# Millar Functional Medicine

***Live Longer, Younger***

---


Dr. Greg Millar, DC PhD CPFM CCEP
Dr. Bonnie Sims, ND
Sandra Boldog, BSN RN
Bobby Hartway, Certified Health Coach




**2021 Clinton Ave West, Suite A**
**Huntsville Alabama 35805**

**(256) 539-4000 appointments • (256) 513-4888 Clinic Phone • (256) 513-4887 Fax**

**www.millarfunctionalmedicine.com**

# PERSONAL INFORMATION

Thank you for choosing Millar Functional Medicine to assist you with your health care needs. 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 4+ hours to fill out this form. Take your time and be thorough.** Sometimes we ask a question twice in different formats to help jog your memory. You're spending a lot of time and money on your healthcare so be honest and complete. Thanks

**Today's Date:**_____ Nick Name or Preferred to be Called _____

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

Address _____ City _____ State _____ Zip Code_____

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

Private Email Address For the Doctor to Contact You? _____

Age _____ Date of Birth ____/____/_____ Place of birth_____ Gender: Female☐ Male☐
City or town & State if US | country, if not US

**Marital Status:** Single☐ Married☐ Divorced☐ Widowed☐ Long Term Partnership☐

**Primary Care Physician: Name, phone number & address: Dr.** _____

**(_____) _____-_____** _____

**Other critical physician #1: Name, phone number, specialty: Dr.**_____

(_____) _____-_____ Specialty _____City_____ State _____

**Other critical physician #2: Name, phone number, specialty: Dr.**_____

(_____) _____-_____ Specialty _____City_____ State _____

**Emergency Contact #1:** _____ (____) ____-_____
Relationship Name Phone

Email Address:_____

**Emergency Contact #2:** _____ (____) ____-_____
Relationship Name Phone

Email Address:_____

**Your Occupation** _____ Hours per week _____ Retired ☐

Job Title _____ Nature of Business _____

Highest Level Schooling Completed:☐High School ☐Bachelors ☐Masters ☐Doctorate ☐Post Grad Study

**Genetic or Ethnic Background:** For Medical Purposes (Please check appropriate box(es):

☐ African American ☐ Arabic ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian

☐ Mediterranean ☐ Native American ☐ Northern European ☐ Other _____

## CURRENT HEALTH PROBLEMS

**List Your Top Current Health Problems in Order of Importance. List 1-2-3-4 as your top four HEALTH PROBLEMS. Then List 5-8 as your other problems. Here we're just going to list them. We'll discuss each on in detail next**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

**Please give us more information on your CURRENT problems in the order you stated above.**

| Problem | Date of Onset | Severity | Frequency | Success |
|---|---|---|---|---|
| **Example:** Headaches | May 2020 | Mild \| Moderate \| Severe | Constant \| Frequent \| Occasional | Better \| Worse \| Same |
| **1.** | | | | |
| **2.** | | | | |
| **3.** | | | | |
| **4.** | | | | |
| **5.** | | | | |
| **6.** | | | | |
| **7.** | | | | |
| **8.** | | | | |

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

_____

**What seems to trigger your symptoms?** _____

**What seems to make you feel worst?** _____

**What seems to make you feel better?** _____

**When was the last time that you felt well?** _____

**How long has your current condition or symptoms been going on?** _____

# TIMELINE OF HEALTH PROBLEMS

**TIMING OR WHEN DID YOUR HEALTH PROBLEMS START. Your Current Age _____**

**List age and health problems for each age group below.**

**A. Prenatal** _____

**B. Age 0-9 Child** _____

**C. Age 10-19 Adolescent** _____

**D. Age 20-29 Early Young Adult** _____

**E. Age 30-39 Middle Young Adult** _____

**F. Age 40-49 Adult** _____

**G. Age 50-59 Middle Age** _____

**H. Age 60-69 Late Middle Age** _____

**I. Age 70-79 Late Adulthood** _____

**J. Age 80-89 Young At Heart** _____

**K. Age 90-99 Nonagenarian** _____

**L. Age 100-Plus Centenarian** _____

**What medical conditions or diseases have you been diagnosed with by other physicians?**

| Diagnosis | 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 | WHAT PROBLEM | WHEN |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

**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?**_____

_____

**What functional limitations (what can't you do anymore) are caused by your conditions?** _____

_____

_____

_____

# PAST MEDICAL HISTORY

**If you have any of these illness or problems, please indicate, Yes or NO; Onset; Past or Still, and Treatment.** If your illness is not listed please list under "other" at end of the past medical history.

| ILLNESSES | YES or NO | ONSET | PAST or STILL | TREATMENT |
|---|---|---|---|---|
| ADD or ADHD | | | | |
| Acne | | | | |
| Adrenal Gland Disorder | | | | |
| AFIB – Heart | | | | |
| Anxiety disorder - GAD | | | | |
| Allergies - | | | | |
| Alzheimer's | | | | |
| Anemia | | | | |
| Angina (heart) | | | | |
| Aortic Aneurysm | | | | |
| Arthritis–Osteoarthritis, Rheumatoid | | | | |
| Arrhythmia (Heart) | | | | |
| Asthma | | | | |
| Atherosclerosis | | | | |
| Atrial Fibrillation – AFIB (Heart) | | | | |
| Autistic spectrum disorder | | | | |
| Autoimmune disorders | | | | |
| Bipolar disorder | | | | |
| Bleeding Ulcer | | | | |
| Bronchitis | | | | |
| Cancer - Skin | | | | |
| Cancer of _____ | | | | |
| Cancer Metastatic to _____ | | | | |
| Carpal Tunnel Syndrome | | | | |
| Cataracts | | | | |
| Celiac Disease | | | | |
| Chicken Pox | | | | |
| Chronic Cough | | | | |
| Chronic Fatigue Syndrome | | | | |
| Chronic Lung Disease | | | | |
| Chronic Pain Syndrome | | | | |
| Chronic Disease _____ | | | | |
| Cirrhosis of the Liver | | | | |
| COVID – Long COVID | | | | |

| ILLNESSES | YES or NO | ONSET | PAST or STILL | TREATMENT |
|---|---|---|---|---|
| Concussion or Past Concussion | | | | |
| CHD – Congenital Heart Disease | | | | |
| CHF – Congestive Heart Failure | | | | |
| Constipation (Chronic) | | | | |
| CAD - Coronary Artery Disease | | | | |
| COPD | | | | |
| Crohn's Disease | | | | |
| Cystitis | | | | |
| Diarrhea (Chronic) | | | | |
| Diverticulitis or Diverticulosis | | | | |
| DVT - Deep Vein Thrombosis | | | | |
| Depression | | | | |
| Diabetes Type I or II | | | | |
| Diabetic Ulcer | | | | |
| Diverticulitis or Diverticulosis | | | | |
| Dry Mouth | | | | |
| Dementia | | | | |
| Dysbiosis of the Gut | | | | |
| Dysphagia (swallowing Issues) | | | | |
| Earache | | | | |
| Eating Disorders | | | | |
| Emphysema | | | | |
| Epilepsy, convulsions, or seizures | | | | |
| Epstein-Barr Virus | | | | |
| Fibromyalgia - FMS | | | | |
| Fatty Liver – Alcoholic -NAFL | | | | |
| Fungal Infection | | | | |
| Gallbladder Issues | | | | |
| Gallstones | | | | |
| Gastroenteritis /Gastritis | | | | |
| Genital Issues | | | | |
| GERD | | | | |
| Gout | | | | |
| Gum Disease | | | | |
| Headaches | | | | |
| Hearing Loss | | | | |

| ILLNESSES | Yes or No | ONSET | PAST or STILL | TREATMENT |
|---|---|---|---|---|
| Heart Disease | | | | |
| Heart Attack - MI | | | | |
| Heart Failure - CHF | | | | |
| Heart Palpitations | | | | |
| Heart Valve Disease or Disorder | | | | |
| Hemorrhoids | | | | |
| Hepatitis A \| B \| C \| NonA/NonB | | | | |
| Herpes I – HSV1 | | | | |
| Herpes II – HSV2 | | | | |
| HIV | | | | |
| High Fasting Blood Sugar | | | | |
| High A1C - 6.5 or above | | | | |
| High cholesterol or triglycerides | | | | |
| High blood pressure (hypertension) | | | | |
| Hormone Imbalance - Female | | | | |
| Hormone Imbalance - Male | | | | |
| Hypoglycemia | | | | |
| Incontinence (bowel or bladder) | | | | |
| Inflammation | | | | |
| Inflammatory Bowel Disease - IBD | | | | |
| Infertility | | | | |
| Influenza A or B | | | | |
| IBS - Irritable bowel disease | | | | |
| Kidney (renal) failure or disease | | | | |
| Kidney stones | | | | |
| Liver Disease | | | | |
| Low Back Pain (Chronic) | | | | |
| Lung and Lung Disease | | | | |
| Lyme's disease | | | | |
| Measles | | | | |
| Migraines | | | | |
| Mononucleosis | | | | |
| Mumps | | | | |
| Neck Pain (Chronic) | | | | |
| Neuropathy | | | | |
| Non-Alcoholic Fatty Liver | | | | |

| ILLNESSES | Yes or No | ONSET | PAST or STILL | TREATMENT |
|---|---|---|---|---|
| Obesity | | | | |
| Osteoarthritis | | | | |
| Osteoporosis/ Osteopenia | | | | |
| PAD – Peripheral Artery Disease | | | | |
| Pancreatitis | | | | |
| Parasites | | | | |
| Peptic Ulcer Disease - PUD | | | | |
| POTS | | | | |
| Pneumonia | | | | |
| Rhinitis (nose symptoms - allergies) | | | | |
| Rheumatic Fever | | | | |
| Rheumatoid arthritis | | | | |
| Restless Leg Syndrome | | | | |
| SIBO or SIFO | | | | |
| Sinusitis | | | | |
| Shingles | | | | |
| Sleep Apnea | | | | |
| Sleep Disorders | | | | |
| Strep or Staff or | | | | |
| Stroke or TIA | | | | |
| Thyroid disease | | | | |
| Toxicity Issues | | | | |
| Ulcerative Colitis | | | | |
| UTI's (Chronic) | | | | |
| Viruses – EBV, CMV, Others | | | | |
| Weight Issues | | | | |
| Whooping Cough | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |

| INJURIES | WHEN | SEVERITY | PAST OR STILL | TREATMENT |
|---|---|---|---|---|
| Achilles Injury | | | | |
| Amputation | | | | |
| ACL Injury | | | | |
| Brain Injury (TBI) | | | | |
| Back injury | | | | |
| Bursitis | | | | |
| Concussion X _____ (how many) | | | | |
| Contusion (serious bruise) | | | | |
| Fall Injury | | | | |
| Fractures | | | | |
| Groin Strain | | | | |
| Head Injruy (Open) - laceration | | | | |
| Head Injury (Closed)– No laceration | | | | |
| Hip Injury | | | | |
| Home Injury | | | | |
| Internal Organ Injruy | | | | |
| Joint Dislocation | | | | |
| Knee Injury | | | | |
| Motor Vehicle Injury | | | | |
| Neck injury | | | | |
| Pulled Hamstring | | | | |
| Pulled Muscle | | | | |
| Repetitive Motion Injury | | | | |
| Severe Burn | | | | |
| Shin Spints | | | | |
| Shoulder Injury | | | | |
| Slip and Fall | | | | |
| Spinal Cord Injury | | | | |
| Sports Injury | | | | |
| Sprains and Strains | | | | |
| Sprained Ankle | | | | |
| Tendonitis | | | | |
| Tennis Elbow | | | | |
| Work Injury | | | | |
| Other | | | | |
| Other | | | | |

| DIAGNOSTIC STUDIES | OF WHAT | WHERE (Facility) | RESULTS |
|---|---|---|---|
| Biopsy | | | |
| Blood Tests (last one) | | | |
| Blood Test (previous ones) | | | |
| Bone Density Test | | | |
| Bone Scan | | | |
| Carotid Artery Ultrasound | | | |
| CAT Scan #1 | | | |
| CAT Scan #2 | | | |
| CAT Scan #3 | | | |
| CAT Scan #4 | | | |
| Colonoscopy | | | |
| Endoscopy | | | |
| EEG electroencephalogram | | | |
| ECG electrocardiogram | | | |
| Genetic Testing | | | |
| Mammogram | | | |
| MRI #1 | | | |
| MRI #2 | | | |
| MRI #3 | | | |
| MRI #4 | | | |
| Parasites | | | |
| PET scan | | | |
| Occult Blood | | | |
| Stool Test | | | |
| Ultrasound #1 | | | |
| Ultrasound #2 | | | |
| Urinalysis | | | |
| X-Ray Neck or | | | |
| X-Ray Low Back | | | |
| X-Ray Other | | | |
| Other | | | |
| Other | | | |
| Other | | | |
| Other | | | |
| | | | |

| SURGERIES | WHEN | OUTCOME | COMMENTS |
|---|---|---|---|
| Angioplasty | | | |
| Appendectomy | | | |
| Arthroscopy of Joint | | | |
| Back Surgery | | | |
| Brain Surgery | | | |
| Breast | | | |
| Cancer surgery | | | |
| Carotid endarterectomy | | | |
| Cataract surgery | | | |
| Cesarean section | | | |
| Cosmetic | | | |
| Colon surgery | | | |
| Coronary bypass or stents | | | |
| Dental surgery or implants | | | |
| Female Specific Surgery | | | |
| Fractured Bone Repair | | | |
| Gallbladder | | | |
| Heart Surgery | | | |
| Hernia | | | |
| Hysterectomy | | | |
| Joint replacement #1 | | | |
| Joint replacement #2 | | | |
| Male Specific Surgery | | | |
| Neck Surgery | | | |
| Organ Surgery | | | |
| Prostate | | | |
| Spine | | | |
| Stomach | | | |
| Tonsillectomy | | | |
| Tubes in Ears | | | |
| Urologic Procedures | | | |
| Vein Surgery | | | |
| Other | | | |
| Other | | | |
| Other | | | |
| | | | |

## HOSPITALIZATIONS

| WHERE HOSPITALIZED | WHEN | REASON |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

## Antibiotics & Steroids

| 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). If none or not that age put N/A | Less than 5 times | More than 5 times | Comments |
|---|---|---|---|
| Infancy/Childhood (Age 0-9) | | | |
| Adolescent (Age 10-19) | | | |
| Young Adult (Age 20-29) | | | |
| Middle Young Adult (Age 30-39) | | | |
| Adult (Age 40-49) | | | |
| Middle Age (Age 50-59) | | | |
| Late Middle Age (Age 60-69) | | | |
| Late Adulthood (Age 70-79) | | | |
| Young At Heart (Age 80-89) | | | |

What was the last antibiotic that you were on? _____

When? _____ How Many Days? _____ For? _____

Did you take a probiotic during and after the antibiotic? Yes ☐ No ☐

What was the last oral or injectable steroid that you were on? _____

When? _____ How Many Days? _____ For? _____

Did you take a probiotic during and after the steroid? Yes ☐ No ☐

Do you eat fermented foods? Yes ☐ No ☐

## MEDICATIONS

**List all CURRENT prescription medications you are currently taking.**
**Include only prescription medications below. If None put None.**

| Medication Name | Strength (mg) | Times A Day | Take This Medication For My |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | | | |
| 16. | | | |
| 17. | | | |
| 18. | | | |
| 19. | | | |
| 20. | | | |

**Pleased list all prescription medications that you are NO Longer taking. If none put none.**

| Medication Name | Strength (mg) | Date Stopped | Took This Medication For My |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

| | | | |
|---|---|---|---|
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | | | |
| 16. | | | |
| 17. | | | |
| 18. | | | |
| 19. | | | |
| 20. | | | |

**List all supplements, vitamins, minerals, herbals, oils, that you are currently taking. Please indicate the strength, dosage, date, and why. If none put none.**

| Name | Strength (mg) | Times A Day | Date Started | Take This For My |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |
| 15. | | | | |
| 16. | | | | |
| 17. | | | | |
| 18. | | | | |
| 19. | | | | |
| 20. | | | | |

**List all vitamins, minerals, herbals, oils, and any supplements that you are NO Longer taking. Please indicate the strength, dosage, date, and why. IF None put None.**

| Name | Strength (mg) | Times A Day | Date Started | Took This For My |
|---|---|---|---|---|
| 1. | | | | |
| 2, | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |

**Are you allergic to any medication, vitamin, mineral, or nutritional supplement? YES ☐ NO ☐**

**Below please list all prescription medications, supplements, vitamins, minerals, oils, and herbals that you are allergic to or sensitive to taking.**

| Name | Strength (mg) | Times A Day | Date Started | Date Stopped | Reaction |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |

**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 or Epi nose spray (Neffy)? Yes ☐ No ☐**
**Have you ever had to use it? 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 (Age 0-9) & ADOLESCENCE (Age 10-19) ILLNESSES

**Please indicate which of the following problems/conditions you experienced as a Child or Adolescence 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 (Age 0-9) 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:____/____/_____

Please tell us about your about your cycle symptoms._____

_____

_____

Do you experience breast tenderness, water retention, or irritability, or (PMS) symptoms?
Yes ☐ No ☐. If so, tell us about it:

_____

_____

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._____

## HORMONAL HISTORY

**Do you have hormone problems or symptoms?** Yes ☐ No ☐

Please tell us about any other hormone symptoms or problems 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 OR Bio-identical hormone therapy ? Yes ☐ No ☐

Do you now Yes ☐ No ☐ OR have you ever taken or used natural hormone therapy or supplements? Yes ☐ No ☐ If yes please indicate which ones below:

| | | | | |
|---|---|---|---|---|
| ☐ Wild Yam | ☐ Black cohosh | Red Clover | Maca root | Phytoestorgens in soy products |
| ☐ Vitamin E | ☐ Avena Sativa | L-Arginine | DHEA | Evening Primrose Oil |
| ☐ Licorice | ☐ Hops | Dong gui | Ginger | Arilla quinquefolia |
| ☐ Isoflavones | ☐ Calcium | Antioxidants | Diet | Cimicifuga racemosa |

☐ Other: _____:

Has a doctor ever given you prescriptive compounded hormone therapy? 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 density _____/_____/_____ Results: High____ Low____ Within normal range____

Have you had any hormone testing? Yes ☐ No ☐

## DIFFICULT FEMALE QUESTIONS (These answers will remain completely confidential)

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? _____

Have you ever had prostatitis? Yes ☐ No ☐ When was the last time? _____

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 prostate cancer? Yes ☐ No ☐

Do you have a past history of prostate cancer? Yes ☐ No ☐ If yes, tell us some more about it:

_____

_____

Have you ever had prostate surgery procedures? Yes ☐ No ☐ If yes, tell us about it:

_____

_____

Do you have low testosterone? Yes ☐ No ☐

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

☐ Injections ☐ Cream

*If you have or have or have had any of the follow please (Check box if applicable) then tell us more below:*

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

If you checked any of the above please tell us more about your problem or condition:

_____

_____

_____

# YOUR REVIEW OF SYMPTOMS

**Check (✓) for those that you have currently have.**
**Mark (X) for those problems that you had in the *past but no longer*.**

| GENERAL OR CONSTITUTIONAL: | Current | Past |
|---|---|---|
| Alcohol or Drug Abuse | ☐ | ☐ |
| Alcohol or Drug Addiction | ☐ | ☐ |
| Sugar Addiction | ☐ | ☐ |
| History of High Blood Pressure | ☐ | ☐ |
| History of Low Blood Pressure | ☐ | ☐ |
| My Temperature is normally Low | ☐ | ☐ |
| Fever (chronic or recent) | ☐ | ☐ |
| Recent Infection | ☐ | ☐ |
| Recent Acute Illness (past 6 months) | ☐ | ☐ |
| Recent Acute cardiac Issue (Past 6 months) | ☐ | ☐ |
| Recent Respiratory Issue (Past 6 months) | ☐ | ☐ |
| Recent Hospitalization (Past 6 months) | ☐ | ☐ |
| Recent ER visit (Past 6 months) | ☐ | ☐ |
| Recent Weight Loss (unintentional) | ☐ | ☐ |
| Recent Changes to Bowell | ☐ | ☐ |
| Chills or Cold all over | ☐ | ☐ |
| Aches and Pains | ☐ | ☐ |
| Fatigue | ☐ | ☐ |
| General Weakness | ☐ | ☐ |
| Malaise – Feeling Not Well | ☐ | ☐ |
| Difficulty sweating | ☐ | ☐ |
| Excessive Sweating | ☐ | ☐ |
| Swollen Glands | ☐ | ☐ |
| Cold hands & Feet | ☐ | ☐ |
| Difficulty falling asleep | ☐ | ☐ |
| Insomnia difficulty staying asleep | ☐ | ☐ |
| Sleepwalker | ☐ | ☐ |
| Nightmares | ☐ | ☐ |
| No dream recall | ☐ | ☐ |
| Early waking | ☐ | ☐ |
| Daytime sleepiness or drowsiness | ☐ | ☐ |
| Distorted vision | ☐ | ☐ |

| ALLERGIES: | Current | Past |
|---|---|---|
| Anaphylaxis (history of or past) | ☐ | ☐ |
| Food Allergies to:_____ | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| Do you have an Epi Pen | | |
| Rashes with exposure | | |
| Itching with exposure | ☐ | ☐ |
| Seasonal Allergies | ☐ | ☐ |
| Hay Fever/ Allergic rhinitis) | ☐ | ☐ |
| Latex Allergy | ☐ | ☐ |
| Mold Allergies | ☐ | ☐ |
| Pet Allergies | ☐ | ☐ |
| Drug Allergies to_____ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| SKIN: | Current | Past |
|---|---|---|
| Acne | ☐ | ☐ |
| Allergies | ☐ | ☐ |
| Hair Growth or Hair loss Other than Head | ☐ | ☐ |
| Paresthesia (numbness or crawling feeling) | ☐ | ☐ |
| Skin lesions | ☐ | ☐ |
| Cuts heal slowly | ☐ | ☐ |
| Bruise easily – Bleed Easy | ☐ | ☐ |
| Rashes | ☐ | ☐ |
| Pigmentation or color changes | ☐ | ☐ |
| 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 | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| HEAD: | Current | Past |
|---|---|---|
| Past or Current Head Injury | ☐ | ☐ |
| Poor Concentration | ☐ | ☐ |
| Confusion | ☐ | ☐ |
| Headaches: | ☐ | ☐ |
| After Meals | ☐ | ☐ |
| Severe | ☐ | ☐ |
| Migraine | ☐ | ☐ |
| Frontal | ☐ | ☐ |
| Afternoon | ☐ | ☐ |
| Occipital | ☐ | ☐ |
| Afternoon | ☐ | ☐ |

| | | |
|---|---|---|
| Daytime | ☐ | ☐ |
| Relieved by: _____ | ☐ | ☐ |
| Past Concussions _____ times | ☐ | ☐ |
| Current Concussion | ☐ | ☐ |
| Whiplash | ☐ | ☐ |
| Mental sluggishness | ☐ | ☐ |
| Forgetfulness | ☐ | ☐ |
| Indecisive | ☐ | ☐ |
| Face twitch or tick | ☐ | ☐ |
| Face Pain, Tingling, Burning or Numbness | ☐ | ☐ |
| Poor memory | ☐ | ☐ |
| Hair loss | ☐ | ☐ |
| Past history of Bell's Palsy | ☐ | ☐ |
| TMJ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **EYES:** | **Current** | **Past** |
|---|---|---|
| Wears glasses or contacts | ☐ | ☐ |
| Blindness – one or both eyes | ☐ | ☐ |
| Changes to Vision | ☐ | ☐ |
| Eye Pain | ☐ | ☐ |
| Dry Eyes | ☐ | ☐ |
| Wet Eyes – Chronic Tearing | ☐ | ☐ |
| Feeling of sand in eyes | ☐ | ☐ |
| Double vision | ☐ | ☐ |
| Blurred vision | ☐ | ☐ |
| See bright flashes | ☐ | ☐ |
| Halo around lights | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ |
| Retina Disorders or Issues | ☐ | ☐ |
| Dark circles under eyes | ☐ | ☐ |
| Strong light irritates | ☐ | ☐ |
| Cataracts | ☐ | ☐ |
| Cataract Surgery | ☐ | ☐ |
| Floaters in eyes | ☐ | ☐ |
| Visual hallucinations | ☐ | ☐ |
| Eye Movement Disorders | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **EARS:** | **Current** | **Past** |
|---|---|---|
| Hearing Aids | ☐ | ☐ |
| Aches | ☐ | ☐ |
| Discharge/Conjunctivitis | ☐ | ☐ |
| Ear Drainage | ☐ | ☐ |
| Pains | ☐ | ☐ |
| Ringing or Tinnitus | ☐ | ☐ |
| Hearing loss or Deafness | ☐ | ☐ |
| Itching | ☐ | ☐ |
| Pressure | ☐ | ☐ |
| Ear Pain | ☐ | ☐ |
| Ear Infection(s) | ☐ | ☐ |
| Tubes in ears | ☐ | ☐ |
| Sensitive to loud noises | ☐ | ☐ |
| Hearing hallucinations | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **NOSE - SINUSES** | **Current** | **Past** |
|---|---|---|
| Stuffy | ☐ | ☐ |
| Bleeding | ☐ | ☐ |
| Running/Discharge | ☐ | ☐ |
| Watery nose | ☐ | ☐ |
| Congested | ☐ | ☐ |
| Infection | ☐ | ☐ |
| Polyps or Cyst | ☐ | ☐ |
| Acute smell | ☐ | ☐ |
| Drainage | ☐ | ☐ |
| Sneezing spells | ☐ | ☐ |
| Postnasal drip | ☐ | ☐ |
| Sinus Headaches | ☐ | ☐ |
| Sinus Infections | ☐ | ☐ |
| No sense of smell or lost 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 | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **MOUTH:** | **Current** | **Past** |
|---|---|---|
| Amalgams How Many? _____ | ☐ | ☐ |
| Implants | ☐ | ☐ |
| Dentures | ☐ | ☐ |
| Extractions How Many_____ | ☐ | ☐ |
| Root Canals How Many_____ | ☐ | ☐ |
| Crowns How Many_____ | ☐ | ☐ |
| Missing Teeth How Many_____ | ☐ | ☐ |
| Periodontal (Gun) disease | ☐ | ☐ |
| Bleeding Gums | ☐ | ☐ |
| Coated tongue | ☐ | ☐ |
| Sore tongue | ☐ | ☐ |
| Canker Sores | ☐ | ☐ |
| TMJ | ☐ | ☐ |
| Cracked lips/ corners | ☐ | ☐ |
| Chapped lips | ☐ | ☐ |
| Fever blisters | ☐ | ☐ |
| Grind teeth when sleeping | ☐ | ☐ |
| Bad breath | ☐ | ☐ |
| Dry mouth | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **THROAT:** | **Current** | **Past** |
|---|---|---|
| Hoarseness | ☐ | ☐ |
| Chronic Sore Throat | ☐ | ☐ |
| Change to voice sound | ☐ | ☐ |
| Mucus | ☐ | ☐ |
| Difficulty swallowing | ☐ | ☐ |
| Chokes Easly | ☐ | ☐ |
| Tonsillitis | ☐ | ☐ |
| Enlarged glands | ☐ | ☐ |
| Constant clearing of throat | ☐ | ☐ |

| | | |
|---|---|---|
| Chronic Cough | ☐ | ☐ |
| Throat closes up | ☐ | ☐ |

| NECK: | Current | Past |
|---|---|---|
| Stiffness | ☐ | ☐ |
| Swelling | ☐ | ☐ |
| Lumps | ☐ | ☐ |
| Neck glands swell | ☐ | ☐ |
| Past history of whiplash | ☐ | ☐ |
| Neck Pain that is localized | ☐ | ☐ |
| Neck Pain that radiates | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| CIRCULATION - RESPIRATION: | Current | Past |
|---|---|---|
| Asthma | ☐ | ☐ |
| COPD | ☐ | ☐ |
| Bronchitis | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Lung Cancer | ☐ | ☐ |
| Use a nebulizer | ☐ | ☐ |
| Difficulty Breathing | ☐ | ☐ |
| Low Oxygen saturation | ☐ | ☐ |
| Sleep Apnea | ☐ | ☐ |
| Use C-PAP or B-PAP | ☐ | ☐ |
| MTFHR Gene Positive | ☐ | ☐ |
| On Blood Thinners | ☐ | ☐ |
| On Diuretic medications | ☐ | ☐ |
| Swollen ankles, legs or feet | ☐ | ☐ |
| Sensitive to hot | ☐ | ☐ |
| Sensitive to cold | ☐ | ☐ |
| Extremities cold or clammy | ☐ | ☐ |
| Hands/Feet go to sleep/numbness/tingling | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Chest Pain or Tightness | ☐ | ☐ |
| Left jaw and/or Left arm pain | ☐ | ☐ |
| Pain between shoulders | ☐ | ☐ |
| Carotid Artery Ultrasound, CT or CTA | ☐ | ☐ |
| Carotid Artery Blockage or Surgery | ☐ | ☐ |
| Dizziness upon standing | ☐ | ☐ |
| Fainting spells | ☐ | ☐ |
| High cholesterol | ☐ | ☐ |
| High triglycerides | ☐ | ☐ |
| Wheezing | ☐ | ☐ |
| Irregular heartbeat | ☐ | ☐ |
| Palpitations | ☐ | ☐ |
| Shortness of Breath – Lung Related | ☐ | ☐ |
| Shortness of Breath – Heart Related | ☐ | ☐ |
| Low exercise tolerance | ☐ | ☐ |
| Frequent coughs | ☐ | ☐ |
| Breathing heavily | ☐ | ☐ |
| Frequently sighing | ☐ | ☐ |
| Night sweats | ☐ | ☐ |
| Varicose veins - spider veins | ☐ | ☐ |
| Claudication (leg pain) | ☐ | ☐ |
| PAD – Peripheral Artery Disease | ☐ | ☐ |
| Atherosclerosis | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ |
| Murmurs | ☐ | ☐ |
| Congestive Heart Failure – CHF | ☐ | ☐ |
| Congenital Heart Defect | ☐ | ☐ |
| Skipped heartbeat | ☐ | ☐ |
| Heart enlargement | ☐ | ☐ |
| Angina pain | ☐ | ☐ |
| Bronchitis - Pneumonia | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Croup | ☐ | ☐ |
| Frequent colds | ☐ | ☐ |
| Heavy - Tight chest | ☐ | ☐ |
| Prior heart attack ? When ____/_____/_____ | ☐ | ☐ |
| Heart Surgery (stint or bypass) | ☐ | ☐ |
| Heart Surgery (other) for | ☐ | ☐ |
| Pacemaker or Defibrillator | ☐ | ☐ |
| Prior Stroke or TIA | ☐ | ☐ |
| Phlebitis | ☐ | ☐ |
| History of or Current Blood Clots | ☐ | ☐ |
| Diagnosed with lung Disease _____ | ☐ | ☐ |
| Diagnosed with heart Disease_____ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| COVID: SARS COV-2: | Current | Past |
|---|---|---|
| Had Original COVID _____ times | ☐ | ☐ |
| Had Delta COVID_____ times | ☐ | ☐ |
| Had Omicron COVID _____times | ☐ | ☐ |
| Was hospitalized for _____ days | ☐ | ☐ |
| Was put on a vent _____ days | ☐ | ☐ |
| I have No Long COVID symptoms | ☐ | ☐ |
| Yes I have Long COVID symptoms | ☐ | ☐ |
| **If yes, my long COVID symptoms are:** | ☐ | ☐ |
| Extreme tiredness (fatigue) | ☐ | ☐ |
| Extreme tiredness (fatigue) | ☐ | ☐ |
| Loss of smell | ☐ | ☐ |
| Muscle aches or Joint aches | ☐ | ☐ |
| Lung (respiratory) symptoms | ☐ | ☐ |
| Brain fog | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| GASTROINTESTINAL: | Current | Past |
|---|---|---|
| Abdominal Pain | ☐ | ☐ |
| Black or Tarry Stools | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Swinging back and forth between Diarrhea and Constipation | ☐ | ☐ |
| Peptic/Duodenal Ulcer | ☐ | ☐ |
| Henriods | ☐ | ☐ |
| Anal Fisher | ☐ | ☐ |
| Poor appetite | ☐ | ☐ |
| Excessive appetite | ☐ | ☐ |
| Gallstones | ☐ | ☐ |
| Gallbladder pain | ☐ | ☐ |

| | | |
|---|---|---|
| Nervous stomach | ☐ | ☐ |
| Full feeling after small meal | ☐ | ☐ |
| Indigestion | ☐ | ☐ |
| Heartburn | ☐ | ☐ |
| Acid Reflux or Regurgitation | ☐ | ☐ |
| Acid Stomach | ☐ | ☐ |
| Hiatal Hernia | ☐ | ☐ |
| Nausea | ☐ | ☐ |
| Vomiting | ☐ | ☐ |
| Vomiting blood | ☐ | ☐ |
| Abdominal Cramps | ☐ | ☐ |
| Gas | ☐ | ☐ |
| Painful Gas or trapped Gas | ☐ | ☐ |
| Changes in bowels | ☐ | ☐ |
| Rectal bleeding | ☐ | ☐ |
| Tarry stools | ☐ | ☐ |
| Rectal itching | ☐ | ☐ |
| Use laxatives | ☐ | ☐ |
| Use of Stool Softener | ☐ | ☐ |
| Bloating | ☐ | ☐ |
| Belching | ☐ | ☐ |
| Flatulence | ☐ | ☐ |
| Rumble Tummy (Stomach Noise) | ☐ | ☐ |
| Anal itching | ☐ | ☐ |
| Anal fissures | ☐ | ☐ |
| Bloody stools | ☐ | ☐ |
| Abnormal Stool Caliber | ☐ | ☐ |
| Abnormal Stool Color | ☐ | ☐ |
| Abnormal Stool Size | ☐ | ☐ |
| Undigested food in stools | ☐ | ☐ |
| Last Colonoscopy when _____ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **KIDNEY - URINARY TRACT:** | **Current** | **Past** |
|---|---|---|
| Burning | ☐ | ☐ |
| Frequent urination | ☐ | ☐ |
| Blood in urine | ☐ | ☐ |
| Nighttime urination | ☐ | ☐ |
| Problem passing urine | ☐ | ☐ |
| Kidney pain | ☐ | ☐ |
| Kidney stones | ☐ | ☐ |
| Painful urination | ☐ | ☐ |
| Bladder infections | ☐ | ☐ |
| Kidney infections | ☐ | ☐ |
| Incontinence | ☐ | ☐ |
| Bedwetting | ☐ | ☐ |
| Have trichomonas | ☐ | ☐ |
| Kidney or Renal Failure (stage _____) | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ |

| **LIVER FUNCTION:** | **Current** | **Past** |
|---|---|---|
| Elevated Liver Enzymes | ☐ | ☐ |
| Alcoholic Liver | ☐ | ☐ |
| Non-Alcoholic Fatty Liver | ☐ | ☐ |
| Hepatitis A | ☐ | ☐ |
| Hepatitis B | ☐ | ☐ |
| Hepatitis C | ☐ | ☐ |
| Hepatitis D or E | ☐ | ☐ |
| Autoimmune Hepatitis | ☐ | ☐ |
| Cirrhosis | ☐ | ☐ |
| (PBC) Primary Biliary Cirrhosis | ☐ | ☐ |
| History of Primary Sclerosing Cholangitis | ☐ | ☐ |
| Hemochromatosis | ☐ | ☐ |
| Wilson's Disease | ☐ | ☐ |
| Alpha-1 antitrypsin (AT) deficiency | ☐ | ☐ |
| Liver Cancer | ☐ | ☐ |
| History of Jaundice | ☐ | ☐ |
| Hepatic porphyria | ☐ | ☐ |
| Hemochromatosis | ☐ | ☐ |
| Liver Tumor(s) | ☐ | ☐ |
| Liver Transplant | ☐ | ☐ |
| Metabolic Disease | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **WOMEN'S HISTORY (for women only):** | **Current** | **Past** |
|---|---|---|
| On Birth Control medication | | |
| On Hormone Replacement Therapy | ☐ | ☐ |
| Positive HER 1 or 2 | ☐ | ☐ |
| Have BRAC 1 or 2 | ☐ | ☐ |
| Breast Cancer | ☐ | ☐ |
| Fibrocystic breasts | ☐ | ☐ |
| Lumps in breast | ☐ | ☐ |
| Fibroid Tumors/Breast | ☐ | ☐ |
| Spotting | ☐ | ☐ |
| Heavy periods | ☐ | ☐ |
| Fibroid Tumors/Uterus | ☐ | ☐ |
| Painful periods or Cramps | ☐ | ☐ |
| Change in period | ☐ | ☐ |
| Breast soreness before period | ☐ | ☐ |
| Endometriosis | ☐ | ☐ |
| Non-period bleeding | ☐ | ☐ |
| Breast soreness during period | ☐ | ☐ |
| Vaginal dryness | ☐ | ☐ |
| Vaginal discharge | ☐ | ☐ |
| Vaginal Bleeding | ☐ | ☐ |
| Partial/total hysterectomy | ☐ | ☐ |
| Hot flashes | ☐ | ☐ |
| Mood swings | ☐ | ☐ |
| Concentration/Memory Problems | ☐ | ☐ |
| Ovarian cysts | ☐ | ☐ |
| Pregnant | ☐ | ☐ |
| Infertility | ☐ | ☐ |
| Decreased libido | ☐ | ☐ |
| Heavy bleeding | ☐ | ☐ |
| Joint pains | ☐ | ☐ |
| Headaches - Migraines | ☐ | ☐ |
| Weight gain | ☐ | ☐ |
| Loss of bladder control | ☐ | ☐ |
| Palpitations | ☐ | ☐ |
| Burning urination | ☐ | ☐ |
| Urine Retention | ☐ | ☐ |

| | | |
|---|---|---|
| Circle pme: Reproductive years: | ☐ | ☐ |
| Perimenopausal | ☐ | ☐ |
| Menopause | ☐ | ☐ |
| Postmenopausal | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| MEN'S HISTORY (for men only): | Current | Past |
|---|---|---|
| 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 | ☐ | ☐ |
| ED Difficulty obtaining erection | ☐ | ☐ |
| ED Difficulty maintaining an erection | ☐ | ☐ |
| Nocturia (urination at night) | ☐ | ☐ |
| How many times at night? _____ | ☐ | ☐ |
| Urgency/Hesitancy/Change in Urinary Stream | ☐ | ☐ |
| Loss of bladder control | ☐ | ☐ |
| Dribbling | ☐ | ☐ |
| Low Testosterone – Low T | ☐ | ☐ |
| Burning Urination | ☐ | ☐ |
| Urine Retention | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| HEMATOLOGY: | Current | Past |
|---|---|---|
| Anemia | ☐ | ☐ |
| Blood Issues | ☐ | ☐ |
| Bleeding or Bleed Easy | ☐ | ☐ |
| Blood Clotting Issues | ☐ | ☐ |
| History of Blood Transfusions | ☐ | ☐ |
| Bruises Easly | ☐ | ☐ |
| Lymph Node Swelling | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| BONES - JOINT- MUSCLES -TENDONS: | Current | Past |
|---|---|---|
| Back Pain | ☐ | ☐ |
| Joint Pain | ☐ | ☐ |
| Joint Swelling | ☐ | ☐ |
| Past Fracture of _____ | ☐ | ☐ |
| Surgery to fix Fracture above | ☐ | ☐ |
| Pins, Rods or Screws | ☐ | ☐ |
| Pain wakes you | ☐ | ☐ |
| Weakness in legs | ☐ | ☐ |
| Weakness in arms | ☐ | ☐ |
| Balance problems | ☐ | ☐ |
| Muscle cramping | ☐ | ☐ |
| Head injury | ☐ | ☐ |
| Muscle stiffness in morning | ☐ | ☐ |
| Damp weather bothers you | ☐ | ☐ |
| Joint Surgery | ☐ | ☐ |
| Joint Replacement | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| ENDOCRIN: | Current | Past |
|---|---|---|
| Fatigue | ☐ | ☐ |
| Hormone Issues | ☐ | ☐ |
| Cold or Heat Intolerance | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ |
| Diabetes Insulin Dependent | ☐ | ☐ |
| Excessive Appetite | ☐ | ☐ |
| Excessive Hunger | ☐ | ☐ |
| Excessive Thirst | ☐ | ☐ |
| Frequent Urination | ☐ | ☐ |
| Hypothyroid | ☐ | ☐ |
| Hyperthyroid | ☐ | ☐ |
| Goiter | ☐ | ☐ |
| Other Thyroid Problems | ☐ | ☐ |
| Hair Loss | ☐ | ☐ |
| Renal or Kidney Problems | ☐ | ☐ |
| Unusual Hair Growth | ☐ | ☐ |
| Anxiety | ☐ | ☐ |
| Weight change Circle One: Gain Loss | ☐ | ☐ |
| Anxiety Issues | ☐ | ☐ |
| Dry Skin | ☐ | ☐ |
| Changes in Vision | ☐ | ☐ |
| Changes in neck size | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |
| | ☐ | ☐ |

| NERVOUS SYSTEM: | Current | Past |
|---|---|---|
| Nervous Breakdown | ☐ | ☐ |
| Balance Issues | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Narcolepsy | ☐ | ☐ |
| Fainting – Syncope | ☐ | ☐ |
| Facial; Weakness, ticks or tremors | ☐ | ☐ |
| Headaches or Migraine | ☐ | ☐ |
| Limb weakness | ☐ | ☐ |
| Concussion | ☐ | ☐ |
| Loss of Consciousness | ☐ | ☐ |
| Memory Loss | ☐ | ☐ |
| Dementia | ☐ | ☐ |
| Alzheimer's | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Sleep Disorders | ☐ | ☐ |
| Slurred Speech | ☐ | ☐ |
| Brain Tumor's | ☐ | ☐ |
| Nervous Breakdown | ☐ | ☐ |
| Brain Lesions | ☐ | ☐ |
| Brain Cancer | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ |

| | | |
|---|---|---|
| Parkinson's Disease | ☐ | ☐ |
| Huntington's | ☐ | ☐ |
| ALS – Amyotrophic lateral Sclerosis | ☐ | ☐ |
| Guillian-Barre Syndrome | ☐ | ☐ |
| Tremors | ☐ | ☐ |
| Unsteady Gait | ☐ | ☐ |
| Walks with assistance: cane walker | ☐ | ☐ |
| Neuropathy: circle: Feet Hands | ☐ | ☐ |
| Neuroma | ☐ | ☐ |
| Numbness _____ | ☐ | ☐ |
| Carpal Tunnel Syndrome | ☐ | ☐ |
| Bell's Palsy | ☐ | ☐ |
| Traumatic Brain Injury | ☐ | ☐ |
| Spinal Cord injury | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **EMOTIONAL:** | **Current** | **Past** |
|---|---|---|
| GAD – General Anxiety Disorder | ☐ | ☐ |
| Bipolar Disorder | ☐ | ☐ |
| Obsessive Compulsive Disorder | ☐ | ☐ |
| Panic Disorder | ☐ | ☐ |
| Panic Attacks | ☐ | ☐ |
| PTSD | ☐ | ☐ |
| Psychiatric Problems | ☐ | ☐ |
| Stress | ☐ | ☐ |
| Convulsions | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Fainting Spells | ☐ | ☐ |
| Blackouts/Amnesia | ☐ | ☐ |
| Had prior shock therapy | ☐ | ☐ |
| Frequently keyed up and jittery | ☐ | ☐ |
| Startled by sudden noises | ☐ | ☐ |
| Anxiety Controlled | ☐ | ☐ |
| 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 numbness | ☐ | ☐ |
| Often break out in cold sweat | ☐ | ☐ |
| 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 | ☐ | ☐ |
| Suicide Thoughts | ☐ | ☐ |
| Suicide Plans | ☐ | ☐ |
| Attempted Suicide | ☐ | ☐ |
| Hospitalized for Evaluation | ☐ | ☐ |
| Manic | ☐ | ☐ |
| Depressive | ☐ | ☐ |
| Bi-polar Disorder | ☐ | ☐ |
| Severe Mood Swings or Changes | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **VIRUSES, BACTERIA, PARASITES** | **Current** | **Past** |
|---|---|---|
| Coronavirus | ☐ | ☐ |
| Herpes Simplex HSV-1 | ☐ | ☐ |
| Herpes Genital HSV-2 | ☐ | ☐ |
| Shingles – Herpes Zoster | ☐ | ☐ |
| Hunman Herpesvirus 6 or 7 or 8 | ☐ | ☐ |
| Chickenpox | ☐ | ☐ |
| Mumps | ☐ | ☐ |
| Measles | ☐ | ☐ |
| Mononucleosis | ☐ | ☐ |
| Epstein Barr Virus | ☐ | ☐ |
| Human Cytomegalovirus (HCMV) | ☐ | ☐ |
| Human Papillomavirus (HPV) | ☐ | ☐ |
| Hepatitis A virus (HAV) | ☐ | ☐ |
| Hepatitis B virus (HBV) | ☐ | ☐ |
| Hepatitis C virus (HCV) | ☐ | ☐ |
| Hepatitis D virus (HDV) | ☐ | ☐ |
| Hepatitis E virus (HEV) | ☐ | ☐ |
| Human Adenovirus (HAdV) | ☐ | ☐ |
| RSV Respiratory Syncytial Virus | ☐ | ☐ |
| Zika virus | ☐ | ☐ |
| Rubella | ☐ | ☐ |
| Bird Flu – Avian Influenza A Virus (IAV) H5N | ☐ | ☐ |
| Diphtheria | ☐ | ☐ |
| Flu Influenza A | ☐ | ☐ |
| Flu Influenza B | ☐ | ☐ |
| HIb - Haemophilus influenzae type b | ☐ | ☐ |
| HIV -1 or HIV -2 or AIDS | ☐ | ☐ |
| Japanese Encephalitis (JE) | ☐ | ☐ |
| Mpox | ☐ | ☐ |
| Norovirus (NoV) | ☐ | ☐ |

| | | |
|---|---|---|
| Meningococcal Disease | ☐ | ☐ |
| Pneumococcal Disease | ☐ | ☐ |
| Polio | ☐ | ☐ |
| Rabies | ☐ | ☐ |
| Rotavirus | ☐ | ☐ |
| Rubella (German Measles) | ☐ | ☐ |
| Tetanus | ☐ | ☐ |
| Whooping Cough (Pertussis) | ☐ | ☐ |
| Zika | ☐ | ☐ |
| HMPV Human Metapneumovirus | ☐ | ☐ |
| Colorado Tic Fever Virus (CTFV | ☐ | ☐ |
| HFMD – Hand, Foot, and Mouth Disease | ☐ | ☐ |
| West Nile Virus Chlamydia | ☐ | ☐ |
| Yellow Fever | ☐ | ☐ |
| Bacterial vaginosis | ☐ | ☐ |
| Pneumonia | ☐ | ☐ |
| Salmonella | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Meningitis | ☐ | ☐ |
| Stap | ☐ | ☐ |
| Sepsis | ☐ | ☐ |
| MRSA – Methicillin-resistant Staphylococcus Aureus | ☐ | ☐ |
| Strep | ☐ | ☐ |
| Shigellosis (Shigella) | ☐ | ☐ |
| Sepsis | ☐ | ☐ |
| Lyme disease | ☐ | ☐ |
| Campylobacter | ☐ | ☐ |
| Impetigo | ☐ | ☐ |
| Clostridioides Difficile (C. Diff) | ☐ | ☐ |
| Tetanus | ☐ | ☐ |
| Cholera | ☐ | ☐ |
| Botulism | ☐ | ☐ |
| Pseudomonas infection | ☐ | ☐ |
| Syphilis | ☐ | ☐ |
| Anthrax | ☐ | ☐ |

| | | |
|---|---|---|
| Leptospirosis | ☐ | ☐ |
| Tick Borne Diseases | ☐ | ☐ |
| Gonorrhea | ☐ | ☐ |
| Cellulitis | ☐ | ☐ |
| Legionella | ☐ | ☐ |
| Leprosy (Hansen's Disease) | ☐ | ☐ |
| Listeriosis (Listeria) | ☐ | ☐ |
| Malaria | ☐ | ☐ |
| Ringworm | ☐ | ☐ |
| Scarlet Fever | ☐ | ☐ |
| Chlamydia | ☐ | ☐ |
| E. Coli | ☐ | ☐ |
| Meningitis | ☐ | ☐ |

| **COVID (Sars-CoV-2) Vaccine Record:** | **Current** | **Past** |
|---|---|---|
| Took Pfizer mRNA Vaccine | ☐ | ☐ |
| Took Moderna mRNA Vaccine | ☐ | ☐ |
| 2nd Dose….Date _____ | ☐ | ☐ |
| Booster #1..Date _____ | ☐ | ☐ |
| Booster #2..Date _____ | ☐ | ☐ |
| Took Novax Protein Subunit Vaccine | ☐ | ☐ |
| 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** | ☐ | ☐ |

## CANCER: IF NO HISTORY OF PAST OR CURRENT CANCER THEN CHECK ☐ None

**WE DO NOT TREAT CANCER PERSAY. WE TREAT THE NUTRITIOAL COMPONENT AND BIOCHEMICAL PATHWAYS OF CANCER**

- ☐ Currently have active cancer Yes ☐ No ☐
- ☐ Where: _____
- ☐ Stage _____
- ☐ Cancer Surgery to where _____
  At what hospital or facility _____
- ☐ Currently Having Chemotherapy Yes ☐ No ☐
- ☐ Currently Having Radiation Yes ☐ No ☐
- ☐ Currently Having Immunotherapy Yes ☐ No ☐
- ☐ Have you had genetic or genomic testing for your cancer
- ☐ Did you have a signatura test if so what was your ctDNA or cfDNA number _____
- ☐ Has your cancer metastasized ☐ No ☐ Yes
- ☐ Past History of Cancer: when _____
- ☐ Past history of Chemotherapy… when _____
- ☐ Past History of Radiation…when _____
- ☐ Past History of Immunotherapy… when _____
- ☐ On a Special Cancer Diet… ☐ No ☐ Yes | Describe Diet _____
- ☐ Taking cancer supplements
  1. _____ Strength _____ Dosage _____
  2. _____ Strength _____ Dosage _____
  3. _____ Strength _____ Dosage _____
  4. _____ Strength _____ Dosage _____
  5. _____ Strength _____ Dosage _____
  6. _____ Strength _____ Dosage _____
  7. _____ Strength _____ Dosage _____
  8. _____ Strength _____ Dosage _____
  9. _____ Strength _____ Dosage _____
  10. _____ Strength _____ Dosage _____
- ☐ Father had _____ Cancer(s)
- ☐ Mother had _____ Cancer(s)
- ☐ Brother had _____ Cancer(s)
- ☐ Sister had _____ Cancer(s)
- ☐ My oncologist is: _____ of _____

Tell us your cancer story _____

_____

_____

_____

# FAMILY HEALTH HISTORY

**Please indicate current and past history with "C" or "P" in the box.**

| Place a C in the box for current problems and a P in the box for past history. | 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 Hashimoto's, Rheumatoid Arthritis) | | | | | | | | | |
| Bipolar Disease | | | | | | | | | |
| Bladder disease | | | | | | | | | |
| Blood clotting problems | | | | | | | | | |
| Celiac disease | | | | | | | | | |
| COVID (Sars-CoV-2) | | | | | | | | | |
| Dementia | | | | | | | | | |
| Depression | | | | | | | | | |
| Diabetes | | | | | | | | | |
| Eczema | | | | | | | | | |
| Emphysema | | | | | | | | | |
| Environmental Sensitivities | | | | | | | | | |

| Place an C in the box for current problems and a P in the box for past history. | 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: | | | | | | | | | |

# 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

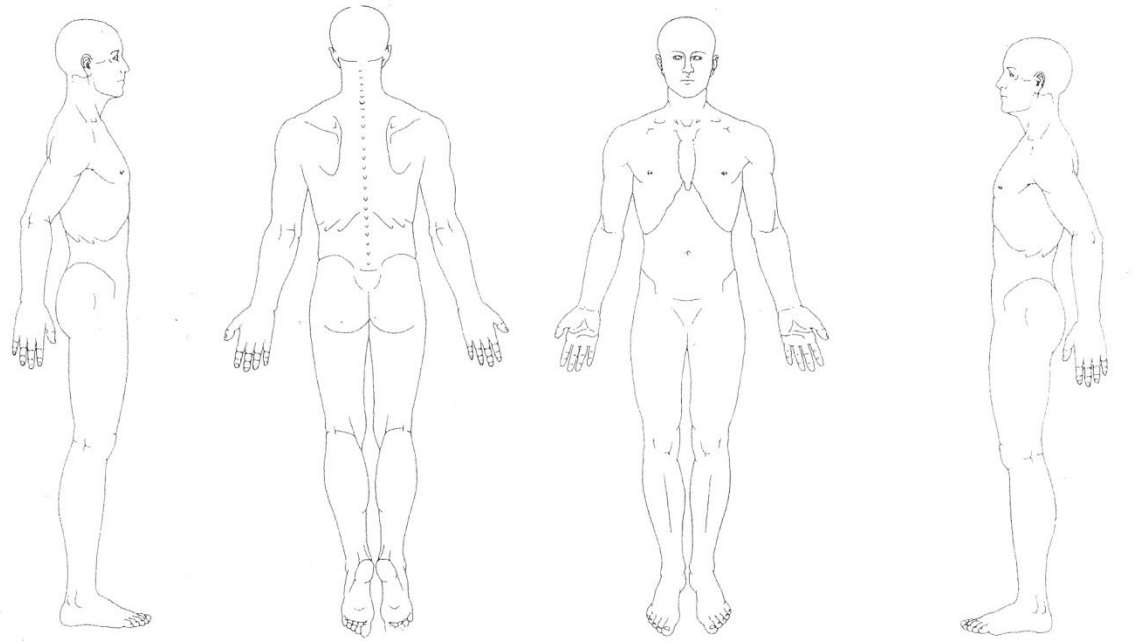
**Area 2**._____
1 2 3 4 5 6 7 8 9 10

**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 & 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 diagnoses?**

1. _____ 2. _____

3. _____ 4. _____

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

1) _____

2) _____

3) _____

4) _____

## FATIGUE ASSESSMENT

1. **I am bothered by fatigue?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
2. **I get tired very quickly?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
3. **I don't do much during the day?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
4. **I always have enough energy for everyday life?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
5. **Physically, I feel exhausted?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
6. **I have problems starting things?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
7. **I have problems thinking clearly?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
8. **I feel no desire to do anything?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
9. **Mentally, I feel exhausted?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always
10. **When I am doing something I can concentrate quite well?** ☐ Never ☐ Sometimes ☐ Regularly ☐ Often ☐ Always

## ANXIETY ASSESSMENT

**Over the past 4 weeks have you been bothered by any of the following problems?**

**1. Feeling nervous, anxious or on edge?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Neary every day

**2. Not being able to stop or control worrying?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Neary every day

**3. Worrying too much about different things?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Neary every day

**4. Trouble relaxing?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Neary every day

**5. Being so restless that it is hard to sit still?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Neary every day

**6. Becoming easily annoyed or irritable?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Neary every day

**7. Feeling afraid as if something awful might happen?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Neary every day

## ENVIROMENTAL EXPOSURE EVALUATION

**To your knowledge, have you ever been exposed to toxic materials, heavy 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, Heavy Metals or Mold? Yes ☐ No ☐**

**To your knowledge, have you ever been exposed to mold or fungus in your job or at home or work? Yes☐ No☐**

If yes, indicate which

- ☐ Mold
- ☐ Fungus
- ☐ Other _____

**Have you ever done a heavy metals, mold, or toxic chemicals detoxification program? Yes ☐ No ☐**

## ENVRIOMENTAL EXPOSURE EVALUATION

Thousands of toxic chemicals in the environment (home 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 | ☐ Asbestos |
| ☐ 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 |
| ☐ _____ | ☐ _____ | ☐ _____ |
| ☐ _____ | ☐ _____ | ☐ _____ |
| | | ☐ _____ |

## MENTAL SCREENING

*"YES, a Change" indicates that there has been a change in the last several years caused by cognitive, thinking and memory.*

1. **Problems with judgement? (e.g., problems making decisions, bad financial decisions, problems with thinking)**
   ☐YES, a Change ☐No, No Change ☐N/A Don't know

2. **Less interest in hobbies/activities?**
   ☐ YES, a Change ☐No, No Change ☐N/A Don't know

3. **Repeats the same things over and over again** (questions, stories, statements)
   ☐YES, a Change ☐No, No Change ☐N/A Don't know

4. **Trouble learning how to use a tool, appliance, or gadget? (computer, microwave, remote control, phone)**
   ☐YES, a Change ☐No, No Change ☐N/A Don't know

5. **Forgets correct month or year?**
   ☐YES, a Change ☐No, No Change ☐N/A Don't know

6. **Trouble handling complicated financial affairs? (balancing checkbook, bank accounts, credit cards, paying bills)**
   ☐YES, a Change ☐No, No Change ☐N/A Don't know

7. **Trouble remembering appointments?**
   ☐YES, a Change ☐No, No Change ☐N/A Don't know

8. **Daily problems with thinking and/or memory?**
   ☐YES, a Change ☐No, No Change ☐N/A Don't know

# 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: _____

When did you finally quit? _____

How did you finally quit?_____

Are you now or have you in the past been 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 ☐

Do you have an activity just for you? Yes ☐ No ☐

Do you have an activity with your spouse or significant other? Yes ☐ No ☐

Do you volunteer? Yes ☐ No ☐ What _____

# 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: (What and How Often/when was the last time)**

_____

_____

**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** | | | |
| **Activity (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 _____

_____

## FINAL QUESTIONS

**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?**

_____

**If you could wave a magic wand and make two of your problems disappear, what would they be?**

1. _____
2. _____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

---

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 the taking of a history, examination and the ordering and taking of any imaging, blood work test, urine test, saliva test, DNA testing or other 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 further understand that this informed consent will be replaced by a more comprehensive written informed consent in the future.

I hereby accept the terms and conditions set forth herein that all appointments with Greg Millar, DC PhD CPFM; Bonnie Sims, ND M.Div; Sandra Boldog BSN RN, or Bobby Hartway, certified health coach, hereafter (the "Providers"), are a Private Contact between you and the Providers. This Private Contract provides that all appointments and services are self-pay. The Providers do not accept any insurance. Appointments with the Providers are not billed to or through insurance. We do not send any insurance

claims or file any insurance paperwork on your or our behalf. However, they will provide you with a superbill receipt for services performed. We do not guarantee payment or reimbursement from anyone. The Providers do NOT use traditional CPT codes, traditional Diagnostic codes or make traditional SOAP notes for services rendered. The Providers 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 Providers 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 patient encounter SOAP notes to any insurance companies or Government entities or participate in any audit or refund.

For up to (7) seven years after your last date of service we will fax or email, at no charge to you, a copy of your medical records to another medical provider. We will gladly provide you, at no cost to you, with a copy of your medical records within ten (10) business days after you have completed a FMF records request form. If your medical records are mailed then the actual cost of mailing (postage and envelope cost) will be collected.

Furthermore, The Providers 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 Providers. This Private Contract provides that all appointments and services are self-pay, and you agree NOT to submit receipts for services rendered by the Providers 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 Providers 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 Signature** Date

For Millar Functional Medicine.

_____ _____

**Doctor** Date

Thank you for taking the time to complete this health history medical questionnaire. The information derived from your intake forms will provide invaluable data in identifying the underlying “Root Cause” of your health problems rather than simply treating the symptoms.

We look forward to helping you achieve Optimal Health and Wellbeing and *Live Longer, Younger*

Sincerely,

*Dr. Greg Millar, DC PhD CPFM*
*Dr. Bonnie Sims, ND M.Div*
*Sandra Boldog, BSN RN*
*Bobby Hartway, Certified Health Coach*