

Millar Functional Medicine

Live Longer, Younger

Dr. Greg Millar, DC PhD CPFM CCEP

Dr. Bonnie Sims, ND

Dr. Helen Stoddart, MD

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.

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 CURRENT HEALTH PROBLEMS

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

List health problem and age when your health problems started.

- A. Prenatal _____**

- B. Age 0-9 Child Illness/Problems _____**

- C. Age 10-19 Adolescent Illness/Problems _____**

- 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?

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

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

PHYSICAIN NAME	SPECIALTIY	WHEN
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 experienced any of these illness or problems, please indicate when or how often under comments. If NOT listed, please put under other at the bottom of the page.

ILLNESSES	ONSET	STILL “yes ”	COMMENTS
ADD or ADHD			
Acne			
AFIB – Heart			
Anxiety disorder			
Allergies			
Alzheimer’s			
Anemia			
Arthritis–Osteoarthritis, Rheumatoid			
Asthma			
Autistic spectrum disorder			
Autoimmune disorders			
Bipolar disorder			
Bronchitis			
Cancer			
Carpal Tunnel Syndrome			
Cataracts			
Celiac disease			
Chicken Pox			
Chronic Cough			
Chronic Fatigue Syndrome			
Chronic Lung Disease			
Chronic Pain Syndrome			
Cirrhosis of the Liver			
Concussion or Past Concussion			
CHD – Congenital Heart Disease			
Constipation (Chronic)			
COPD			
COVID-19			
Crohn’s Disease			
Cystitis			
Diarrhea (Chronic)			
Diverticulitis or Diverticulosis			
Deep Vein Thrombosis (blood clots)			
Depression			

ILLNESSES	ONSET	STILL “yes ”	COMMENTS
Diabetes Type I or II			
Dry Mouth			
Dementia			
Dysphagia (swallowing Issues)			
Earache			
Eating Disorders			
Emphysema			
Epilepsy, convulsions, or seizures			
Epstein-Barr Virus			
Fibromyalgia			
Fatty Liver – Alcoholic -NAFL			
Fungal Infection			
Gallbladder Issues			
Gallstones			
Genital Issues			
GERD			
Gout			
Gum Disease			
Headaches and Migraines			
Hearing Loss			
Heart Disease			
Heart Attack, Angina			
Heart Failure - CHF			
Heart Palpitations			
Hemorrhoids			
Herpes I or II			
Hepatitis A B C NonA/NonB			
Herpes Lesions			
HIV			
High cholesterol or triglycerides			
High blood pressure (hypertension)			
Hypoglycemia			
Incontinence (bowel or bladder)			
Infertility			
Influenza A or B			
Irritable bowel disease			

ILLNESSES	ONSET	STILL “yes”	COMMENTS
Kidney (renal) failure or disease			
Kidney stones			
Liver Disease			
Low Back Pain (Chronic)			
Lyme’s disease			
Measles			
Mononucleosis			
Mumps			
Neck Pain (Chronic)			
Neuropathy			
Non-Alcoholic Fatty Liver			
Obesity			
Osteoarthritis			
Osteoporosis/ Osteopenia			
PAD – Peripheral Artery Disease			
Pancreatitis			
POTS			
Pneumonia			
Rhinitis (nose symptoms - allergies)			
Rheumatic Fever			
Rheumatoid arthritis			
Restless Leg Syndrome			
Sinusitis			
Shingles			
Sleep Apnea			
Sleep Disorders (
Stroke or TIA			
Thyroid disease			
Ulcerative Colitis			
UTI’s (Chronic)			
Whooping Cough			
Other			
Other			

INJURIES	WHEN	Resolved	TREATMENT
Brain Injury (TBI)			
Back injury			
Broken bones or fractures (describe)			
Head injury or Concussion			
Fall Injury			
Motor Vehicle Injury			
Neck injury			
Sports Injury			
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			
Colonoscopy			
Endoscopy			
EEG electroencephalogram			
ECG electrocardiogram			
Mammogram			
MRI #1			
MRI #2			
PET scan			
Ultrasound #1			
Ultrasound #2			
X-Ray Neck or Low Back			
X-Ray Other			
Other			
Other			
Other			

SURGERIES	WHEN	OUTCOME	COMMENTS
Angioplasty			
Appendectomy			
Breast			
Cancer surgery			
Carotid endarterectomy			
Cataract surgery			
Cesarean section			
Cosmetic			
Colon surgery			
Coronary bypass or stents			
Dental surgery or implants			
Gall Bladder			
Heart			
Hernia			
Hysterectomy			
Joint replacement #1			
Joint replacement #2			
Spine			
Stomach			
Tonsillectomy			
Tubes in Ears			
Vein Surgery			
Other			
Other			
Other			

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS

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

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

List all **CURRENT** prescription 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 supplements that you are **NO Longer taking.**

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

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

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

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

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

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

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

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

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

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

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

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

CHILDHOOD & ADOLESCENCE HISTORY

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

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

CHILDHOOD AND ADOLESCENCE IMMUNIZATION HISTORY

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

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

CHILDHOOD DIET (Age 0-9)

- At what age did your mother/father start giving you solid food? _____
- What was your first and second solid food? _____
- Did you have any childhood (Age 0-10) food allergies or sensitivities? Yes ____ No ____
- 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 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

- | | | |
|---|---|---|
| <input type="checkbox"/> Pregnancies _____ | <input type="checkbox"/> Cesarean _____ | <input type="checkbox"/> Vaginal deliveries _____ |
| <input type="checkbox"/> Miscarriage _____ | <input type="checkbox"/> Abortion _____ | <input type="checkbox"/> Living Children _____ |
| <input type="checkbox"/> Post partum depression _____ | <input type="checkbox"/> Toxemia _____ | <input type="checkbox"/> Gestational diabetes _____ |

GYNECOLOGICAL HISTORY

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

Painful: Yes _____ No _____ Clotting: Yes _____ No _____ Flow: Lite _____ Medium _____ Heavy _____

Date of last menstrual period: ____/____/____

Are you menopausal? (12 months since menstruation) Yes _____ No _____ If yes, age you went into menopause _____

Are you post-menopausal? (over 12 months since last menstruation) Yes _____ No _____ If yes, age you became post-menopausal _____

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

Do you currently use contraception? Yes _____ No _____ If yes, what please indicate which form:

Non-hormonal

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

Hormonal

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

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

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

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

HORMONAL HISTORY

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

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

Do you currently take hormone replacement? Yes ___ No ___ If yes, what type and for how long? _____

☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin ☐ Progesterone ☐ Provera
☐ Other _____

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

FEMALE DIAGNOSTIC TESTING

Last PAP test: Date ___/___/___ Normal: ___ Abnormal: ___

Last Mammogram: Date ___/___/___ Normal: ___ Abnormal: ___

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

Date of last bone density ___/___/___ Results: High ___ Low ___ Within normal range ___

Have you had any hormone testing? Yes ___ No ___

DIFFICULT FEMALE QUESTIONS

Have you ever been sexually abused? Yes ___ No ___ Raped? Yes ___ No ___

Have you ever been verbally abused? Yes ___ No ___

Have you ever been emotionally abused? Yes ___ No ___

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

MALE MEDICAL HISTORY

(for men only)

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

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

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

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

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

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


Do you have low testosterone? Yes ___ No ___

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

(Check box if applicable)

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

YOUR REVIEW OF SYMPTOMS

Circle  the problem 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

- ☐ 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: _____

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
- ☐ Other: _____

SKIN:

- ☐ Acne
- ☐ Hair Growth or Hair loss Other than Head
- ☐ Paresthesia (numbness or crawling feeling)
- ☐ Skin lesions
- ☐ Cuts heal slowly

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
- ☐ Acute smell
- ☐ Drainage
- ☐ Sneezing spells
- ☐ Postnasal drip
- ☐ Sinus Headaches
- ☐ Sinus Infections
- ☐ No sense of smell
- ☐ Do the change of seasons tend to make your symptoms worse? Yes/No

If yes, is it worse in the:

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter
- ☐ Other: _____

MOUTH:

- ☐ Amalgams How Many? _____
- ☐ Implants
- ☐ Dentures
- ☐ Extractions How Many _____
- ☐ Root Canals How Many _____
- ☐ Crowns How Many _____
- ☐ Missing Teeth How Many _____
- ☐ Periodontal (Gum) 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 Easily

- ☐ 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 heart 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 Easily
- ☐ 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
- ☐ Human 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 Tick Fever Virus (CTFV)
- ☐ HFMD – Hand, Foot, and Mouth Disease
- ☐ West Nile Virus Chlamydia
- ☐ Yellow Fever
- ☐ Bacterial vaginosis
- ☐ Pneumonia
- ☐ Salmonella
- ☐ Tuberculosis
- ☐ Meningitis
- ☐ Staph
- ☐ 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:

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

- ☐ Currently have active cancer
 - ☐ Where: _____
 - ☐ Stage _____
 - ☐ Cancer Surgery to where _____
At what hospital or facility _____
 - ☐ Currently Having Chemotherapy
 - ☐ Currently Having Radiation
 - ☐ Currently Having Immunotherapy
 - ☐ 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 special 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 to the best of your knowledge

Place an "X" under Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus, Hashimoto's)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
COVID (Sars-CoV-2)									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

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

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

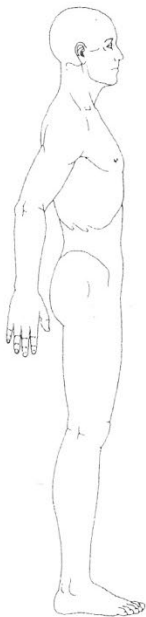
B= burning

N= numbness

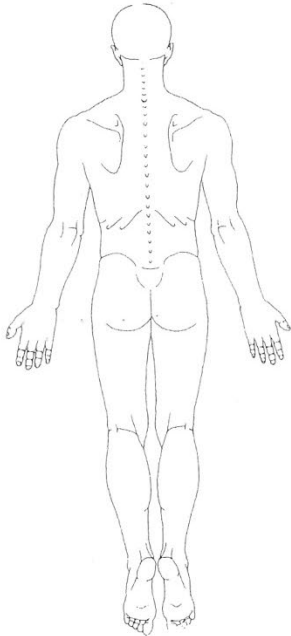
S= stiffness

T=tingling

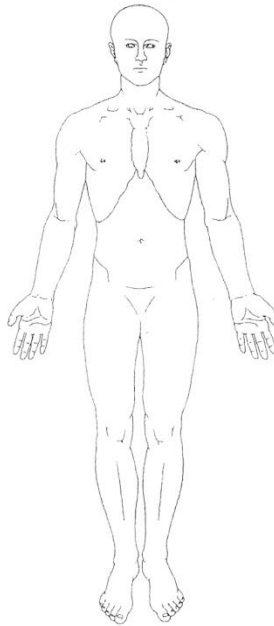
Z=sharp/shooting



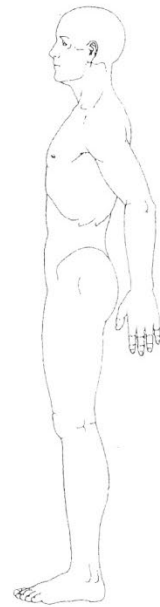
Right Side



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 _____

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

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:

- | | |
|--|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined Sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| <input type="checkbox"/> High FODMAP foods | <input type="checkbox"/> Caffeine foods |
| | <input type="checkbox"/> Other _____ |

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

- | | |
|--|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| <input type="checkbox"/> Low FODMAP foods | <input type="checkbox"/> 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?

- | | |
|--|---|
| <input type="checkbox"/> Dairy (Lactose intolerance) | <input type="checkbox"/> Food Colorings or Dyes |
| <input type="checkbox"/> Dairy (Cassin) | <input type="checkbox"/> Fructose |
| <input type="checkbox"/> Gluten | <input type="checkbox"/> Aspartame |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Salicylates | <input type="checkbox"/> MSG |
| <input type="checkbox"/> Amines | <input type="checkbox"/> Yeast |
| <input type="checkbox"/> FODMAP Foods | <input type="checkbox"/> Sugar |
| <input type="checkbox"/> Sulfites | <input type="checkbox"/> 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 ☐ Nearly every day

2. Not being able to stop or control worrying?

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

3. Worrying too much about different things?

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

4. Trouble relaxing?

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

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

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

6. Becoming easily annoyed or irritable?

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

7. Feeling afraid as if something awful might happen?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly 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 ___

ENVIRONMENTAL 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.

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

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

<input type="checkbox"/> Beer	<input type="checkbox"/> Whisky (Tennessee, Irish, Rye, Canadian)
<input type="checkbox"/> Brandy	<input type="checkbox"/> Rum
<input type="checkbox"/> Wine	<input type="checkbox"/> Bourbon
<input type="checkbox"/> Vodka	<input type="checkbox"/> Hard Cider
<input type="checkbox"/> Tequila	<input type="checkbox"/> Everclear
<input type="checkbox"/> Gin	<input type="checkbox"/> Scotch
<input type="checkbox"/> Hard Cider	<input type="checkbox"/> Sake
<input type="checkbox"/> Moonshine	<input type="checkbox"/> 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:

- | | |
|--|---|
| <input type="checkbox"/> Snore | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Have sleep apnea | <input type="checkbox"/> Have breathing problems at night |
| <input type="checkbox"/> Have bladder problems | <input type="checkbox"/> Do you have sleep paralysis? |
| <input type="checkbox"/> Have restless leg syndrome | <input type="checkbox"/> Use sleeping aids? (Medications or herbal) |
| <input type="checkbox"/> Have medical conditions that effect sleep | |

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			
	1x	2x	3x	4x	5XPlus	≤15	16-30 min	31-45 min	>45
Type of exercise									
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 CPM; Helen Stoddart, MD; Bonnie Sims, ND M.Div; or Bobby Hartway, certified health coach, hereafter (the "Providers"), are a Private Contract 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

Dr. Helen Stoddart, MD

Bobby Hartway, Certified Health Coach