Karla Koch, ND, DOM, RN

Introductory Patient Information

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IMPORTANT PATIENT INFORMATION

Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is Dr. Koch'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. Koch 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. Koch assist in helping you. The medical questionnaire will allow Dr. Koch to quickly narrow in on the probable causes of your health problems.

It is **VERY** important for you to carefully and thoroughly complete all of these forms and questionnaires prior to your first consultation with Dr. Koch**.** Once Dr. Koch 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 are requested.

3. Once Dr. Koch has your completed questionnaires and copies of all your medical records, a 90-minute appointment will be scheduled to review your case. The cost for the 90-minute appointment as well as Dr. Koch's time for reviewing your medical questionnaire, medical records and written report is **$295**

4. Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain comprehensive blood chemistry. The blood chemistry test may include:
   - ❑ **Comprehensive Executive Metabolic Panel,** which includes 24 important disease markers such as SGOT, SGPT, GGT, Bilirubin (Liver), BUN, Creatinine, Uric acid (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:** Free T3, Free T4, TSH, Thyroid antibodies
   - ❑ **CBC differential:** White Blood Cells and Red Blood Cells, Platelets
   - ❑ **Inflammatory markers:** Sedimentation Rate, C-reactive protein

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 cash, check and/or credit card.**

6. 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 **detailed results of your tests, the possible causes of your health problem and the recommended treatment protocol**.

7. Follow-up consultations will be scheduled from every 3-12 weeks allowing you the opportunity to discuss your progress and any concerns with Dr. Koch. Dr. Koch 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 $120 per hour, or $75 for 30 minutes.

8. **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 **Karla Koch, ND, DOM**

Today's Date _____/_____/_____

How did you hear about this clinic? Internet ____ Radio/TV ___ Flyer ____Referral (name) _____

Patient Demographics

Patient Name: (last)_____(first)_____

Date of Birth: _____/_____/____ Age: _____ Sex: _____

E-mail Address _____

Street Address: _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation _____ Employer _____

Whom may we contact in case of emergency _____ Phone _____ Relation _____

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 **Salubrio** 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*:* O Yes O No

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

Genetic Testing O Yes O 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 Salubrio; 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 the 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: Karla Koch, ND, DOM

Address: 3536 Anderson Ave. SE, Albuquerque, NM 87106

Telephone number 505-573- HEAL (4325)

Fax: 505-404-0875

PERSONAL DESCRIPTIVE INFORMATION

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 of these 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
e.g., Headaches	June 2007	4 times per week	Mild / moderate / severe

What diagnosis or explanation has 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)

- None
- Chiropractic
- Acupuncture
- Iridology
- Colonics
- Massage
- Rolfing
- Reiki
- Homeopathy
- Biofeedback
- Yoga
- Hypnosis
- Ayurveda
- Light therapy
- Meditation
- Environmental medicine
- Nutritional Therapy
- Biological Dentistry
- IV (chelation) therapy
- 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

High blood pressure

Irritable bowel

Kidney stones

Mononucleosis

Pneumonia

Rheumatic fever

ILLNESSES	Date	Date	Date	Comments
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	**Date**	**Date**	**Date**	**Comments**
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES	**Date**	**Date**	**Date**	**Comments**
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 Ultra-sound				
Blood Tests				
Other (describe)				
OPERATIONS	**Date**	**Date**	**Date**	**Comments**
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 age 12) by indicating the approximate age of onset.

_____ Frequent colds or flu

_____ Bronchitis

_____ Measles

_____ Chicken Pox

_____ Strep Infections

_____ Significant dental work

_____ ADD

_____ Difficulty learning:

_____ High # of absences from school

_____ Jaundice

_____ Ear infections

_____ Premature at birth

_____ Fever blisters

_____ Abusive or alcoholic parent (s)

_____Tonsillitis

_____ Ear Infections

_____ Mumps

_____ Whooping Cough

_____ Seasonal allergies

_____ Behavior problems

_____ Hyperactivity

_____ Frequent headaches

_____ Upset stomach, indigestion

_____ Colic

_____ Congenital abnormalities

_____ Pneumonia

_____ Parent (s) smoked

_____ Skin disorders (eczema)

_____ Major illness(s) that required hospitalization.

If yes, please explain your illness(es):

_____
_____
_____
_____
_____
_____
_____
_____

IMMUNIZATION HISTORY

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

- ❑ Smallpox
- ❑ Tetanus
- ❑ Diphtheria
- ❑ Pertussis
- ❑ Polio (oral or Injection)
- ❑ Flu
- ❑ Pneumonia
- ❑ Mumps
- ❑ Measles
- ❑ Rubella (German measles)
- ❑ Typhoid
- ❑ Cholera
- ❑ Gardasil

FEMALE MEDICAL HISTORY (for women only)

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

- ❑ Pregnancies _____
- ❑ Caesarean _____
- ❑ Vaginal deliveries _____
- ❑ Miscarriage _____
- ❑ Abortion _____
- ❑ Living Children_____
- ❑ Post partum depression
- ❑ Toxemia
- ❑ Gestational diabetes
- ❑ Baby over 8 pounds
- ❑ Breast feeding For how long?_____

Age at 1st 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?

- ❑ Condom
- ❑ Diaphragm
- ❑ Partner Vasectomy
- ❑ IUD

Have you ever used hormonal contracep-tion? Yes ____ No ____

If yes, when ____ ____ ____ ____ ____ ____

Use of hormonal contra-ception:

❑ 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 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irri-tability (PMS)? ❑ Yes ❑ No

Last Mammo-gram _____ _____ _____

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 _____ If yes, age at Menopause _____

Do you use: ❑ Estrogen ❑ Progesterone Other_____

How long have you been on hormone replacement? _____

GYNECOLOGICAL HISTORY

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												
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												
Headache												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)												
Inflammatory Bowel Disease												
Insomnia												
Irritable Bowel Syndrome												
Kidney disease												
Multiple Sclerosis												
Nervous breakdown												
Obesity												
Osteoporosis												
Parkinson's												
Psoriasis												
Psychiatric disorders												
Sleep Apnea												
Smoking addiction												
Stroke												
Substance abuse (such as alcoholism)												

Any other family history we should know about? Yes _____ No _____

If yes, please comment: _____

What is the attitude of those close to you about your illness? ❑ Supportive ❑ Non-supportive

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 many 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 *<u>been unable</u>* to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)

_____
_____
_____
_____
_____
_____
_____
_____

List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

_____
_____
_____
_____
_____
_____
_____
_____

Are there any other health goals you want to achieve?

_____
_____
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Check only those items with which you identify, ***in the past (Column 1) and in the present (Column 2)***. 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

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
□ □ Have overused alcohol
□ □ Family history of overused alcohol
□ □ Cry often
□ □ Feel insecure
□ □ Have overused drugs
□ □ Been addicted to drugs
□ □ Extremely shy

DENTAL HISTORY

Have you had sore gums (gingivitis) often over the years? Yes ____ No _____

Has ringing in the ears (tinnitus) been present? Yes ____ No _____

Have TMJ (temporal mandibular joint) problems been a concern? Yes ____ No _____

Do you often have a 'metallic' taste in your mouth? Yes ____ No _____

Do you have a lot of bad breath (halitosis) or white tongue (thrush)? Yes ____ No _____

Have you worn or do you presently wear braces? Yes ____ No _____

Do you have problems chewing? Yes ____ No _____

Do you floss regularly? Yes _____ No _____

Did your mother have dental fillings prior to giving birth to you? Yes ____ No _____

Did you have fillings as a child? Yes ____ No _____

If yes, about how many fillings did you have up to 18 yrs? _____

Did you have dental fillings as an adult? Yes ____ No _____

How many amalgam fillings do you have now? _____

Did you play with mercury as a child or adult? Yes ____ No _____

Have you eaten a lot of fish in your life? Yes ____ No _____

List the approximate age and the type of dental work done from childhood until present:

Age	Describe Dental Work	Health Problems following dental work? (describe)

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

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

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

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

- ❑ Acid Blocking Drugs
- ❑ Anti-anxiety medications
- ❑ Antibiotics
- ❑ Anticonvulsants
- ❑ Antidepressants
- ❑ Anti-fungals
- ❑ Aspirin/Ibuprofen
- ❑ Asthma inhalers
- ❑ Beta blockers
- ❑ Birth control pills/implant contraceptives
- ❑ Chemotherapy
- ❑ Cholesterol lowering medications
- ❑ Cortisone/steroids
- ❑ Diabetic medications/insulin
- ❑ Diuretics
- ❑ Estrogen or progesterone (pharmaceutical, prescription)
- ❑ Estrogen or progesterone (natural)
- ❑ Heart medications
- ❑ High blood pressure medications
- ❑ Laxatives
- ❑ Relaxants/Sleeping pills
- ❑ Testosterone (natural or prescription)
- ❑ Thyroid medication
- ❑ Acetaminophen (Tylenol)
- ❑ Ulcer medications
- ❑ Sildenafil citrate (Viagra or similar)

MEDICATION LOG

Please indicate the type of medications you are taking now. Please include non-prescription drugs.

Medication Name	Date started	Dated Stopped	Dosage	# per day

Medication Name	**Date started**	**Dated Stopped**	**Dosage**	**# per day**

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for use

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

Yes ____ No _____ If yes, please describe:_____

_____

_____

ALLERGIES

Medication/Supplement/Food	Reaction
_____ –	_____ –
_____ –	_____ –
_____ –	_____ –
_____ –	_____ –

NUTRITION & LIFESTYLE HISTORY

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

Please check any specific food restrictions you have:

❑ Dairy
❑ Soy
❑ Wheat
❑ Corn
❑ Eggs
❑ All gluten
❑ Other_____

Is there anything special about your diet that I should know?

_____

_____

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 _____

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 your current lifestyle and eating habits:

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

What is your typical meal for breakfast, lunch and dinner?

Breakfast: _____

Lunch: _____

Dinner: _____

What snacks do you eat or drink between:

Breakfast & Lunch: _____

Lunch & Dinner: _____

After Dinner: _____

How much of the following do you consume each day/week?

ITEM	Daily	Weekly	Favorite Type
Candy			
Cheese			
Chocolate			
Cups of caffeine containing coffee			
Cups of decaffeinated coffee or tea			
Cups of hot chocolate			
Cups of caffeine containing tea			
Diet sodas (12-ounce can/bottle)			
Sodas with caffeine (12-ounce can/bottle)			
Sodas without caffeine (12-ounce can/bottle)			
Energy Drinks (12-ounce can/bottle)			

Ice cream			
Salty foods			
Slices of white bread (rolls/bagels)			

❑ **Water:** Glasses/day___ **Type**: Tap:___ Distilled:___ Spring:___ Well:___ Reverse Osmosis:___

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?

Yes _____ No _____ If yes, please explain:_____

_____

If yes, are these symptoms associated with a particular food or supplement(s)? Yes _____ No _____

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

Food	Symptom	Other comments

Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes _____ No _____

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

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

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

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals greatly affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or really “pigged out” 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) _____

_____

The most important thing I should change about my diet to improve my health is: _____

_____

_____

TOBACCO HISTORY

Currently using tobacco? Yes _____ No _____ How many years? _____ Packs per day: _____
If yes, what type? Cigarette _____ Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____
Attempts to quit: _____
Previous smoking: How many years? _____ Packs per day: _____
Are you exposed to 2nd hand smoke? If yes, please explain: _____
_____

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 _____ *If none skip to "Other Substances"*

Previous alcohol intake? Yes ____ (Mild _____ Moderate _____ High _____)

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:
_____

_____
_

Do you feel unusually fatigued after exercise? Yes _____ No _____

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 immunes 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 ands 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 ____

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other _____

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 sub-station
- ❑ 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
- ❑ 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
- ❑ 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 (non-organic)
- ❑ 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
- ❑ Had new carpets. When? _____
- ❑ Use waxes and polishes on your floor
- ❑ Been around resin glues and plastic
- ❑ Have a wood-burning stove
- ❑ Have draperies
- ❑ 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
- ❑ Lived or traveled outside the US.
  Where?_____
- ❑ Bought new furniture?
  What type of material? _____
- ❑ 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?

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._____

Please indicate the occupation of your parents during your childhood:

_____

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, Karla Koch, ND, DOM