Millar Functional Medicine

Live Longer, Younger

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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	Treatment Approach	Success
Example: Headaches	May 2020	Mild | Moderate | Severe Constant | Frequent | Occasional	Acupuncture/Aspirin OTC prescription medication name	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

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

GENERAL OR CONSTITUTIONAL:

- ❑ 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:

- ❑ 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:

- ❑ 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:

- ❑ 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:

- ❑ 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
- ❑ Poor night 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:

- ❑ 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

- ❑ 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:

- ❑ 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:

- ❑ 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:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell
- ❑ Past history of whiplash
- ❑ Neck Pain that is localized
- ❑ Neck Pain that radiates
- ❑ Other:_____

CIRCULATION - RESPIRATION:

- ❑ 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 heat Disease _____
- ❑ Other:_____

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
- ❑ I have No Long COVID symptoms
- ❑ Yes 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
- ❑ Other _____
- ❑ Other _____

GASTROINTESTINAL:

- ❑ 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:

- ❑ 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:

- ❑ 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):

- ❑ 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):

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:

- ❑ Anemia
- ❑ Blood Issues
- ❑ Bleeding or Bleed Easy
- ❑ Blood Clotting Issues
- ❑ History of Blood Transfusions
- ❑ Bruises Easly
- ❑ Lymph Node Swelling
- ❑ Other:_____

BONES - JOINT- MUSCLES -TENDONS:

- ❑ 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:

- ❑ 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:

- ❑ 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
- ❑ 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:

- ❑ 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

- ❑ 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) H5N1
- ❑ 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:

- □ 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

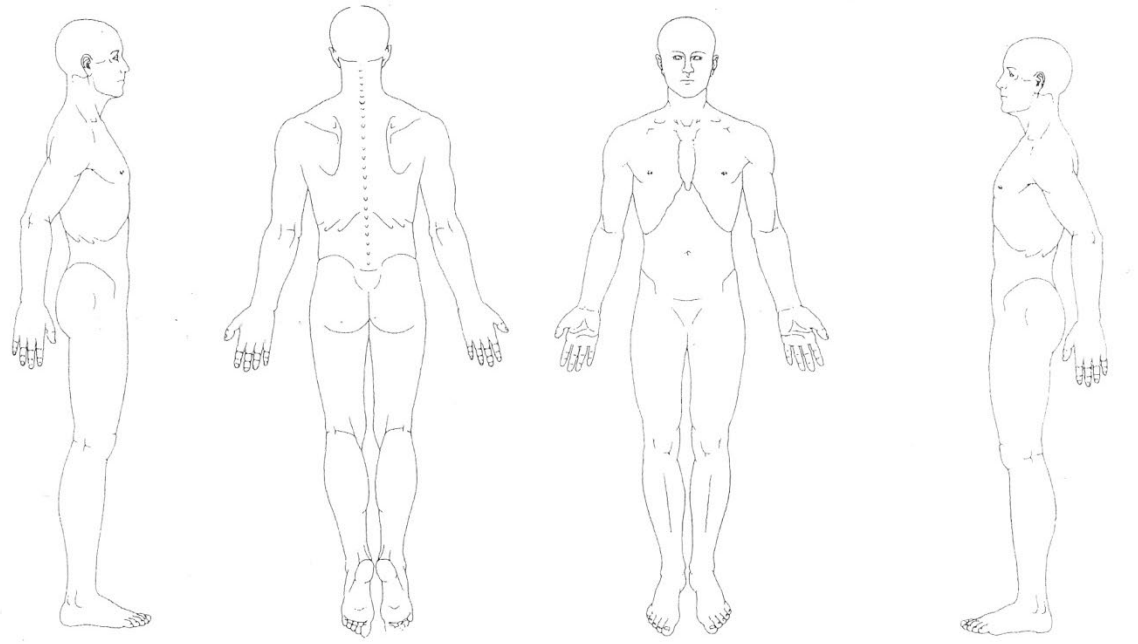
Area 2._____
1 2 3 4 5 6 7 8 9 10

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