

# **Acupuncture and Chiropractic Center**

## **Introductory Patient Information And Consent Forms**

**945 Michigan Ave Suite 8 B  
Pensacola Florida 32505**

**(850) 469 9633**

**(850) 469 1590**

**[www.acuchiroctr.com](http://www.acuchiroctr.com)  
[chiroacucenter@bellsouth.net](mailto:chiroacucenter@bellsouth.net)**

## FREQUENTLY ASKED QUESTIONS

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

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

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

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

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

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

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

### ***Do you take insurance?***

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

### ***What credit cards do you accept?***

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

### Patient Acceptance Policy

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

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

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

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

- 2. Medical Records** from all physicians since you were **first diagnosed** with your health condition **MUST** be obtained prior to scheduling an appointment.
- 3.** Once Dr. Cowan has your completed questionnaires and copies of all your medical records, a one-hour appointment will be scheduled either on a **Tuesday or Thursday** to review your case. Dr. Cowan will provide a **detailed written medical report** at the time of your scheduled appointment. The cost for the one-hour appointment as well as Dr. Cowan's time for reviewing your medical questionnaire, medical records and written report is \$175.00.
- 4.** Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain a **comprehensive blood chemistry**. The blood chemistry test may include the following. Depending on your circumstances, Biomarkers may be added or subtracted from the profile we need for you health related problem.
- Comprehensive Executive Metabolic Panel**, which includes 24 important disease markers such as SGOT, SGPT, GGT, Bilirubin (Liver), BUN, Creatinine, Uric (Kidney), Alkaline Phosphatase (Bone)
  - Cardiovascular Panel:** Cholesterol, Triglycerides, LDL, HDL, Cholesterol/HDL Ratio, LDL/HDL Ratio, C Reactive Protein (hs-CRP), Homocysteine, Fibrinogen
  - Thyroid Panel:** Total T3, Total T4, Free T3, Free T4, TSH
  - Magnesium**
  - CBC differential:** White Blood Cells and Red Blood Cells, Platelets
  - Inflammatory markers:** Sedimentation Rate, or CRP

5. Based on your medical history, questionnaire, medical records and initial consultation, it may be necessary to order additional medical laboratory tests. You will be presented with detailed information on the **specific tests recommended**. The cost for your initial Laboratory tests will be discussed at that time. **Payment can be made via check and/or credit card.** We accept **Visa, Mastercard, Discover**.
6. If you have not had a physical examination within the last two years or since the start of your most recent health problem, it is required to either schedule an appointment with **Dr. Cowan** or with your primary physician.
7. The results of your lab tests may take approximately **three weeks**, at which point, you will be scheduled for an appointment. This appointment usually takes approximately one to one and half hours. You will be presented with a written report **detailing the results of your tests, the possible causes of your health problem and the recommended treatment protocol**. It is recommended that you have your spouse or a supportive family member attend this appointment.
8. Your treatment may consist of dietary and lifestyle changes as well as prescribed **Natural Pharmaceuticals**, which must be paid at the time of purchase.
9. It is strongly recommended that you have access to a computer with Internet Connection. **A progress medical questionnaire** will be posted to your e-mail one week before your next scheduled appointment. Completion of the progress questionnaire is required every 6-12 weeks to monitor your progress. Correspondence by e-mail is strongly encouraged and is **Free of Charge**. If you do not have access to the internet, then a copy of the progress questionnaire will be mailed or faxed. If you would prefer to schedule an appointment to discuss any questions, you may do so either on [practice day] or [practice day].
10. Follow-up consultations will be scheduled every **3, 6 or 12 weeks** allowing you the opportunity to discuss your progress and any concerns with **Dr. Cowan**. **Dr. Cowan** will at this time determine what direction to take to help you continue your progress. Your cooperation in taking "**personal responsibility**" in your health care will go a long way in getting better. Consultations can be conducted either by phone or in person (at the office). The fee for follow-up consultations is **\$45.00 for 20 minutes**.
11. **Abnormal laboratory tests** will need to be re-evaluated. The success of your treatment will not only be measured on the reduction of elimination of your physical symptoms, but on abnormal laboratory tests returning to a normal status.  
For example: Many physicians will prescribe Lipitor for individuals suffering with high cholesterol. Your physician will also require periodic cholesterol blood tests to monitor the success of the medication. Laboratory fees can vary depending on what needs to be re-tested.

I, \_\_\_\_\_ have read and fully understand the **Patient Acceptance Policy**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Dr. Robert Cowan**

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

## Requesting Records of Doctor:

Name of Facility or Person: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number ( ) \_\_\_\_ - \_\_\_\_\_ Fax number ( ) \_\_\_\_ - \_\_\_\_\_

## THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to **Acupuncture and Chiropractic Center / Robert F. Cowan DC, Cap, DACBN** all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

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

Alcohol or Drug Abuse:  Yes  No

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

Genetic Testing  Yes  No

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

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

I hereby release **Acupuncture and Chiropractic Center / Robert F. Cowan DC, Cap, DACBN**; its employees, agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

*Please Print*

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**\*PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM\***

## Records Requested by:

Doctor's \_\_\_\_\_ Name: \_\_\_\_\_

\_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Telephone number ( ) \_\_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_

# Acupuncture and Chiropractic Center

## Health Questionnaires

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# Acupuncture and Chiropractic Center

## GENERAL INFORMATION

Name \_\_\_\_\_

Preferred Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of birth \_\_\_\_\_ Gender: female male \_\_\_\_\_

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Partnership \_\_\_\_\_

Right Handed: \_\_\_\_\_ Left Handed: \_\_\_\_\_ Mixed Dominance: \_\_\_\_\_

Number of Sisters: \_\_\_\_\_ (# deceased: \_\_\_\_\_) # of Brothers: \_\_\_\_\_ (# deceased: \_\_\_\_\_) Birth Order: \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

Nature of Business \_\_\_\_\_

How did you hear about our clinic? Book \_\_\_\_\_ Website \_\_\_\_\_ Media \_\_\_\_\_ Friend/ family member \_\_\_\_\_

Other \_\_\_\_\_

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

Next of Kin or other to reach in an emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Genetic Background: Please check appropriate box(es):

- |   |                                    |  |                                |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Mediterranean     | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American  | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

Who is your primary medical physician? \_\_\_\_\_

Primary medical physician address & office phone # \_\_\_\_\_

## PERSONAL DESCRIPTIVE INFORMATION

**Marital status:**

- Single
  Married
  Divorced  
 Widow
  Long Term Partnership

**List Children:**

Child's Name	Age	Gender

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

\_\_\_\_\_

\_\_\_\_\_

Do you have any pets or farm animals? Yes \_\_\_\_ No \_\_\_\_

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

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

If so, when and where? \_\_\_\_\_

\_\_\_\_\_

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

If yes, please comment: \_\_\_\_\_

\_\_\_\_\_

Have you experienced any major losses in life? Yes \_\_\_\_ No \_\_\_\_

If so, please comment: \_\_\_\_\_

\_\_\_\_\_

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

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

Previous jobs: \_\_\_\_\_

\_\_\_\_\_

Please list your highest level of education:

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

# Functional Diagnostic Medicine Questionnaire

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

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

**Please print or write legibly.**

## COMPLAINTS/CONCERNS

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

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

What diagnosis or explanations have been given to you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was the last time you felt well? \_\_\_\_\_

\_\_\_\_\_

Did something trigger your change in health? \_\_\_\_\_

\_\_\_\_\_

What makes you feel **worse**? \_\_\_\_\_

\_\_\_\_\_

What makes you feel **better**? \_\_\_\_\_

\_\_\_\_\_

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

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

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

- |                                       |                                      |  |   |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> None         | <input type="checkbox"/> Massage     | <input type="checkbox"/> Yoga          | <input type="checkbox"/> Environmental medicine |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Rolfing     | <input type="checkbox"/> Hypnosis      | <input type="checkbox"/> Nutritional Therapy    |
| <input type="checkbox"/> Acupuncture  | <input type="checkbox"/> Reiki       | <input type="checkbox"/> Ayurveda      | <input type="checkbox"/> Biological Dentistry   |
| <input type="checkbox"/> Iridology    | <input type="checkbox"/> Homeopathy  | <input type="checkbox"/> Light therapy | <input type="checkbox"/> IV (chelation) therapy |
| <input type="checkbox"/> Colonics     | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Meditation    | <input type="checkbox"/> Naturopathic medicine  |

## PAST MEDICAL & SURGICAL HISTORY

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

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

## HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

### AGE OF ONSET OF ILLNESSES

Please indicate which, if any, of the following problems/conditions developed when you were a child (ages birth to age12) by indicating the approximate age of onset.

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

If yes, please explain your illness:

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## IMMUNIZATION HISTORY

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

- |  |   |
|--|---|
| <input type="checkbox"/> Smallpox          | <input type="checkbox"/> Mumps                    |
| <input type="checkbox"/> Tetanus           | <input type="checkbox"/> Measles                  |
| <input type="checkbox"/> Diphtheria        | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Pertussis         | <input type="checkbox"/> Typhoid                  |
| <input type="checkbox"/> Polio (oral)      | <input type="checkbox"/> Cholera                  |
| <input type="checkbox"/> Polio (Injection) |   |

## FEMALE MEDICAL HISTORY (for women only)

### OBSTETRICS HISTORY Check box if yes and provide number of

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pregnancies _____      | <input type="checkbox"/> Caesarean _____                    | <input type="checkbox"/> Vaginal deliveries _____ |
| <input type="checkbox"/> Miscarriage _____      | <input type="checkbox"/> Abortion _____                     | <input type="checkbox"/> Living Children _____    |
| <input type="checkbox"/> Post partum depression | <input type="checkbox"/> Toxemia                            | <input type="checkbox"/> Gestational diabetes     |
| <input type="checkbox"/> Baby over 8 pounds     | <input type="checkbox"/> Breast feeding For how long? _____ |   |

### GYNECOLOGICAL HISTORY

Age at 1<sup>st</sup> period: \_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length: \_\_\_\_\_ Pain: Yes \_\_\_ No \_\_\_

Clotting: Yes \_\_\_\_\_ No \_\_\_\_\_ Has your period skipped? \_\_\_\_\_ For how long? \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

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

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

Have you ever used hormonal contraception? Yes \_\_\_ No \_\_\_ If yes, when \_\_\_\_\_

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

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

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

Last Mammogram \_\_\_\_\_ Breast Biopsy/Date \_\_\_\_\_

Last PAP Test: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

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

Are you in menopause? Yes \_\_\_ No \_\_\_ Age at Menopause \_\_\_\_\_

Do you take:  Estrogen  Ogen  Estrace  Premarin Other \_\_\_\_\_  
 Progesterone  Provera Other \_\_\_\_\_

How long have you been on hormone replacement? \_\_\_\_\_

## FAMILY HISTORY

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

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Heart Attack												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Glaucoma												
Headache												
Heart Disease												
High Blood Pressure												
High Cholesterol												

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

Any other family history we should know about? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please comment: \_\_\_\_\_  
 \_\_\_\_\_

# ESTABLISHING HEALTH GOALS

## Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve in your visit with us? \_\_\_\_\_  
\_\_\_\_\_

If you had a magic wand and could erase three problems, what would they be?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

## Have you made the decision to change? To do what it takes to get well?

Yes \_\_\_\_\_ No \_\_\_\_\_

I have read something interesting: ***“The definition of insanity is to keep doing the same thing and expecting different results”***. If you keep following the same course of treatment you have been following will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they're made the decision to change. But how many people have truly decided to change? Very few! Why? Because there is a big difference between deciding something and having “reasons” to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

List up to 5 things that you have ***been unable*** to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
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**HAVE YOU COMPLETED THE LAST SECTION?**

**IF NOT, PLEASE GO BACK AND ANSWER ALL THE QUESTIONS!**

**PLEASE DO NOT SKIP THIS SECTION!!**

**GIVE CAREFUL THOUGHT TO WHY YOU WANT TO GET BETTER AND  
HOW IT WOULD AFFECT YOUR LIFE!**

## REVIEW OF SYSTEMS

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

### GENERAL

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

### SKIN:

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

### HEAD:

- Poor Concentration
- Confusion
- Headaches:

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

### EYES:

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

### EARS:

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

### NOSE/SINUSES

- Stuffy
- Bleeding
- Running
- Discharge
- Watery Nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage

- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

**If yes, is it worse in the:**

- Spring
- Summer
- Fall
- Winter

***MOUTH:***

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

***THROAT:***

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

***NECK:***

- Stiffness
- Swelling
- Lumps
- Neck glands swell

***CIRCULATION/RESPIRATION:***

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

- Night Sweats
- Varicose Veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Past Heart Attack ?? When \_\_\_\_\_
- Phlebitis
- Spider Veins

***GASTROINTESTINAL/DIGESTION***

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

***KIDNEY/URINARY TRACT:***

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

### **WOMEN'S HISTORY (for women only)**

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

### **MEN'S HISTORY (for men only)**

Have you had a PSA done?

Yes \_\_\_\_\_ No \_\_\_\_\_

PSA Level:

- 0 – 2
- 2 – 4
- 4 – 10
- >10
- Prostate enlargement
- Prostate infection
- Change in libido
- Impotence
- Diminished libido
- Poor libido
- Infertility
- Lumps in testicles
- Sore on penis
- Genital pain
- Hernia
- Prostate cancer
- Low sperm count
- Difficulty Obtaining Erection
- Difficulty Maintaining an Erection
- Nocturia (urination at night)
- How many times at night? \_\_\_\_\_
- Urgency/Hesitancy/Change in Urinary Stream
- Loss of Control of Urine
  - Have overused alcohol
  - Family history of overused alcohol

### **JOINT/MUSCLES/TENDONS**

- Pain wakes me up
- Weakness in Legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle Stiffness in Morning
- Damp weather bothers you

### **EMOTIONAL:**

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts
- Amnesia
- Had shock therapy
- Frequently keyed up and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Forgetful
- Listless
- Withdrawn feeling
- Feel "lost" in time
- Had nervous breakdown
- Had "burnout"
- Feel groggy
- Unable to concentrate
- Short attention span
- Vision changes
- Unable to reason
- Considered a nervous person
- Worried over little things
- Anxiety
- Unusual tension
- Frustration
- Numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Been admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Aggressive
- Misunderstood by others
- Irritable
- Easily flare in anger
- Feeling of hostility
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide

- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

## MEDICATIONS & SUPPLEMENTS

### ANTIBIOTIC USE

**Antibiotics: How often have you taken antibiotics?**

	<b>&lt; 5 times</b>	<b>&gt; 5 times</b>
Infancy/Childhood		
Teen		
Adulthood		

### STEROID USE

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

	<b>&lt; 5 times</b>	<b>&gt; 5 times</b>
Infancy/Childhood		
Teen		
Adulthood		

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

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



Have your medications or supplements ever caused you unusual side effects or problems?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ALLERGIES	
<b>Medication/Supplement/Food</b>	
_____	_____
_____	_____
_____	_____
_____	_____

## NUTRITION & LIFESTYLE HISTORY

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

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

*Check all that apply:*

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

**Please check any specific food restrictions you have:**

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

Is there anything else?

**Reaction**  
 \_\_\_\_\_  
 \_\_\_\_\_

Height (feet/inches) \_\_\_\_\_ Current Weight \_\_\_\_\_

Usual weight range +/- 5 lbs \_\_\_\_\_ Desired Weight range +/- 5 lbs \_\_\_\_\_

Highest adult weight \_\_\_\_\_ Lowest adult weight \_\_\_\_\_

Weight fluctuations (>10lbs) Yes \_\_\_\_\_ No \_\_\_\_\_ Body Fat % \_\_\_\_\_

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

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

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

Food	Symptom	Other comments

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

Do you grocery Shop? Yes\_\_\_\_\_No\_\_\_\_\_If no, who does the shopping? \_\_\_\_\_

When you shop do you purchase the following?

Organic Foods  Hormone free and antibiotic free meat

Do you read food labels? Yes\_\_\_\_\_No \_\_\_\_\_

Do you Cook? Yes\_\_\_\_\_No\_\_\_\_\_If no, who does the cooking? \_\_\_\_\_

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

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

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

## TOBACCO HISTORY

Currently using tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

## ALCOHOL INTAKE

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

None\_\_ 1-3\_\_ 4-6\_\_ 7-10\_\_ >10\_\_

## OTHER SUBSTANCES

Are you currently using recreational drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what types?: \_\_\_\_\_

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

If yes, what types?: \_\_\_\_\_

## EXERCISE

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

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

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

List problems that limit activity: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Do you usually sweat when exercising? Yes \_\_\_\_\_ No \_\_\_\_\_

## SOCIAL HISTORY

### PSYCHOSOCIAL

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

Are you happy? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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

Do you like the work you do? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you experienced major losses in your life? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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

### STRESS/COPING

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

Please do your best to answer the following questions:

Did you feel safe growing up? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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

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

Have you ever sought counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

Currently? Yes \_\_\_\_\_ No \_\_\_\_\_ Previously? Yes \_\_\_\_\_ No \_\_\_\_\_ If previously from \_\_\_\_\_ to \_\_\_\_\_

What kind? \_\_\_\_\_

Comments: \_\_\_\_\_

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

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

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

Work \_\_\_\_\_ Family \_\_\_\_\_ Social \_\_\_\_\_ Finances \_\_\_\_\_ Health \_\_\_\_\_ Other \_\_\_\_\_

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

Check all that apply:

Yoga  Meditation  Imagery  Breathing  Tai Chi  Prayer  Other

Hobbies and leisure activities: \_\_\_\_\_

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

a. \_\_\_\_\_ not at all important      b. \_\_\_\_\_ somewhat important      c. \_\_\_\_\_ extremely important

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

Yes \_\_\_\_\_ No \_\_\_\_\_

## TOXIC STRESS TRIGGERS

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

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

### DO YOU WORRY OVER?

- Home life
- Marriage
- Children
- Job
- Income

### IS YOUR LIFE:

- Satisfactory
- Boring
- Demanding
- Unsatisfactory
- Money Problems

## SLEEP/REST

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

Do you have trouble falling asleep? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you feel rested upon awakening? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have problems with insomnia? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you snore? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use sleeping aids? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

## ENVIRONMENTAL INFLUENCES

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

### Electromagnetic Factors

- Live or have you lived within 200 yards from high-voltage wires or transformers  
When? \_\_\_\_\_
- Live or have lived near an electric distribution substation
- Bed is close to the main electrical current
- Have a fan directly over your bed
- Have an alarm clock or radio close to your bed (plugged in)
- Live or have you lived near a television transmitter
- Sleep with an electric blanket, heating pad
- Sleep on a waterbed

#### Position of your head of your bed is facing:

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

What is your occupation?  
\_\_\_\_\_

### Toxin Exposure

#### Trichloroethylene/TCE

- Work close to a copy machine
- Worked in a printing shop
- Drink decaffeinated coffee
- Use typewriter correction fluid

- Use rug cleaners
- Use disinfectants
- Use carbonless paper
- Use spot removers
- Use cleaning supplies
- Use metal degreasers
- Do recreational painting

#### Formaldehyde

- Wear many dry-cleaned clothes
- Noticed changes of your health since you moved into your home
- Wear many polyester clothes and permanent press
- You use Spray Starch
- Have foam wall insulation
- Have particleboard, chip board or interior plywood
- Put up wallpaper in the last 2 years
- Have foam cushions or foam mattresses
- Live or lived in a trailer
- Worked in a laboratory
- Your home been insulated since your illness
- Had new carpets.  
When? \_\_\_\_\_
- Use waxes and polishes on your floor
- Been around resin glues and plastics
- Have exterior grade plywood on your home
- Home made of stucco, plaster or concrete
- Have a wood-burning stove
- Have draperies
- Have used acid-cured resin floor finishes
- Have fire-proof material in your home
- Smoke in your home
- Have a photography darkroom
- Use nail polish remover
- Use fingernail hardeners

## Pesticides & Herbicides

### (Organochlorines, Organophosphate, Carbamate, Chlorinated Cyclodiene, Botanical & Microbial)

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

## Volatile Organic Compounds

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

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

## Phenols

Do you use the following?

- Household cleaners
- Nasal Sprays
- Styrofoam cups
- Cough Syrup
- Decongestants
- Hair sprays
- Scented deodorants

- Scotch tape
- Newsprint
- Lysol
- Epoxy
- Listerine
- Chloraseptic throat sprays
- Noxema
- Mildew cleaners
- Perfumes
- Air Fresheners
- Disinfectants
- Polishes
- Glues
- Waxes
- Mouthwash
- Hard saucepan handles
- Smoke in the house
- Have you been exposed to chemicals?  
When? \_\_\_\_\_
- Have you had your home treated for termites  
When? \_\_\_\_\_
- Wash own vehicle by hand.  
What type of cleaners do you use? \_\_\_\_\_

## Carbon Monoxide/Nitrogen Oxide/Sulfur Dioxide

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

## Ozone

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

## Carbon Dioxide

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

## Asbestos

- Live in an old home

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

**Please note the “brand” of product you use**

**For example: Toothpaste: Crest**

Shampoo: \_\_\_\_\_

Toothpaste: \_\_\_\_\_

Hair Conditioner: \_\_\_\_\_

Makeup: \_\_\_\_\_

Lipstick: \_\_\_\_\_

Make-up Foundation: \_\_\_\_\_

Deodorant: \_\_\_\_\_

Perfume: \_\_\_\_\_

Hairspray: \_\_\_\_\_

Shaving Cream: \_\_\_\_\_

Cologne: \_\_\_\_\_

Facial Creams: \_\_\_\_\_

Body Creams: \_\_\_\_\_

Do you have hair permanents?  Yes  No  
If yes, how often? \_\_\_\_\_

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

**Do you use Latex products?**

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

**General Miscellaneous**

- Have basement Molds
- Home is damp
- Use a humidifier? If yes, when the last time you cleaned it? \_\_\_\_\_

- Use black hair dye (Nitrosamines)
- Worked in beauty shop.  
When? \_\_\_\_\_
- Take any illicit drugs as an adolescent/young adult?  
What type? \_\_\_\_\_
- Open your windows at home
- Work in a machine shop
- Work in a garden?
- Work or have you worked on a farm  
When? \_\_\_\_\_
- Have mercury fillings
- Had mercury fillings removed?  
When? \_\_\_\_\_
- Been exposed to radiation  
When? \_\_\_\_\_
- Have a hot tub
- Use chlorine or bromine
- Have a well
- Work around PVC pipe (Vinyl chloride)
- Home well ventilated
- Moved to a new office in the last two years
- Live in an apartment?  
How old? \_\_\_\_\_
- Eat at salad bars
- Eat raw fish (Sushi)
- Buy food from street vendors
- For Women:** Have breast implants. The implant was made of saline \_\_\_ silicone\_\_\_
- Has any type of metal been used in implants or joint replacements in your body?  
What type? \_\_\_\_\_  
Where \_\_\_\_\_
- Notice more symptoms at work than at home or vice versa?
- Symptoms worse going into a mall
- Have you ever worked in a mall?  
When? \_\_\_\_\_
- Have live plants in your home
- Have pets in your home
- Owned a new vehicle since your symptoms began
- Furniture been put in storage or possibly fumigated
- Stained furniture in the last 2 years
- Have a tool shop in your garage
- Live on or near a golf course
- Live in or near an industrial area

- Lived or traveled outside the US.  
Where? \_\_\_\_\_
- Bought new furniture?  
What type of material? \_\_\_\_\_
- Installed drop ceilings
- Painted indoors
- Sided your home
- Changed your heating system, stove, clothes dryer  
or water heater
- Lived in a brand new home
- Lived in a new office
- Noticed changes of your health since you moved into  
your home?
- Have a water purification system?
- Live near a landfill?
- Have a water filter on your shower?

**Describe the contents of your bedroom**

- What type of mattress? \_\_\_\_\_
- Have hardwood floors
- Have carpeting
- Have blinds
- Have draperies
- Use a foam pillow
- Use a feather pillow
- Use a Dacron pillow
- Use wool blankets
- Use cotton blankets
- Use quilts
- Use synthetic blankets
- Use an electric blanket
- Have a ceiling fan
- Have material under your bed
- Have real plants in your bedroom

**Please indicate the occupation of your parents during your childhood:**

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- Have artificial plants in your bedroom
- Use aromatherapy in your bedroom
- Burn scented candles in your bedroom
- Have central heat
- Have a fireplace in your room
- Have an electric baseboard
- Use gas heat
- Use an air filter in your bedroom  
What type? \_\_\_\_\_
- When was the last time you changed your filter in  
your room? \_\_\_\_\_
- Have central air conditioning
- Sleep with your windows open
- Live close to a high traffic road
- Smoke in bed
- Allow any pets in your room  
What type? \_\_\_\_\_
- Have plugged in air fresheners

**Art and Leisure Activities**

- Silk-screening
- Make stained glass
- Make pottery & ceramic products
- Make jewelry
- Buy art and craft supplies
- Use airbrush and spray paints
- Do quilting and weaving
- Gardening
- Make soapstone carvings
- Use acrylic paint

**What hobbies do you have? Please list:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## READINESS ASSESSMENT

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

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

Significantly modify your diet – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

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

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

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

Practice relaxation techniques – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Engage in regular exercise – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

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

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

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

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

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

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

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

Sincerely,

Robert F. Cowan DC CAP DACBN