a photocopier

Carbon Dioxide

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

Asbestos

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

Please note the "brand" of product you use

For example: Toothpaste: Crest

Shampoo: _____

Toothpaste: _____

Hair Conditioner: _____

Makeup: _____

Lipstick: _____

Make-up Foundation: _____

Deodorant: _____

Perfume: _____

Hairspray: _____

Shaving Cream: _____

Cologne: _____

Facial Creams: _____

Body Creams: _____

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

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

Do you use Latex products?

- Baby bottle nipples
- Balloons
- Bandages
- Diaphragms
- Hot water bottles
- Latex gloves
- Dishwashing gloves
- Rubber dams for dental work
- Tires
- Worked in a rubber industry

General Miscellaneous

- Have basement Molds
- Home is damp
- Use a humidifier? If yes, when the last time you cleaned it? _____
- Use black hair dye (Nitrosamines)
- Worked in beauty shop.
When? _____
- Take any illicit drugs as an adolescent/young adult?
What type? _____
- Open your windows at home
- Work in a machine shop
- Work in a garden?
- Work or have you worked on a farm
When? _____
- Have mercury fillings
- Had mercury fillings removed? When?

- Been exposed to radiation
When? _____
- Have a hot tub
- Use chlorine or bromine
- Have a well
- Work around PVC pipe (Vinyl chloride)

- Home well ventilated
- Moved to a new office in the last two years
- Live in an apartment?
How old? _____
- Eat at salad bars
- Eat raw fish (Sushi)
- Buy food from street vendors
- For Women:** Have breast implants. The implant was made of saline ___ silicone___
- Has any type of metal been used in implants or joint replacements in your body?
What type? _____
Where _____
- Notice more symptoms at work than at home or vice versa?
- Symptoms worse going into a mall
- Have you ever worked in a mall?
When? _____
- Have live plants in your home
- Have pets in your home
- Owned a new vehicle since your symptoms began
- Furniture been put in storage or possibly fumigated
- Stained furniture in the last 2 years
- Have a tool shop in your garage
- Live on or near a golf course
- Live in or near an industrial area
- Lived or traveled outside the US.
Where? _____
- Bought new furniture?
What type of material? _____
- Installed drop ceilings
- Painted indoors
- Sided your home
- Changed your heating system, stove, clothes dryer or water heater
- Lived in a brand new home
- Lived in a new office
- Noticed changes of your health since you moved into your home?
- Have a water purification system?
- Live near a landfill?
- Have a water filter on your shower?

Describe the contents of your bedroom

- What type of mattress? _____
- Have hardwood floors
- Have carpeting
- Have blinds
- Have draperies
- Use a foam pillow
- Use a feather pillow
- Use a Dacron pillow
- Use wool blankets
- Use cotton blankets
- Use quilts
- Use synthetic blankets
- Use an electric blanket
- Have a ceiling fan
- Have material under your bed
- Have real plants in your bedroom
- Have artificial plants in your bedroom
- Use aromatherapy in your bedroom
- Burn scented candles in your bedroom
- Have central heat
- Have a fireplace in your room
- Have an electric baseboard
- Use gas heat
- Use an air filter in your bedroom
What type? _____
- When was the last time you changed your filter in
your room? _____
- Have central air conditioning
- Sleep with your windows open
- Live close to a high traffic road
- Smoke in bed
- Allow any pets in your room
What type? _____
- Have plugged in air fresheners

- Do quilting and weaving
- Gardening
- Make soapstone carvings
- Use acrylic paint

What hobbies do you have? Please list:

1. _____
2. _____
3. _____

Art and Leisure Activities

- Silk-screening
- Make stained glass
- Make pottery & ceramic products
- Make jewelry
- Buy art and craft supplies
- Use airbrush and spray paints

Please indicate the occupation of your parents during your childhood:

READINESS ASSESSMENT

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

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

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

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

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

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

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

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

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

Comments _____

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

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

5 _____ 4 _____ 3 _____ 2 _____ 1 _____

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

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

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

Comments _____

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

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

5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments _____

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

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

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