ANew Health

Health ~ Strength ~ Vitality

Dear New Client,

I am pleased that you have decided to explore an integrative approach to wellness with me. I have created a check list to help simplify the process.

Intake Forms:
Print and fill out the Comprehensive Health History, ANew Health Polices, Health Timeline, and either the Adult or Minor Consent form. If I asked you to fill out additional forms, they are listed here. If you have any questions, please email me.

- X Comprehensive Health History
- X ANew Health Policies
- X Health Timeline (Best at Initial Consultation)
- X Consent Form, Adult or Minor
- ___ Adrenal Fatigue Questionnaire
- ___ Candida Self Assessment
- ___ CFS & FM Self Assessment
- ___ Fibromyalgia Pain Assessment
- ___ Food Diary
- ___ GERD Self Assessment
- ___ Leaky Gut Risk Evaluation
- ___ SIBO Self Assessment
- ___ Sleep Log
- ___ Thyroid Questionnaire
- ___ Thyroid Temperature Record

Medical Tests and Lab Tests:
1. Gather the last 2-3 years of lab and medical tests. With more complicated or chronic conditions, significant test results over a longer period of time are needed.
2. Make a copy of your test results for my office.

How to Schedule Your Appointment:
1. You may schedule your Initial Consultation without all test results as long as they are in process.
2. Your intake forms need to be accurately and thoroughly filled out; including all medications and supplements or this will delay the development of your treatment program.
3. Your Health Timeline is best at the Initial Appt. It is due no later than your first follow-up.

Initial Consultation -Office**:**
1. Schedule your appointment by email when your intake forms + lab/medical tests are complete.
2. Send a current, close-up photo of yourself from your Client Portal. (plus full length for Weight Loss)
3. Pay for your appointment (Online Payment Center), or at the time of your appointment.
4. Make checks payable to Wings of Healing.

Initial Consultation - Telephone:
1. Mail your intake forms + lab/medical tests to my office.
2. Schedule your appointment by email; at least 12 business days from the date forms were mailed.
3. Send a current, close-up photo of yourself from your Client Portal.
4. Pay for your appointment (Online Payment Center), at least 4 days prior to your appointment.
5. Email my office when you have paid for your appointment.

I look forward to partnering with you to improve your health.

To Your Health,
Tricia Trafford, FNP

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Comprehensive Health History

My ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these written questions, even including symptoms that you may consider minor.

Please make sure to list all of your medications, over-the-counter drugs, and supplements. This includes the dose, strength, and frequency of each one. If this information is not provided, it will delay the development of your treatment program. Thank you. Tricia, FNP

Date _____ Name you prefer to be called _____
First Name _____ Last Name _____
Address _____ City _____
State _____ Zip Code _____ Cell _____
Best No. to Call _____ Home _____
Email _____ DOB _____ Age_____
Place of Birth _____ Gender: ____Female ____ Male
Referred By _____
Primary Physician _____Tel _____
Name of Practice _____
Marital Status ___ Single ___Married ___Divorced ___Widowed ___ Partner
Name of Spouse or Partner _____
Occupation _____ Hours/Week _____
Nature of Work _____
Health Insurance ___Yes ___No Insurance _____
_____
Emergency Contact Name_____ Relationship_____
First No. to Call _____2nd No._____

GENETIC BACKROUND: Put an **X** by all that apply.
___ African American ___Hispanic ___Caucasian ___Mediterranean ___Asian
___Native American ___Northern European ___ Other _____

ADULT VACCINES: List current vaccines, any reactions to vaccines, and the year of vaccine.

NAME OF VACCINE	REACTION	YEAR

TRAVEL: List countries you have traveled to even if you did not get sick before or afterwards.

COUNTRY	GOT SICK	TREATMENT RECEIVED	YEAR

CURRENT HEALTH STATUS AND YOUR CONCERNS

Please provide information about your current and ongoing problems.

LIST YOUR TOP THREE HEALTH CONCERNS IN ORDER OF PRIORITY

1.
2.
3.

HEALTH PROBLEMS: List problem, severity of problem, any treatment, and results of treatment.

PROBLEM	MILD-SEVERE	TREATMENT	RESULTS

What diagnosis or explanation has been given to you for your concerns?
1. _____ 2. _____ 3._____
When was the last time that you felt well? _____ Month _____Year
What seems to trigger your symptoms? _____
_____
What seems to worsen your symptoms? _____
_____
What seems to make you feel better? _____
_____
What physician/health care provider have you seen for these conditions? Please list their names.
1. _____ 2. _____ 3. _____
How much time have you missed from work or school in the past year due to these conditions?
___ Missed less than 2 weeks ___ Missed about 1 month ___ Missed between 1-2 months
___ Other _____
Have you been exposed to or had a tic on you? ___ Yes ___ No _____Year _____ State

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when & how often.

ILLNESS	WHEN	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Candida-Yeast Overgrowth		
Chicken Pox		
Chronic Fatigue Syndrome or FM		
Dementia or Alzheimer's		
Emphysema		
Epilepsy-Convulsions-Seizures		
Epstein Barr Virus or CMV		
Gallstones		
German Measles		

PAST MEDICAL AND SURGICAL HISTORY, CONTINUED

If you have experienced reoccurrence of an illness, please indicate when & how often.

ILLNESS	WHEN	COMMENTS
Gout		
Heart Attack or Angina		
Hepatitis		
Herpes Lesions - Shingles		
High Cholesterol Triglycerides		
High Blood Pressure		
IBS or Chronic Diarrhea		
Kidney Stones		
Measles		
Mononucleosis		
Mumps		
Lupus		
Lyme's Disease		
Positive TB Test		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid Disease - List Diagnosis		
Valley Fever		
Whooping Cough		
Other		
Other		
Other		

INJURIES	WHEN	COMMENTS
Back Injury		
Broken Bones - Fractures		
Head Injury		
Neck Injury		
Whip Lash		
Other		
Other		

DIAGOSTIC TESTS	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Carotid Artery Ultrasound		
CAT Scan of		
Colonoscopy or Sigmoidoscopy		
EKG		
MRI		
Mammogram		
X-Ray of the Chest - Most Recent		
Other		
Other		

PAST MEDICAL AND SURGICAL HISTORY, CONTINUED

If you have experienced reoccurrence of an illness, please indicate when & how often in comments.

SURGERIES	WHEN	COMMENTS
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Other		
Other		
Other		

HOSPITALIZAITONS: List name of hospital, year, and why hospitalized.

NAME OF HOSPITAL	WHEN	WHAT REASON

MEDICATIONS AND OVER-THE-COUNTER DRUGS

How often have you taken **ANTIBIOTICS**?

Infancy/Childhood: ___Less than 5 times ___More than 5 times
Teen Years: ___Less than 5 times ___More than 5 times
Adulthood: ___Less than 5 times ___More than 5 times

How often have you taken **STEROIDS**? Indicate Oral or Injections.

Infancy/Childhood: _____Less than 5 times _____More than 5 times
Teen Years: _____Less than 5 times _____More than 5 times
Adulthood: _____Less than 5 times _____More than 5 times

List **ALL** Medications you are currently taking, including Over-the-Counter Non-Prescription Drugs.
IMPORTANT: Go to Page 19 for additional space to list all of your medications, allergies, and supplements.

MEDICATION	DOSE/STRENGTH	START DATE

ALLERGIES: List **ALL** Allergic Reactions to Medications, Supplements, and Foods.

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING

List **ALL** Vitamins, Minerals, and Nutritional Supplements that you are currently taking.
IMPORTANT: Go to Page 19 for additional space to list all of your medications, allergies, and supplements.

SUPPLEMENT	BRAND	DOSE/STRENGTH	START DATE

CHILDHOOD HISTORY

Please use an **X** to answer these questions to the best of your knowledge.

AS A BABY	YES	NO	UNKNOWN	COMMENT
Were you a full-term baby				
A Premature birth				
Breast fed				
Bottle fed				

Did Your Mom, when Pregnant w/You:	YES	NO	UNKNOWN	COMMENT
Smoke tobacco				
Use recreational drugs				
Drink alcohol				
Take Diethylstilbesterol				
Prescription - Non-prescription drugs				
Other				
Other				

IMMUNIZATION HISTORY - CHILDHOOD ONLY

Please use **X** to answer if you were vaccinated against any of the following diseases as a child.

CHILDHOOD VACCINATIONS	YES	NO	UNKNOWN	COMMENT
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio Oral				
Polio Injection				
Mumps				
Measles				
Rubella - German Measles				
Typhoid				
Cholera				
Other				
Other				

CHILDHOOD HISTORY, CONTINUED

CHILDHOOD DIET

Was your Childhood Diet high in:	YES	NO	UNKNOWN	COMMENT
Sugar - Sweets, Candy, Cookies, Soda, etc.				
Fast foods - prepared foods - sweeteners				
Milk - Cheeses - Other Dairy Products				
Meat - Vegetables - and Potato Diet				
Vegetarian Diet: List how long				
Diet High in White Bread				

Comments: _____

_____

Were there foods that you had to avoid because they gave you symptoms? ___Yes ___No

If Yes, please explain: _____

_____

CHILDHOOD ILLNESSES

Please indicate with an **X** which of the following problems or conditions you experienced as a child.

CHILDHOOD ILLNESS	YES	AGE
ADD or ADHD		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Ear Infections		
Fever Blisters		
Frequent Colds or Flu		
Frequent Headaches		
Hyperactivity		
Jaundice		
Mumps		

CHILDHOOD ILLNESS	YES	AGE
Measles		
Pneumonia		
Seasonal Allergies		
Skin Disorders		
Strep Infections		
Tonsillitis		
Upset Stomach - Digestion		
Whooping Cough		
Other		
Other		

AS A CHILD, DID YOU?	YES	NO
Have a high absence from school		
Experience chronic exposure to second hand smoke in home		
Experience verbal or physical abuse		
Have alcoholic parents		
Sexual abuse - molestation - incest		
Other		
Please explain any Yes Responses:		

FEMALE MEDICAL HISTORY - FOR WOMEN ONLY

OBSTETRICS HISTORY

Please put an **X** if Yes, and **write the Number** of Pregnancies, Occurrences, or Conditions.

_____Pregnancies _____Caesareans _____Vaginal Deliveries

_____Miscarriages _____Abortions _____ Living Children

_____Post-Partum Depression _____Toxemia _____ Gestational Diabetes

_____Other: _____

_____

FEMALE MEDICAL HISTORY, CONTINUED

GYNECOLOGICAL HISTORY

Your Age at first menstrual cycle? _____ Frequency_____ Length in Days _____
Painful Menstrual Periods? ___ Yes ___No Clotting? ___Yes ___No
Date of Your Last Menstrual Period _____ - _____ - _____
Currently use contraception? ___Yes ___No Currently sexually active? ___Yes ___No
If using contraception, please indicate which form:

Non-Hormonal
___Condom
___Diaphragm
___IUD
___Partner Vasectomy
___Other_____

Hormonal
___Birth Control Pills _____
___Patch
___Nova Ring
___Other _____

Even if you are not currently using contraception, but have used hormonal birth control in the past, please indicate what you were on and for how long _____
_____
Did you experience breast tenderness, water retention or irritability (PMS) symptoms the second half of your menstrual cycle? ___Yes ___No
Please list any other symptoms that you feel are significant _____
_____
Are you menopausal? ___Yes ___No If Yes, what age and what year? _____Age _____Year
Do you currently take Hormone Replacement? ___Yes ___No
If Yes, what are you taking? ___ Bio-Identical Hormones ___ Premarin ___Vaginal Estrogen
___Synthetic Progesterone ___Other _____

HORMONE MEDICATION	DOSE/STRENGTH	START DATE

DIAGNOSTIC TESTING

Last Pap Test _____ Normal ____ Abnormal _____
Last Mammogram _____ Breast Biopsy _____
Last Bone Density _____ Results: ___High ___Low ___ Normal

FAMILY HEALTH HISTORY

Please put an **X** under the health condition of the person it applies to.

MGM=Mom's Mom MGF=Mom's Dad PGM=Dad's Mom PGF=Dad's Dad

ILLNESS	DAD	MOM	SIBLINGS	CHILDREN	MGM	MGF	PGM	PGF
Age if living								
Age at death								
Colon Cancer								
Breast Cancer								
Uterus Cancer								
Ovarian Cancer								
Skin Cancer								
ADD - ADHD								
ALS - Similar								
Alzheimer's								
Anemia								
Anxiety								
Arthritis								

FAMILY HEALTH HISTORY, CONTINUED

Please put an **X** under the health condition of the person it applies to.

MGM=Mom's Mom MGF=Mom's Dad PGM=Dad's Mom PGF=Dad's Dad

ILLNESS	DAD	MOM	SIBLINGS	CHILDREN	MGM	MGF	PGM	PGF
Asthma								
Autism								
Autoimmune								
Bipolar								
Breakdown								
Bladder								
Blood Clots								
Celiac Disease								
Depression								
Diabetes								
Eczema								
Emphysema								
Environment								
Epilepsy								
Flu								
Genetic								
Glaucoma								
Headaches								
Heart Disease								
Heart Attack								
Hypertension								
High Cholesterol								
Insomnia								
IBS								
Kidney								
MS								
Obesity								
Osteoarthritis								
Parkinson's								
Pneumonia, etc.								
Psoriasis								
Mental Illness								
Schizophrenia								
Sleep Apnea								
Smoking Issue								
Stroke								
Substance Abuse								
Ulcers								
Other								
Other								
Other								

Comments: _____

_____

_____

_____

_____

_____

REVIEW OF YOUR SYMPTOMS

Put an **X** next to those items that applied to Past Symptoms. **Circle** those that apply Now.

X = Past symptoms Circle Current Symptoms

GENERAL
___Fever
___Chills/Cold all over
___Aches/Pains
___General weakness
___Difficulty sweating
___Excessive sweating
___Swollen glands
___Cold hands and feet
___Fatigue
___Difficulty falling asleep
___Sleepwalker
___Nightmares
___No dream recall
___Early waking
___Daytimes sleepiness
___Distorted vision
___Nails split
___Deafness/Hearing loss
___Nails split
___White spots/lines on nails
___Healing aid
___Sensitive to loud noises
___Frequent infections
___Strong body odor
___Hearing hallucinations

SKIN
___Cuts heal slowly
___Bruise easily
___Rashes
___Pigmentation
___Changing moles
___Calluses
___Eczema
___Psoriasis
___Dryness/cracking skin
___Oiliness
___Itching
___Acne
___Boils
___Hives
___Fungus on nails
___Peeling skin
___Shingles
___Crawling sensation
___Burning on bottom of feet
___Athletes foot
___Cellulite
___Bugs like to bite you
___Bumps on arms/legs
___Skin cancer

Is your skin sensitive to: ___Sun ___Fabrics ___Detergents ___Lotions/Creams ___Soaps ___Other
Comments: _____
_____

X = Past Symptoms Circle Current Symptoms

HEAD
___Poor Concentration
___Confusion
___**Headaches**
- ___After meals
- ___Severe
- ___Migraine
- ___Frontal
- ___Afternoon
- ___Back of head
- ___Daytime
- ___Relieved by eating sweets
- ___Concussion/Whiplash

___Mental sluggishness
___Forgetfulness
___Indecisive
___Face twitch
___Poor memory
___Hair loss

NOSE/SINUSES
___Stuffy nose
___Bleeding
___Running/Discharge
___Watery nose
___Congested
___Infection
___Polyps
___Acute smell
___Post nasal drip/drainage
___Sneezing spells
___No sense of smell
___Do the change of seasons make your symptoms worse? ___Yes ___No
If yes, is it worse in:
___Spring ___Summer
___Fall ___Winter

REVIEW OF YOUR SYMPTOMS, CONTINUED

Put an **X** next to those items that applied to Past Symptoms. **Circle** those that apply Now.

X = Past Symptoms Circle Current Symptoms

EYES
___Dry feeling in eyes
___Double vision
___Blurred vision
___Poor night vision
___Seek bright flashes
___Halo around lights
___Eye pains
___Dark circles under eyes
___Strong light irritates
___Cataracts
___Floaters in eyes
___Visual hallucinations
___Infections
___Contacts

EARS
___Earaches often
___Infections with discharge
___Pain in ears
___Ringing in ears
___Popping sound in ears

NECK
___Stiffness of neck
___Swelling
___Lumps
___Neck glands swell

CIRCULATION/RESPIRATION
___Swollen ankles
___Sensitive to hot or cold (Please circle)
___Extremities cold or clammy
___Hands/Feet get numb or tingling
___High Blood Pressure
___Chest Pain
___Pain between shoulders
___Dizziness upon standing
___Fainting spells
___High cholesterol or triglycerides (Please circle)
___Wheezing
___Irregular heartbeat
___Palpitations
___Low exercise tolerance to aerobics
___Low exercise tolerance to any exercise
___Frequent coughing
___Shortness of breath
___Night sweats
___Varicose veins/spider veins (Please circle)
___Mitral valve prolapse
___Heart murmurs
___Angina pain
___Bronchitis/Pneumonia

MOUTH
___Coated tongue
___Sore tongue
___Teeth problems
___Bleeding gums
___Canker sores
___TMJ
___Cracked lips/corners
___Fever blisters
___Wear dentures
___Grind teeth when sleep
___Bad breath
___Dry mouth
___Chapped lips often

THROAT
___Mucous in throat
___Difficulty swallowing
___Tonsillitis
___Enlarged glands
___Frequent hoarseness
___Throat closes up

GASTROINTESTINAL
___Peptic/Duodenal ulcer
___Poor appetite
___Excessive appetite
___Gallstones
___Nervous or upset stomach
___Full feeling after eating small meal
___Indigestion
___Heartburn
___Acid Reflux
___Hiatal hernia
___Nausea
___Vomiting
___Vomiting blood
___Abdominal pains/cramps
___Gas
___Diarrhea
___Constipation
___Changes in bowels
___Rectal bleeding
___Use laxatives
___Rectal hemorrhoids
___Rectal itching
___Bloated of Abdomen
___Belch frequently
___Anal fissures
___Bloody stools
___Undigested food in stools

REVIEW OF YOUR SYMPTOMS, CONTINUED

Put an **X** next to those items that applied to Past Symptoms. **Circle** those that apply Now.

X = Past Symptoms Circle Current Symptoms

CIRCULATION/RESPIRATION
___Croup
___Frequent colds
___Heavy/tight chest
___Prior Heart Attack: Date ____/____/_____
___Phlebitis
___Emphysema

WOMEN'S HISTORY (for women only)
___Fibrocystic breasts
___Lumps in breast
___Fibroid tumors-breast
___Spotting
__
___Heavy periods
___Fibroid tumors-uterus
___Painful periods
___Change in periods
___Breast soreness before period
___Endometriosis
___Non-period bleeding
___Breast soreness w/period
___Vaginal dryness
___Vaginal discharge
___Partial/total hysterectomy: Year _____
___Hot flashes: For how long_____
___Mood swings
___Memory/Concentration problems
___Breast cancer: Year_____
___Ovarian cysts
___Pregnant now: LMP _____
___Infertility
___Decreased libido
___Heavy bleeding
___Joint Pains
___Headaches
___Weight gain
___Loss of bladder control

EMOTIONAL HISTORY
___Convulsions
___Dizziness
___Fainting spells
___Blackouts/Amnesia
___Had prior shock therapy
___Frequently keyed up/Jittery
___Startled by loud noises
___Anxiety/Feeling of panic
___Go to pieces easily
___Forgetful
___Listless/groggy
___Withdrawn feeling/Feeling lost
___Had nervous breakdown
___Unable to concentrate/short attention span

KIDNEY/URINARYTRACT
___Painful urination
___Blood in urine
___Night time urination
___Problem passing urine
___Kidney pain
___Kidney stones
___Burning continually
___Bladder infections
___Leaking of urine. When?_____
_____
___Sexually transmitted infections
Please specify:_____
_____
_____
_____
_____

JOINTS/MUSCLES/TENDONS
___Pain wakes you. Where?_____
_____
_____
___Weakness in legs and arms
___Balance problems
___Muscle cramping
___Head injury
___Muscle stiffness in morning
___Damp weather bothers you
___ Diagnosis of FM: Year _____
___Other _____
_____

MEN'S HISTORY (for men only)
___Have you had a PSA done?
___Yes ___No Date _____
PSA Level ___0-1 ___2-4
___4-10 ___More than10
___Prostate enlargement
___Prostate infection
___Impotence
___Diminished/poor libido
___Infertility
___Sore on penis
___Genital pain
___Prostate cancer
___Hernia
___Low sperm count
___Difficulty obtaining erection
___Urination at night
How many times? _____/night
___Change in urinary stream
___Loss of bladder control

REVIEW OF YOUR SYMPTOMS, CONTINUED

Put an **X** next to those items that applied to Past Symptoms. **Circle** those that apply Now.

X = Past Symptoms Circle Current Symptoms

EMOTIONAL HISTORY
___Considered a nervous person by others
___Tends to worry a lot
___Unusual tension
___Depressed
___Often awakened by frightful dreams
___Family member had nervous breakdown
___Use tranquilizers
___Fatigue
___Restless leg syndrome
___Unable to coordinate muscles
___Am a workaholic
___Have had hallucinations
___Have overused alcohol
___Family history of overuse of alcohol
___Cry often
___Angry often
___Unable to reason

___Vision changes
___Frustration
___Emotional numbness
___Profuse sweating
___Previous admissions psychiatric care
Year(s)_____
_____
___Misunderstood by others
___Hyperactive
___Considered clumsy
___Have difficulty falling asleep
___Have difficulty staying asleep
___Have considered suicide
___Have made a plan to kill myself
___Have cut myself
When?_____
_____
_____

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 when it occurred: _____
_____
_____
_____

If your source of pain is not due to an injury, please describe how long you have experienced this pain and what you believe it could be attributed to:_____
_____
_____
_____

Please use the illustration below to describe the severity and location of your pain.

Pain Scale is 0 to 10
0 = No Pain 10 = Severe Pain

Example: _____Neck Pain_____
0 1 2 3 4 5 6 **{7}** 8 9 10

Area One _____
0 1 2 3 4 5 6 7 8 9 10

Area Two _____
0 1 2 3 4 5 6 7 8 9 10

Area Three _____
0 1 2 3 4 5 6 7 8 9 10

Area Four _____
0 1 2 3 4 5 6 7 8 9 10

Area Five _____
0 1 2 3 4 5 6 7 8 9 10

PAIN ASSESSMENT, CONTINUED

Use these letters provided to describe the area(s) of pain if you listed any on the previous page.

A = Ache **B** = Burning **N** = Numbness **S** = Stiffness **T** = Tingling **Z** = Sharp/Shooting

Put the name of the area of pain from page 12 and then CIRCLE the description of your pain.

Example: Neck Pain
A **{B}** N S T **{Z}**

Area Six _____
A B N S T Z

Area Seven _____
A B N S T Z

Area Eight _____
A B N S T Z

Area Nine _____
A B N S T Z

Area Ten _____
A B N S T Z

DENTAL HISTORY

DENTAL QUESTIONS	YES	NO
Do you have a problem with sore gums (gingivitis)		
Do you have ringing in the ears (tinnitus)		
Do you have TMJ problems (temporal mandibular joint)		
Do you have a metallic taste in your mouth		
Do you have bad breath (halitosis) or white tongue (thrush)		
Do you previously or currently wear braces on teeth		
Do you have problems chewing		
Do you floss regularly? If yes, how often?		
Do you have silver amalgam dental fillings? If yes, how many?		
Did you receive these fillings as a child		
Do you have your teeth cleaned at dental office at least 2x/year		
Any tooth pain now? If yes, where?		
Do your gums bleed easily		
Do you grind your teeth at night		
Do you wear a night guard		
Do you take medication for TMJ		
Did you get sick when amalgam dental fillings were removed		
Do you have any root canals? If yes, how many?		

List major dental work you have had done including removal of sliver amalgam fillings.

AGE/YEAR	DENTAL WORK	PROBLEMS AFTERWARDS

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? ___Yes ___No
If Yes, please explain what these changes are. _____
_____
_____

FOODS THAT YOU EAT ON A REGULAR BASIS
Write down the foods and drinks that you typically consume.

BREAKFAST	LUNCH	DINNER	SNACKS

ADDITIONAL FOODS THAT YOU EAT
Place an **X** next to the foods and drinks you have on a **Regular Basis.**
Place an **O** next to the foods and drinks that you **Occasionally Eat.**

R = Regular Basis **O** = Occasionally

___None
___Bacon/Sausage
___Bagel
___Butter
___Cereal
___Coffee
___Donut
___Eggs
___Fresh fruit
___Fruit juice
___Margarine
___Oat bran
___Oatmeal
___Sugar
___Sweet roll
___Tea
___Toast
___Water
___Wheat bran
___Milk protein shake
___Green's smoothie _____
___Fruit smoothie
___Soy protein
___Whey protein drink
___Rice protein
___Flaxseed/Chia seeds
___Other_____
___Other_____
___Other_____
___Other_____

___None
___Butter
___Coffee
___Eat in a cafeteria
___Eat in restaurant
___Fish sandwich
___Hamburger
___Hot dogs
___Fruit juice
___Leftovers
___Lettuce type_____
___Margarine
___Mayo
___Meat sandwich
___Milk
___Pizza
___Potato chips
___Salad
___Soda
___Soup type_____
___Sugar
___Tomato
___Vegetables
___Water
___Yogurt w/sugar/corn syrup
___Protein shake_____
___Other _____
___Other _____
___Other_____
___Other_____

___None
___Beans (legumes)
___Brown rice
___Carrots
___Coffee
___Fish
___Fresh fruit
___Fruit juice
___Margarine
___Milk
___Pasta
___Potato
___Poultry
___Red meat
___Rice type_____
___Salad
___Salad dressing
___Soda
___Sugar
___Sweetener_____
___Tea
___Vinegar
___Water
___Basmati rice
___White rice
___Yellow vegetables
___Green vegetables
___Other_____
___Other_____
___Other_____

NUTRITIONAL HISTORY, CONTINUED

Do you currently follow a special diet or nutritional program? ___Yes ___No
___Ova-lacto ___Vegetarian ___Vegan ___Diabetic
___Dairy restricted ___Blood type diet ___Candida diet ___Caveman diet
___Other_____ ___Other _____
Please tell me if there is anything special about your diet that I should know:_____
_____
_____

Do you have symptoms immediately after you eat, such as belching, bloating, sneezing, hives, etc?
___Yes ___No List symptoms. _____
If Yes, are these symptoms associated with any particular food or supplement? ___Yes ___No
If Yes, please name the food(s) or supplement(s): _____
_____
_____

Do you feel that you have delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours plus). ___Yes ___No
If Yes, please name the food(s): _____
_____

Do you feel worse when you eat a lot of:
___High fat foods ___High protein foods ___Refined sugar, desserts, sweets
___1-2 alcohol drinks ___High carbohydrate foods (breads, pasta, potatoes)
___Fried foods ___Other: _____

Do you feel better when you eat a lot of:
___High fat foods ___High protein foods ___Refined sugar, desserts, sweets
___1-2 alcohol drinks ___High carbohydrate foods ___Other: _____

Does skipping meals greatly affect your symptoms? ___Yes ___No

Has there ever been a food that you have craved or 'binged' on over a period of time? ___Yes ___No
If Yes, what food(s)?_____
_____
Do you have an aversion to certain foods? ___Yes ___No If yes, what food(s)? _____
_____

COLON HEALTH

Frequency:
___More than 3x/day
___1-3x/day
___4-6/x week
___2-3x week
___1or fewer x/week
___Other_____
___Other_____

Color:
___Medium brown consistently
___Very dark or black
___Greenish brown
___Blood is visible
___Varies a lot
___Dark brown consistently
___Yellow, light brown

Consistency:
___Soft and well-formed ___Often floats ___Difficult to pass
___Diarrhea ___Thin, long or narrow ___Small and hard
___Loose but not watery ___Alternates between hard and loose/watery

Intestinal Gas:
___Daily ___Occasionally ___Excessive ___Little odor
___Excessive ___Present with pain ___Foul smelling ___Other_____

Comments: _____
_____

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? ___Yes ___No

If Yes, what type? ___Cigarette ___Smokeless ___Cigar ___Pipe ___Patch/Gum

How much each day? Be specific. _____

Number of years? _____ If not a current user, Year you quit _____

Attempts to quit? _____

Are you exposed to 2nd-hand smoke regularly? ___Yes ___No If Yes, please indicate where.

___Home ___Office ___Friend's Home ___Other _____

ALCOHOL INTAKE

Have you ever used alcohol? ___Yes ___No

If Yes, how often do you drink alcohol?

___No longer drink alcohol

___Average 1-3 drinks/week

___Average 4-6 drinks/week

___Average 7-10 drinks/week

___Average more than 10 drinks/week

Do you notice a tolerance to alcohol? (can you hold more than others) ___Yes ___No

Have you ever had a problem with alcohol? ___Yes ___No

If Yes, please indicate time period (month/year) From _____ to _____

Do you currently have a problem with alcohol? ___Yes ___No

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? ___No ___Past ___Now

If Yes, what type(s) and method(s)? (IV, inhaled, smoked, etc)_____

_____

To your knowledge, have you ever been exposed to toxic metals in your job or home? ___Yes ___No

If Yes, please indicate what you were exposed to, when, and any symptoms from exposure.

METAL	DATE EXPOSED	SYMPTOMS FROM EXPOSURE
Lead		
Arsenic		
Aluminum		
Cadmium		
Mercury		
Other		

SLEEP AND REST HISTORY

Average number of hours of sleep at night? ___9-10 ___8-10 ___7-8 ___ 6-7 ___ 6 or less

___Have trouble falling asleep ___Snore

___Feel rested upon waking ___Use sleeping aids

___Wake up frequently during night ___Wake up and cannot go back to sleep

___Have problems with insomnia ___Other_____

List **ALL** Sleep Supplements and Medications here if not listed on Page 4.

MEDICATION/SUPPLEMENT	DOSE/STRENGTH	START DATE

LIFESTYLE HISTORY, CONTINUED

EXERCISE HISTORY
Do you exercise regularly? ___Yes ___No
If Yes, please indicate with an **X** under the corresponding number.

TYPE OF EXERCISE	TIMES PER WEEK				LENGTH OF SESSION IN MINUTES				
	1x	2x	3x	4x	< 15	15	16-30	31-45	46+
Jogging or Walking									
Strength Training									
Aerobics									
Pilates - Yoga - Tai Chi, etc.									
Sports - tennis - golf - water									
Other									

If you do not exercise regularly, please indicate what problems limit your activity.
___lack of motivation ___fatigue after exercising ___chronic illness_____
___chronic pain ___chronic fatigue ___other _____
Comments: _____
_____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing, as well as it often leads to illness, immune system dysfunction and emotional disorders, it is important that I am aware of any stressful influences that may be impacting your health. Sharing this information allows me to offer treatment option that will support your journey of healing.

STRESS/PSYCHOSOCIAL HISTORY
Are you happy overall? ___Yes ___No If not, please share what is going on that you are not happy with: _____
_____
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 contemplated suicide? ___Yes ___No
If Yes, how often do you think about it?_____
When was the last time? _____
Do you have a plan? _____
Have you ever sought help through counseling? ___Yes ___No
If Yes, what type? (pastor, psychologist, psychiatrist, etc) _____
When did you do this? _____
Did it help? _____

Please indicate in each area below.

How are Things Going for You?	Very Well	Fine	Poorly	Very poorly	N/A
At School					
At Your Job					
In Your Social Life					
With Close Friends					
With Your Attitude					
With Your Boyfriend/Girlfriend					
With Your Family (parents, siblings, etc)					
With Your Spouse					

SOCIAL HISTORY, CONTINUED

Which of the following provide emotional support for you ? 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, victim of crime, or experienced significant trauma? ___Yes ___No
Did you feel safe growing up? ___Yes ___No
Was alcoholism or substance abuse present in your relationships now? ___Yes ___No
How important is religion (your spiritual walk) to you and your family's life?
___Not at all important ___Somewhat important ___Very important
If your spiritual walk is an integral part of your life, please tell me what this means to you.
_____
_____
How do you relax? _____
_____
Do you practice any of these below? Please put an **X** by those that apply to you.
___Yoga ___Meditation ___Imagery ___ Breathing ___Tai Chi ___Prayer ___Other
Comments: _____
_____

HOBBIES AND LEISURE ACTIVITIES: List hobbies and activities that you enjoy.

Is there anything else that you would like to talk with me about that has not been addressed on this form? ___Yes ___No Please write it here. _____
_____

READINESS ASSESSMENT

On a scale of 1-5: 5 is very willing and 1 is not very willing

In order to Improve My Health, I am Willing To:	VERY WILLING 5	4	3	2	NOT VERY WILLING 1
Significantly modify your diet					
Take nutritional supplements daily					
Keep record of your food intake daily					
Significantly modify your lifestyle					
Engage in regular exercise					
Have periodic lab tests to assess progress					
Comments:					

Your Signature _____ Date _____

IF MINOR:
Name of Parent: _____
Please print your name

Signature of Parent: _____

IMPORTANT
Page 19 is additional space to write your complete list of Medications. Allergies, and Supplements.

MEDICATIONS AND OVER-THE-COUNTER DRUGS

List **ALL** Medications you are currently taking, including Over-the-Counter Non-Prescription Drugs:

MEDICATION	DOSE/STRENGTH	START DATE

ALLERGIES: List **ALL** Allergic Reactions to Medications, Supplements, and Foods.

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING

List **ALL** Vitamins, Minerals, and Nutritional Supplements you are currently taking.

SUPPLEMENT	BRAND	DOSE/STRENGTH	START DATE

Your Signature _____ Date _____

IF MINOR:

Name of Parent: _____

Please print your name

Signature of Parent: _____