Millar Functional Medicine

Live Longer, Younger

Dr. Greg Millar, DC CPFM ASBCE
Dr. Bonnie Sims, ND
Dr. Helen Stoddart, MD

Millar
Functional Medicine

2021 Clinton Ave West, Suite A
Huntsville Alabama 35805
(256) 513-4888 Phone • (256) 513-4887 Fax

COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize your improvement depends largely on the accuracy of the information in which you provide, including symptoms even if you consider them minor. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time. Please allow 1-1.5 hours to fill out this form. Take your time and be thorough. You're spending a lot of time and money on your healthcare so be honest and complete.

Date:_____

Last Name:_____ **MI:**_____ **First:**_____

Address _____ City _____ State _____ Zip Code_____

Cell (_____) _____-_____ Home Phone (_____) _____-_____ Work (_____) _____-_____

Private Email _____

Age _____ Date of Birth ____/____/_____ Place of birth_____ Gender: Female__Male___
City or town & country, if not US

Referred by:_____

Name, address, & phone number of primary care physician:_____

_____

Name, phone number, specialty of other critical physicians:_____

_____

Name, phone number, specialty of other critical physicians:_____

_____

Marital Status: Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: _____
Relationship Name Phone

_____
Address

Your Occupation _____ Hours per week _____ Retired ____

Nature of Business_____

Genetic Background: Please check appropriate box(es):

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

CURRENT HEALTH STATUS/CONCERNS

Please make a list of what you consider your CURRENT health problems.
List 1-2-3 as your top 3

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Please give us some more information on your current and ongoing problems.

Problem	Date of Onset	Severity | Frequency	Treatment Approach	Success
Example: Headaches	May 2021	Mild | Moderate | Severe Constant | Frequent | Occasional	Acupuncture/Aspirin OTC	Better | Worse | Same
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

What explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

What seems to trigger your symptoms?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

When was the last time that you felt well?_____

What medical conditions or diseases have you been diagnosed with so far?

Condition	Date Diagnosed	Doctor/or Clinic
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

What other physician(s) or other health care providers (including alternative or complimentary practitioners) have you seen for these conditions?

PHYSICAIN NAME	SPECIALTIY	WHEN

How are these conditions affecting your daily life? _____

_____

How much time have you lost from work or school in the past year due to these conditions?_____

_____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments. If not listed, please put under other at the bottom of the page.

ILLNESSES	WHEN /ONSET	COMMENTS
ADHD		
Anxiety disorder		
Allergies		
Alzheimer's		
Anemia		
Arthritis		
Asthma		
Autistic spectrum disorder		
Autoimmune disorders		
Bipolar disorder		
Bronchitis		
Cancer		
Celiac disease		
Chicken Pox		
Chronic Fatigue Syndrome		
Chronic Lung Disease		
Chronic Pain Syndrome		
COPD		
Crohn's Disease or e Colitis		
Diverticulitis or Diverticulosis		
Deep Vein Thrombosis (blood clots)		
Depression Clinical		
Diabetes Type I		
Diabetes Type II		
Dry Mouth		
Dementia		
Emphysema		
Epilepsy, convulsions, or seizures		
Fibromyalgia		
Fatty Liver – Alcoholic -NAFL		
Fungal Infection		
Gallstones		
GERD		

Gout		
Gum Disease		
Headaches and Migraines		
Heart Disease		
Heart Attack, Angina		
Heart Failure - CHF		
Hemorrhoids		
Herpes		
Hepatitis A | B | C | NonA/NonB		
Herpes Lesions/Shingles		
HIV		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Hypoglycemia		
Incontinence (bowel or bladder)		
Irritable bowel (or chronic diarrhea)		
Kidney (renal) failure or disease		
Kidney stones		
Liver Disease		
Lyme's disease		
Measles		
Mononucleosis		
Mumps		
Osteoporosis/ Osteopenia		
POTS		
Pneumonia		
Rheumatic Fever		
Restless Leg Syndrome		
Sinusitis		
Shingles		
Sleep Apnea		
Stroke or TIA		
Thyroid disease		
Whooping Cough		
Other		
Other		
Other		

INJURIES	WHEN	COMMENTS
Brain Injury (TBI)		
Back injury		
Broken bones or fractures (describe)		
Head injury (closed head Injury)		
Fall Injury		
Neck injury		
Motor Vehicle Injury		
Sports Injury		
Work Injury		
Other		
Other		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Biopsy		
Blood Tests (last one)		
Blood Test (previous one)		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
Endoscopy		
EEG electroencephalogram		
ECG electrocardiogram		
Liver Scan		
Mammogram		
MRI #1		
MRI #2		
PET scan		
Ultrasound		
X-Ray Neck		
X-Ray Low Back		
X-Ray other		
Other		
Other		
Other		

SURGERIES	WHEN	COMMENTS
Angioplasty		
Appendectomy		
Breast biopsy		
Cancer surgery		
Carotid endarterectomy		
Cataract surgery		
Cesarean section		
Cosmetic		
Colon surgery		
Coronary bypass		
Dental surgery		
Dental Implants		
Gall Bladder		
Hernia		
Hysterectomy		
Joint replacement #1		
Joint replacement #2		
Stent		
Stomach (Lap or Gastric Bypass)		
Tonsillectomy		
Tubes in Ears		
Vein Surgery		
Other		
Other		
Other		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all CURRENT prescription and non-prescription medications you are currently taking. Include all over the counter non-prescription drugs. If none put none.

Medication Name	Strength (mg)	Times A Day	Take This Medication For My

Pleased list all prescription and non-prescription medications that you are NO Longer taking.

Medication Name	Strength (mg)	Date Stopped	Took This Medication For My

List all vitamins, minerals, herbals, and any supplements that you are currently taking.
Please indicate the strength, dosage and why you take this. If none put none.

Name	Strength (mg)	Times A Day	Date Started	Take This For My

List all vitamins, minerals, herbals, and any supplements that you tried in the past but are NO Longer taking. Please indicate the strength, dosage and why you take this. IF None put None.

Name	Strength (mg)	Times A Day	Date Started	Take This For My

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?
Yes___ No ___

Below please list all medications, vitamins, minerals, and any nutritional supplements that you are allergic to or sensitive to taking.

Name	Strength (mg)	Times A Day	Date Started	Date Stopped	Reaction

1. Have you ever had an allergic reaction? Yes ___ No ___ To What? _____

2. Have you ever had an allergic reaction that required you to go to the emergency room or have medical care? Yes___ No ___ To What? _____

3. Have you ever had an anaphylactic allergic reaction? Yes___ No ___ To What? _____

4. Have you ever been prescribed an Epi Pen? Yes___ No ___

CHILDHOOD & ADOLESCENCE HISTORY

Please answer to the best of your knowledge. Consider talking to a parent if possible.
Childhood Age (0-9) & Adolescence Age (10-19)

	Yes	No	Don't Know	Comment
Where you a full-term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

CHILDHOOD AND ADOLESCENCE IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				
COVID-19				

Did you ever have a reaction to any vaccination received? Yes ___ No ___

CHILDHOOD DIET (Age 0-9)

1. At what age did your mother/father start giving you solid food? _____

2. What was your first and second solid food? _____ _____

3. Did you have any childhood (Age 0-10) food allergies or sensitivities? Yes ___ No ___

4. To What food(s)? _____
What Symptoms? _____

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___
If yes, please explain: (Example: milk – diarrhea)_____

Was your childhood (Age 0-9) diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

ADOLESCENCE DIET (Age 10-19)

1. Did you have any Adolescence (Age 10-19) food allergies or sensitivities? Yes ___ No ___

4. To What food(s)? _____
What Symptoms? _____

Age 10-19 were there foods that you had to avoid because they gave you symptoms? Yes___ No___
If yes, please explain: (Example: milk – diarrhea)_____

Was your adolescence (Age 10-19) diet high in	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)				
Soda? artificial sweeteners?				
Sports Drinks?				
Fast food?				
Snack Foods?				
Pre-packaged foods, Pre-processed foods				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
White breads, Cereals?				

CHILDHOOD & ADOLESCENCE MAJOR LIFE PROBLEMS

As a child or Adolescent did your parents divorce? Yes ___ No ___
Was the divorce hard on you? Yes___ No ___
Did you grow-up in a single parent home? Yes ___ No ___
Did you live with your Grandparents? Yes ___ No ___
As a child or adolescent did you have a parent or grandparent die? Yes ___ No ___

CHILDHOOD & ADOLESCENCE ILLNESSES

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 10 years) and the approximate age of onset.

	YES	AGE
ADD (Attention Deficient Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Hyperactivity		
Jaundice		

	YES	AGE
Mumps		
Pneumonia		
Seasonal allergies		
Skin disorders (e.g. dermatitis)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Other (describe)		
Other (describe)		
Measles		
Other:		

As a child did you: Have a high absence from school? Yes___ No___
If yes, why?_____
Experience chronic exposure to second hand smoke in your home? Yes___ No___
Experience abuse (bullied, sexual or mental abuse) Yes___ No___
Have alcoholic parents? Yes___ No___
Did your parents do drugs? Yes___ No___

As a child (up to age 9) did you ever have major illnesses? Yes ___ No ___ What? _____
_____
As a child (up to age 9) were you ever hospitalized? Yes ___ No ___ For how long? _____
For what illness or surgery? _____
_____
As a child (up to age 9) were you ever injured? Yes ___ No ___ What injury? _____
As a child did you ever have out-patient surgery? Yes ___ No ___ What Surgery? _____

As an adolescent (age 10-19) did you ever have major illnesses? Yes ___ No ___ What? _____
_____
As an adolescent (age 10-19) were you ever hospitalized? Yes ___ No ___ For how long? _____
For what illness or surgery? _____
_____
As an adolescent (age 10-19) were you ever injured? Yes ___ No ___ What injury? _____
As an adolescent (age 10-19) did you ever have out-patient surgery? Yes ___ No ___ What Surgery? ___
_____
Did any of your current problems start as a child or adolescent? Yes ___ No ___
What current problem that you have now started as a child or adolescent? _____

FEMALE MEDICAL HISTORY

(For women only)

Do you have any female medical issues? Yes ___ No ___ **If Yes then what problems?** _____

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____
- ❑ Caesarean_____
- ❑ Vaginal deliveries_____
- ❑ Miscarriage _____
- ❑ Abortion _____
- ❑ Living Children_____
- ❑ Post partum depression___
- ❑ Toxemia _____
- ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses?_____ Average Frequency:_____ days | Average Length:_____days

Painful: Yes_____ No_____ Clotting: Yes____ No____ Flow: Lite ____ Medium ____ Heavy ____

Date of last menstrual period:____/____/_____

Are you menopausal? (12 months since menstruation) Yes_____ No_____ If yes, age you went into menopause_____

Are you post-menopausal? (over 12 months since last menstruation) Yes_____ No_____ If yes, age you became post-menopausal_____

Are you sexually active Yes ___ No ___ How old were you when you first has intercourse? _____

Do you currently use contraception? Yes____ No____ If yes, what please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other cycle symptoms that you feel are significant._____

_____

_____

HORMONAL HISTORY

Do you have hormone problems or symptoms? Yes ___ No ___

Please advise of any other hormone symptoms or problem that you feel are significant._____

_____

_____

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

❑ Other _____

Do you now Yes ___ No ___ OR have you ever done hormone replacement pellets? Yes ___ No ___

FEMALE DIAGNOSTIC TESTING

Last PAP test: Date_____/_____/_____ Normal: _____ Abnormal:_____

Last Mammogram: Date_____/_____/_____ Normal: _____ Abnormal:_____

Breast Biopsy? Date:_____/_____/_____ Normal: _____ Abnormal:_____

Date of last bone densitiy_____/_____/_____ Results: High____ Low____ Within normal range____

Have you had any hormone testing? Yes ___ No ___

DIFFICULT FEMALE QUESTIONS

Have you ever been sexually abused? Yes ____ No ____ Raped? Yes _____ No _____

Have you ever been verbally abused? Yes ___ No ___

Have you ever been emotionally abused? Yes ___ No ___

Are you currently in an abusive relationship? Yes ___ No ___

MALE MEDICAL HISTORY

(for men only)

Do you have any male medical issues? Yes ___ No ___ **If Yes then what problems?** _____

_____

Have you had a prostate examination? Yes ___ No ___ When was your last exam? _____

Do you have BHP Benign Hypertrophy of the Prostate (Prostate Enlargement)? Yes ___ No ___

Last PSA test:_____ PSA Level: ☐ 0–2 ☐ 2–4 ☐ 4–10 ☐ >10

Do you have or have you had prostate cancer? Yes ___ No ___ Now ___ Past history ____ When ____

Have you ever had prostate surgery procedures? Yes ___ No ___

Do you have low testosterone? Yes ___ No ___

Are you having now or have you had in the past testosterone treatment? Yes ___ No ___

(Check box if applicable)

☐ Testicular mass ☐ Testicular pain ☐ Change in sex drive ☐ Impotence
☐ Premature ejaculation ☐ Difficulty obtaining an erection ☐ Difficulty maintaining erection
☐ Loss of control of urine ☐ Urinary urgency/hesitancy/change in stream
☐ Vasectomy ☐ Nocturia (urination at night) # of times per night_____
☐ Sexually transmitted disease ☐ (describe)_____

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
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, Hashimoto's)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
COVID (Sars-CoV-2)									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
Other:									

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									
Other:									
Other:									
Other:									

YOUR REVIEW OF SYMPTOMS

Check (√) those items that you had in the ***past***.
Circle ◯ those that you **currently** have.

GENERAL:

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

SKIN:

- ❑ Cuts heal slowly
- ❑ Bruise easily
- ❑ Rashes
- ❑ Pigmentation
- ❑ Changing Moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness/cracking skin
- ❑ Oiliness
- ❑ Itching
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on Nails
- ❑ Peeling Skin
- ❑ Shingles
- ❑ Nails Split
- ❑ White Spots/Lines on Nails
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot
- ❑ Cellulite
- ❑ Bugs love to bite you
- ❑ Bumps on back of arms & front of thighs
- ❑ Skin cancer
- ❑ Strong body odor

Is your skin sensitive to:

- ❑ Sun
- ❑ Fabrics
- ❑ Detergents
- ❑ Lotions/Creams

HEAD:

- ❑ Poor Concentration
- ❑ Confusion
- ❑ Headaches:
  - ❑ After Meals
  - ❑ Severe
  - ❑ Migraine
  - ❑ Frontal
  - ❑ Afternoon
  - ❑ Occipital
  - ❑ Afternoon
  - ❑ Daytime
  - ❑ Relieved by:
    - ❑ Eating Sweets
- ❑ Concussion/Whiplash
- ❑ Mental sluggishness
- ❑ Forgetfulness
- ❑ Indecisive
- ❑ Face twitch
- ❑ Poor memory
- ❑ Hair loss

EYES:

- ❑ Feeling of sand in eyes
- ❑ Double vision
- ❑ Blurred vision
- ❑ Poor night vision
- ❑ See 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
- ❑ 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
- ❑ Past history of whiplash

CIRCULATION/RESPIRATION:

- ❑ Swollen ankles
- ❑ Sensitive to hot
- ❑ Sensitive to cold
- ❑ Extremities cold or clammy
- ❑ Hands/Feet go to sleep/numbness/tingling
- ❑ 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/spider veins
- ❑ Mitral valve prolapse
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/Pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Prior heart attack ? When___/___/_____
- ❑ Phlebitis

COVID: SARS COV-2:

- ❑ Had Original COVID _____ times
- ❑ Had Delta COVID _____ times
- ❑ Had Omicron COVID _____ times
- ❑ Was hospitalized for _____ days
- ❑ Was put on a vent _____ days
- ❑ No Long COVID symptoms
- ❑ I have long COVID symptoms

If yes, my long COVID symptoms are:

- ❑ Extreme tiredness (fatigue)
- ❑ Shortness of breath
- ❑ Loss of smell
- ❑ Muscle aches or Joint aches
- ❑ Lung (respiratory) symptoms
- ❑ Brain fog
- ❑ Headaches
- ❑ Stomachaches

GASTROINTESTINAL:

- ❑ Peptic/Duodenal Ulcer
- ❑ Poor appetite
- ❑ Excessive appetite
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Nervous stomach
- ❑ Full feeling after small 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
- ❑ Kidney or Renal Failure (stage _____)
- ❑ Kidney Disease

WOMEN'S HISTORY (for women only):

- ❑ Fibrocystic breasts
- ❑ Lumps in breast
- ❑ Fibroid Tumors/Breast
- ❑ Spotting
- ❑ Heavy periods
- ❑ Fibroid Tumors/Uterus

WOMEN'S HISTORY (for women only):

- ❑ Painful periods
- ❑ Change in period
- ❑ Breast soreness before period
- ❑ Endometriosis
- ❑ Non-period bleeding
- ❑ Breast soreness during period
- ❑ Vaginal dryness
- ❑ Vaginal discharge
- ❑ 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 bladder control
- ❑ 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/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 bladder control

JOINT/MUSCLES/TENDONS:

- ❑ Pain wakes you
- ❑ 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 prior shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Startled by sudden noises
- ❑ Anxiety/Feeling of panic
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless/groggy
- ❑ Withdrawn feeling/Feeling 'lost'
- ❑ Had nervous breakdown
- ❑ Unable to concentrate/short attention span
- ❑ Vision changes
- ❑ Unable to reason
- ❑ Considered a nervous person by others
- ❑ Tends to worry needlessly
- ❑ Unusual tension

EMOTIONAL (CONTINUED)

- ❑ Emotional numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Previously admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Misunderstood by others
- ❑ Irritable/
- ❑ Feeling of hostility/volatile or aggressive
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness
- ❑ Am a workaholic
- ❑ Have had hallucinations
- ❑ Have considered suicide
- ❑ Have overused alcohol
- ❑ Family history of overused alcohol
- ❑ Cry often
- ❑ Feel insecure
- ❑ Have overused drugs
- ❑ Been addicted to drugs
- ❑ Extremely shy

LIVER FUNCTION:

- ❑ Elevated Liver Enzymes
- ❑ Alcoholic Fatty Liver
- ❑ Non-Alcoholic Fatty Liver
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Hepatitis D
- ❑ Autoimmune Hepatitis
- ❑ Cirrhosis
- ❑ (PBC) Primary Biliary Cirrhosis
- ❑ History of Primary Sclerosing Cholangitis
- ❑ Hemochromatosis
- ❑ Wilson's Disease
- ❑ Alpha-1 antitrypsin (AT) deficiency
- ❑ History of Liver Cancer
- ❑ History of Jaundice

COVID (Sars-CoV-2) Vaccine Record:

□ Took Pfizer-BioNTech Vaccine
- □ 1st Dose… Date _____
- □ 2nd Dose…. Date _____
- □ Booster #1.. Date _____
- □ Booster #2.. Date _____

□ Took Novax Vaccine
- □ 1st Dose… Date _____
- □ 2nd Dose…. Date _____
- □ Booster #1.. Date _____
- □ Booster #1.. Date _____

□ Took Johnson & Johnson Vaccine
- □ 1st Dose… Date _____
- □ 2nd Dose…. Date _____
- □ Booster #1.. Date _____
- □ Booster #2.. Date _____

□ Did Not Take any Covid Vaccines

PAIN ASSESSMENT

Are you currently in pain? Yes ___ No___

Is the source of your pain due to an injury? Yes___ No___

If yes, please describe your injury and the date in which it occurred:_____

_____

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

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

(0= no pain, 10= severe pain)

Example:_____**Neck**_____

0 1 2 3 4 5 (6) 7 8 9 10

Area 1._____

1 2 3 4 5 6 7 8 9 10

Area 2._____

1 2 3 4 5 6 7 8 9 10

Area 3._____

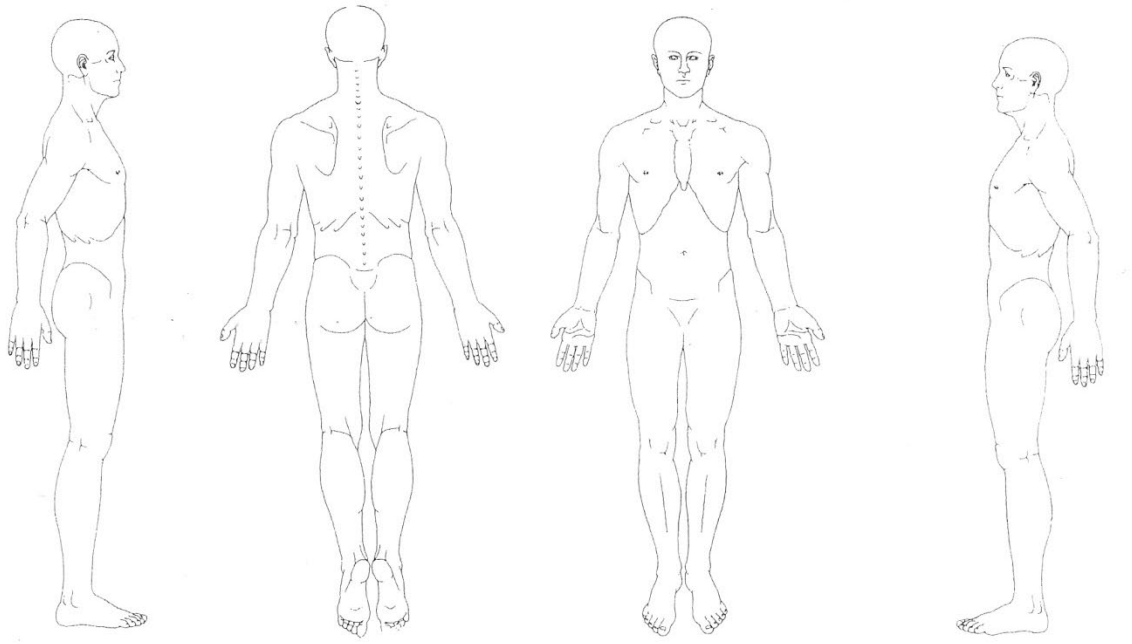
1 2 3 4 5 6 7 8 9 10

Area 4._____

1 2 3 4 5 6 7 8 9 10

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

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



Right Side Back Front Left side

DENTAL HISTORY

	Yes	No
Problem with sore gums (gingivitis)?		
Bleeding Gums with brushing?		
Ringing in the ears (tinnitus)?		
Have TMJ (temporal mandibular joint) problems?		
Metallic taste in mouth?		
Problems with bad breath (halitosis) or white tongue (thrush)?		
Previously or currently wear braces?		
Problems chewing?		
Brush regularly? 1 X Day 2 X Day 3 X Day		
Floss regularly? 1 X Day 2 X Day 3 X Day		
Do you use mouthwash regularly? 1 X Day 2 X Day 3 X Day		
Do you have a dentist that you see regularly?		
Do you get regular dental check-ups and cleanings from your dentist?		

Are you in need of dental work now? Yes _____ No _____
Are you in the middle of a dental work program now? Yes ____ No ____
ie. waiting on a partial, crown, implant: explain _____
How many cavities have you had in your lifetime? _____ (if lots estimate number).
Have you ever had amalgam dental fillings? Yes ____ No ____
Have you ever had amalgam fillings removed? Yes ____ No ____ How many remaining? _____
Did you receive these fillings as a child? Yes ____ No ____
How many root canals have you had in your lifetime? _____ (if lots estimate number)
How many crowns have you had in your lifetime? _____ if lots estimate number
How many pulled teeth (Including wisdom teeth) have you had? _____ estimate number
How many missing teeth do you have now? _____
How many implants have you had? _____ (if lots estimate number)
Do you have a partial? Yes ____ No ____
Do you have dentures? Yes ____ No ____ Upper ____ Lower _____
Have you ever been checked for cavitations? Yes ____ No ____

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

Age	Type of dental work:	Health Problems following dental work? (describe)

DIET and NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes___ No___
Please tell us if there is anything special about your current diet, food plan or eating habits that we should know?_____

_____

Have you ever been diagnosed with an eating disorder? Yes____ No ____ If Yes please explain in detail: _____
Have you ever purged after eating? Yes ____ No ____ Do you currently purge? Yes ____ No ____
Do you have food cravings? Yes ____ No ____ Are you addicted to sugar? Yes ____ No ____
Are you happy with your current weight? Yes ___ No ___ How much weight do you want to lose?____lbs

Place a check mark next to the food/drink that applies to your current diet.

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

How much of the following do you currently consume each week?

Candy and sweets	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet or sugar free soda	
Regular soda with caffeine	
Regular soda without caffeine	
Sports drinks	
Fruit juice drinks	
Pieces of bread (rolls/bagels/buns/donuts/, etc)	
Ice cream	
Salty foods	

Do you currently follow a special diet, food plan or nutritional program? Yes____ No_____

- ❑ Ovo-lacto
- ❑ Vegetarian
- ❑ Vegan
- ❑ Low FODMAP
- ❑ Gluten Free
- ❑ Dairy/Lactose Free
- ❑ Diabetic Diet

If none of the above what diet or food plan are you currently on? _____

What diets have you tried in the past?1) _____2) _____

3)_____4) _____ 5) _____ 6) _____

Have you ever tried time-restricted eating? Yes ___ No ___ Results? _____

Have you ever tried fasting? Yes ___ No ___ How long ____ days? Results? _____

What kind of fast? ie: water, juice, bone broth?_____

Have you ever lost more than 50lbs at one time? Yes ___ No ___ What Diet? _____

Did you keep the weight off? Yes ___ No ___ How long did it take for the weight to go back on? _____

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

If yes, are these symptoms associated with any particular food or supplement? Yes___ No____

If yes, please name the food or supplement and symptom(s). _____

_____

Do you feel that you have ***delayed*** symptoms after eating certain foods, such as fatigue, muscle aches, headaches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more) Yes___ No____

If yes to what foods _____

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

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ High FODMAP foods
- ❑ Refined Sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Caffeine foods
- ❑ Other_____

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

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Low FODMAP foods
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or 'binged' on? Yes _____ No _____

If yes, what food(s) _____

_____

Do you have an aversion to (will not eat) certain foods? Yes _____ No _____

If yes, what food(s) _____

_____

Have you ever been tested for food allergies or sensitivities? Yes ____ No ____

What foods did you test IgE allergic to? 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____ 7) _____ 8)_____

What foods did you test sensitive to? 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____ 7) _____ 8)_____

Do you have a problem with the following food types, or additives?

- ❑ Dairy (Lactose intolerance)
- ❑ Dairy (Cassin)
- ❑ Gluten
- ❑ Caffeine
- ❑ Salicylates
- ❑ Amines
- ❑ FODMAP Foods
- ❑ Sulfites
- ❑ Food Colorings or Dyes
- ❑ Fructose
- ❑ Aspartame
- ❑ Eggs
- ❑ MSG
- ❑ Yeast
- ❑ Sugar
- ❑ Sugar Alcohols

Any other foods, additives or ingredients not listed here that you're sensitive to or give you indigestion or problems? _____

_____

Do you normally have constipation? Yes __ No __ **Do you normally have diarrhea?** Yes __ No ___

Are you swinging back and forth between constipation and diarrhea? Yes ___ No ___

Intestinal gas or flatulence:

- ❑ Daily Or How Often _____
- ❑ Excessive
- ❑ Present with pain
- ❑ Foul smelling
- ❑ Little odor

Acid Reflux symptoms? Heartburn, Backwash (regurgitation), Upper abdominal pain, Chest pain, Trouble swallowing, Chronic Cough, Excessive throat clearing, Sensation of lump in your throat, Excessive salivation, Gas, Bloating.

- ❑ After every meal
- ❑ 1 to 2 times a day
- ❑ 4 times a week
- ❑ Occasionally

What is your worse Reflux symptom? _____

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

Frequency	√	**Color**	√
More than 4 times a day		Medium or dark brown	
3 or 4 times a day		Very dark or black stool (tarry stool)	
1 to 2 times a day		Super green color	
4 times a week		A little green	
2 to 3 times a week		Yellow	
1 or fewer times a week		Red	
Consistency	√	Light brown	
Separate hard lumps, like nuts		Pale white or clay colored	
Sausage-shaped but lumpy		**Other**	√
Sausage or snake like but with cracks		Bright red blood in stool or paper	
Sausage or snake, smooth and soft		Dark red blood visible in stool	
Soft blobs with a clear-cut edges		Difficult to pass	
Fluffy pieces with ragged edges, mushy		Often floats	
Watery, no solid pieces		Greasy, shiny appearance	

Have you seen other doctors for your GI or gut problems? Yes ____ No ____

What GI or gut test have been completed?

1. _____ 2. _____

3. _____ 4. _____

What were your GI or gut diagnosis?

1. _____ 2. _____

3. _____ 4. _____

What treatment for your GI or gut has been tried to date and results?

1) _____

2) _____

3) _____

4) _____

If you could change one thing about your body what would that one thing be?

_____

If you could change one thing about your health what would it be?

_____

What would you like to tell the Doctor that was not included here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ENVIROMENTAL EXPOSURE EVALUATION

Thousands of toxic chemicals in the environment (and workplace) can produce adverse effects on our health status. Please review the list of chemicals and toxins below and check any that apply to you.

❑ Acrylic nail applications	❑ Aerosols	❑ Air Fresheners
❑ Aniline dyes	❑ Around or use herbicides	❑ Celluloid
❑ Chemical industry employee	❑ Coolants for A/C or equipment	❑ Deodorizers
❑ Dewaxing	❑ Do home renovations	❑ Drying/packing
❑ Dyes	❑ Eat foods with food additives	❑ Eat fried foods
❑ Eat non-organic citrus fruits	❑ Emergency worker (fire, police)	❑ Enamellers
❑ Exposure to fungicides	❑ Exposure to dry cleaning fluids	❑ Exposure to pesticides
❑ Exposure to flame retardants	❑ Floor Polishers or chemicals	❑ Food preservatives
❑ Gardener	❑ Heat transfer fluids	❑ Use of waxes (ie floor, auto)
❑ Household cleaners	❑ Hydraulic fluids	❑ Inks
❑ Install swimming pools	❑ Lacquers	❑ Leather working, tooling, dying
❑ Linoleum or work with linoleum	❑ Lithography	❑ Live within 1 mile of landfill
❑ Live near dye plant	❑ Live near highway or railroad	❑ Live near plastic plant
❑ Live near paper plant	❑ Live near plant that has odor	❑ Poultry or livestock worker
❑ Longshoreman	❑ Make or use enamels	❑ Make or use cosmetics
❑ Make or use perfumes	❑ Make soaps	❑ Manufacturer or use fiberglass
❑ Manufacture or wear bronzers	❑ Manufacture or wear rayon	❑ Manufacturer or use degreasers
❑ Manufacture plastic products	❑ Manufacture or use spot remover	❑ Neoprene cement
❑ Ore processing	❑ Paint (work with or use)	❑ Use paint removers
❑ Paint strippers	❑ Paint thinners	❑ Permanent press fabrics/chem
❑ Photographer or dark room	❑ Polymers	❑ Polyurethane exposure
❑ Printer or printing press work	❑ Refinery worker	❑ Resins
❑ Road construction	❑ Radiation worker or therapist	❑ Service station or car mechanic
❑ Shoemaker or shoe dye	❑ Silk cloth or worker	❑ Smoking or breathing smoke
❑ Spray paint	❑ Stains	❑ Trucker
❑ Use antacids	❑ Use aluminum antiperspirants	❑ Use art supplies
❑ Use buffered aspirin	❑ Use disinfectants/anti-bacterial	❑ Use ammonia
❑ Use insect repellent	❑ Use mothballs	❑ Use chemical skin peels
❑ Use lice treatment (ever)	❑ Use plastic shower curtain	❑ Use aluminum pots and pans
❑ Use talc powder	❑ Use kerosene heat	❑ Use scented candles or sprays
❑ Use roundup or other chem	❑ Use bug spray or chemicals	❑ Use fabric softener
❑ Warehouse worker	❑ Wear contact lenses	❑ Work around car or bus exhaust
❑ Work with dyes or cloth	❑ Work around sawdust	❑ Work as pilot or flight attendant
❑ Work with medical X-Rays	❑ Work with gasoline or petroleum	❑ Work with cotton gen or mil
❑ Work in textiles	❑ Work at nuclear plant or reactors	❑ Work on or near a farm
❑ Work in metal fabrication	❑ Work with tires or retreading	❑ Work or worked for paper mill
❑ Work in construction	❑ Work pressure treated lumber	❑ Work around sewage
❑ Work or worked as field worker	❑ Work with acrylics	❑ Work with adhesives or glue
❑ Work or worked in rubber ind	❑ Work with auto clutch or break	❑ Work with bearings or castings
❑ Work with asphalt floor or roof	❑ Work with carpet	❑ Work with agriculture chemicals
❑ Work with insulation	❑ Work with electrical wires	❑ Work with lead batteries

❑ Work with wood preservatives	❑ Work with explosives	❑ Work around fireworks
❑ Work with metal cleaners	❑ Work with photographic film	❑ Work with sheet plastics
❑ Work with sheet metal	❑ Work with pipe metal	❑ Work with stained glass
❑ Work with fertilizer	❑ Work as fumigator	❑ Work in pest control
❑ Work in aerial pesticide	❑ Worked as engraver	❑ Worked with printing ink
❑ Work with laser printers	❑ Work in agriculture industry	❑ Work in the fashion industry
❑ Work as a nurse or healthcare	❑ Work as floral or flowers	❑ Work with farm fishing
❑ Work in food processing	❑ Work in fabric store	❑ Work with/around animal feces
❑ Do you drink tap water	❑ Do you use regular toothpaste	❑ Do you use regular shampoo
❑ Do you have a whole house water filter system	❑ Do you have a under sink water filter system	❑ Do you drink water or use ice from the refrigerator
❑ Do you have air purification system for your home	❑ Do you use plastics in cooking or storing food	❑ Do you wash fruits and vegetables before consumed
❑ Do you have tattoos	❑ Do you eat fast food	❑ Do you use body lotions
❑ Does your workplace smell like fumes or pollution	❑ Does your workplace have an unusual odor	❑ Do you live in a new home with off-gassing.
❑ Do you need to wear a mask or respirator at work	❑ Have you ever had environmental training for your job	❑ Do you use chemicals at work
❑ _____	❑ _____	❑ _____
❑ _____	❑ _____	❑ _____
		❑ _____

ENVRIOMENTAL EXPOSURE EVALUATION

To your knowledge, have you ever been exposed to toxic metals in your job or at home or work? Yes___No___

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury
- ❑ Other _____

Have you ever been tested for Environmental toxicity? Yes ____ No ____

Have you ever done a heavy metals or toxic chemicals detoxification program? Yes ____ No ____

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used any tobacco products? Yes ____ No _____

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

How much/how many?_____per day

Number of years?_____If not a current user, year quit_____

Attempts to quit: _____

How did you finally quit? _____

_____

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

_____

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____ Do you currently drink alcohol? Yes ____ No ____

If yes, please indicate which alcohol you currently use?

❑ Beer	❑ Whisky (Tennessee, Irish, Rye, Canadian)
❑ Brandy	❑ Rum
❑ Wine	❑ Bourbon
❑ Vodka	❑ Hard Cider
❑ Tequila	❑ Everclear
❑ Gin	❑ Scotch
❑ Hard Cider	❑ Sake
❑ Moonshine	❑ Other _____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol at all
- ❑ Average _____ drinks per year
- ❑ Average 1-2 drinks per month
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average greater than 10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more or less than others?) Yes____ No____

Have you ever had a problem with alcohol addiction? Yes____ No____

If yes, indicate time period (month/year) From_____ to _____

Have you ever gone through an alcohol rehab or addiction program Yes ____ No ____

If you currently drink, do you drink alone? Yes ____ No ____

Do you drink alcohol during your workday? Yes ___ No ____ How often? _____

RECREATIONAL DRUGS AND OTHER SUBSTANCES

Do you currently use recreational drugs? Yes____ No____ (These records will stay highly confidential)

If yes, indicate which drugs you currently use:

- ❑ Mamajuana/Pot
- ❑ Cocaine
- ❑ Methamphetamine (Meth, Crystal Meth)
- ❑ Heroin
- ❑ Hallucinogens (LSD, Ecstasy, Mushrooms)
- ❑ Prescription Drugs
- ❑ Other:

Have you previously used recreational drugs? Yes____ No____
If yes, when did you stop using recreational drugs? _____

If yes, indicate which drugs did you previously use:

- ❑ Mamajuana/Pot
- ❑ Cocaine
- ❑ Methamphetamine (Meth, Crystal Meth)
- ❑ Heroin
- ❑ Hallucinogens (LSD, Ecstasy, Mushrooms)
- ❑ Prescription Drugs
- ❑ Other:

If yes, what type(s) and method? (Injection, inhaled, smoked, etc)_____

_____

Have you ever gone through a drug rehab? Yes ____ No____

SLEEP HISTORY AND DISORDERS

Do you have any sleep problems? Yes ____ No ____

If yes explain in your words your sleep problems: _____

_____

Do you wake rested? Yes ____ No ____

Average number of hours that you feel you need at night? _____ hours

Average number of hours that you sleep at night? _____ hours.

What happens to you physically if you do not get the sleep you need? _____

Do you have a set or normal bedtime? Yes ____ No ____. If yes what time? _____ pm

Do you work swing shifts? Yes ____ No ____. What time do you normally get home from work? _____

How old is your mattress? _____ years Is it comfortable to sleep on? Yes ____ No ____

Are your pillows comfortable? Yes ____ No ____ Are your blankets ample and comfortable? Yes ____ No ____

Do you have your bedroom dark? Yes ____ No ____ Do you use night lights? Yes ____ No ____

Do you have any clocks or electronic equipment in your bedroom? Yes ____ No ____

What color light does the electronic equipment have? Red ___ Blue ___ Amber ____ Other ____

Do you like to sleep in a hot room or cold room? _____

Do you sleep with a fan? Yes ____ No ____ Do you sleep with a white noise machine? Yes ___ No ___

Do you wake up if you're too hot? Yes ____ No ____ if you're too cold? Yes ____ No ____

How long on average does it take you to go to sleep? _____ min OR _____ hours

Do you take sleep medications? Yes ____ No ____ If yes what medication? _____

Do you use herbal or natural remedies for sleep? Yes ____ No ____ If yes what remedies? _____

_____

If you use sleep aids and you didn't use them how long would it take you to go to sleep? _____

How many times do you wake during the night? _____

How many times do you go to the bathroom during the night? _____

How long does it take you on average to go back to sleep? _____

Does pain wake you up at night? Yes _____ No _____

Does numbness, tingling or burning of your feet or hands wake you at night? Yes ____ No ____

Do you have drowsiness or tiredness throughout the day? Yes ____ No ____

Difficulty staying awake during the day or when driving? Yes ____ No ____

Do you:

- ❑ Snore
- ❑ Have sleep apnea
- ❑ Have bladder problems
- ❑ Have restless leg syndrome
- ❑ Have medical conditions that effect sleep
- ❑ Narcolepsy
- ❑ Have breathing problems at night
- ❑ Do you have sleep paralysis?
- ❑ Use sleeping aids? (Medications or herbal)

Do you have a sleep monitoring device such as an Oura ring, Apple watch, Samsung watch or other device? Yes ____ No ____ What type of sleep device do you have? _____

Do you sleep in a fetal or knees up to chest position? Yes ____ No ____

Do you wake up easily in the morning? Yes ____ No ____

REST OTHER THAN SLEEP HISTORY (YOUR INTERPERSONAL TIME - YOUR DOWN TIME)

Are you a Type "A" personality? Yes____ No____ Are you a workaholic? Yes ____ No ____

Do you take time for yourself? Yes ____ No ____ Do you take baths? Yes ____ No ____

Do you pray? Yes ____ No ____ Do you meditate? Yes ____ No ____ If Yes how often? _____

What do you do to relax and unwind? _____

Do you have a hobby? Yes ____ No ____ If yes then what? _____

How often do you do your hobby? _____ When was the last time? _____

Are you a Church person? Yes ____ No ____ Do you actively go to church? Yes ____ No ____

Do you belong to and are active in Clubs? Yes ____ No ____ Do you do volunteer work? Yes ____ No ____

Do you belong to and are active in any organizations? Yes ____ No ____

Do you enjoy music? Yes ____ No ____ Do you play an instrument? Yes ____ No ____

Do you do breathing exercises or breath work? Yes ____ No ____ Do you do tapping? Yes ____ No ___

Do you do relaxation exercises? Yes ____ No ____ Do you do mindfulness work? Yes ____ No ____

Do you do creative things for fun like: art, crafts, drawing, sewing, pottery, baking, cooking, coloring, photography, gardening, handicraft, scrapbooking, woodworking, singing, writing and more? Yes ____ No ____

If yes which creative things do you do? _____

Do you practice gratitude? Yes ____ No ____ Do you practice imagery? Yes ____ No ____

EXERCISE HISTORY

Do you exercise regularly? Yes____ No____ How many times per week do you exercise? _____

How long have you been doing your current exercise program? _____

Are you consistent? Yes ____ No ____ How often do you miss? _____

Why do you work out? _____

Tell us more about your exercise program:	Times per week					Length of session			
Type of exercise	1x	2x	3x	4x	5XPlus	≤15	16-30 min	31-45 min	>45
Work out at the gym									
Jogging/Running/Walking									
Aerobics									
Strength Training									
Pilates/Yoga/Tai Chi									
Sports (tennis, golf, pickle ball, etc)									
Pool Exercise/Swimming/Water sports									
Silver Sneakers or Senior Program									
Other									

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

_____

_____

ACTIVITY – OTHER THAN EXERCISE

Do you like to walk? Yes ____ No ____ Can you walk without pain or problems? Yes ____ No ____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

MENTAL STATE - STRESS AND PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

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

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Have you ever had suicidal thoughts? Yes____ No____

If yes, how often? _____ When was the last time?_____

Did you make a suicide plan or purchase any equipment? Yes ___ No ___

Have you ever tried or attempted to commit suicide? Yes ___ No ___

When was the last time? _____
Have you ever been hospitalized for attempted suicide? Yes ___ No ___

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc)_____Did it help?_____

Have you ever been in-patient for psychiatric reasons? Yes ___ No ___ If Yes When _____

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 _____

Have you ever been involved in abusive relationships in your life? Yes ___ No___
Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___
Did you feel safe growing up? Yes ___ No___
Do you feel safe in your home now? 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___
How important is religion (or spirituality) for you and your family's life?
a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

Hobbies and leisure activities:

_____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes_____ No_____

What is the number One stressor in your Life _____

Please rate each of the following:	Good	Fair	Poor
Diet			
Rest (sleep)			
Rest (other than sleep)			
Exercise			
Ability to cope with stress			
Activity Level (other than exercise)			
Mental State			
Water Intake			
Living Arrangements			

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 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 _____

I hereby attest that the information provided herein is true and correct to the best of my knowledge. I understand that I am responsible in the future to inform the Millar Functional Medicine Doctor of any and all changes in my health, symptoms, conditions for better or worse, including but not limited to hospital and ER visits, medications changes and side effects, other treatments, test, accidents, falls, injuries, visits to other health care providers or anything else that affects my health and treatments. I understand that Huntsville Chiropractic and Nutrition Center, LLC., d/b/a Millar Functional Medicine and its doctors are not acting as my primary care physician(s) and they only treat chronic conditions not acute conditions such as would be treated by a primary care physician or the ER.

I hereby authorize and consent to a the taking of a history, examination and the ordering and taking of any imaging or test the Doctor's feel are necessary in my case. I understand that prior to any treatment the Doctor will explain the treatment and I will have time to discuss my treatment with the Doctor.

I hereby accept the terms and conditions set forth herein that all appointments with Greg Millar, DC ASBCE; Helen Stoddart, MD; or Bonnie Sims, ND; hereafter (the "Doctors"), are a Private Contact between you and the Doctors. This Private Contract provides that all appointments and services are self-pay. Appointments with the Doctors are not billed to or through insurance. The Doctors do not accept any insurance and do not file health insurance paperwork on your behalf. However, they will provide you with a superbill receipt for services performed. We do not guarantee payment or reimbursement from anyone. The Doctors do NOT use traditional CPT codes, traditional Diagnostic codes or make traditional SOAP notes for services rendered. The Doctors are NOT in-network with, or providers for, any insurance company or government provider including but not limited to BCBS, Cigna, United Health Care, Aetna, Humana, Tricare, Veterans Administration (VA), Medicare, Medicaid, Alabama Workers Comp or any other(s). The Doctors will not fill out any insurance or Government entity paperwork or fulfill any request for information from an insurance company or Government entity or provide medical records or SOAP notes to insurance companies or Government entities or participate in any audit.

Furthermore, The Doctors do not participate in the Medicare program. If you are a Medicare Part B beneficiary and wish to become or continue as a patient of the Doctors, you hereby accept the terms and conditions set forth herein as a Private Contract between YOU and the Doctors. This Private Contract provides that all appointments and services are self-pay, and you agree NOT to submit receipts for services rendered by the Doctors or Huntsville Chiropractic and Nutrition Center, LLC., d/b/a Millar Functional Medicine to Medicare for possible payment or reimbursement. Furthermore, you agree that absolutely NO Medicare payment(s) will be made to YOU or the DOCTORS or to Huntsville Chiropractic and Nutrition Center, LLC., for the appointments and services provided, even if such appointments and services are covered by Medicare.

Results Vary Patient to Patient. No Guarantee or warranty is made either verbally or in writing.

_____ _____
Patient Date

We hereby accept them as a patient of Millar Functional Medicine>

_____ _____
Doctor Date

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and wellbeing and Live Longer, Younger

Sincerely,
Dr. Greg Millar, DC CPFM ASBCE
Dr. Bonnie Sims, ND
Dr. Helen Stoddart, MD