

| | | | |
|----------------|-------|---------|-------|
| Name: | | Date: | |
| Address: | | Unit: | |
| City: | | State: | Zip: |
| PHONE | Home: | Mobile: | Work: |
| Email Address: | | | |

| | |
|----------------|---|
| Date of Birth: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
|----------------|---|

| | | |
|------|---------|---------|
| Age: | Height: | Weight: |
|------|---------|---------|

Status:

- Married
- Separated
- Divorced
- Widowed
- Single
- Partnership

Live with:

- Spouse
- Partner
- Parents
- Children
- Friends
- Alone

Education:

Occupation: Hours per week: Retired

| | |
|--|--|
| Employer | Work Address |
| <input style="width: 95%; height: 20px;" type="text"/> | <input style="width: 95%; height: 20px;" type="text"/> |

In case of emergency, whom should we contact?

| Name | Relationship | Address | Phone |
|--|--|--|--|
| <input style="width: 95%; height: 20px;" type="text"/> | <input style="width: 95%; height: 20px;" type="text"/> | <input style="width: 95%; height: 20px;" type="text"/> | <input style="width: 95%; height: 20px;" type="text"/> |

How did you hear about our Wellness and Nutrition Program?

What is your major complaint? Please list when each symptom began and be as descriptive as possible:

What are your current medications?

What are your current vitamins and/or supplements?

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.):

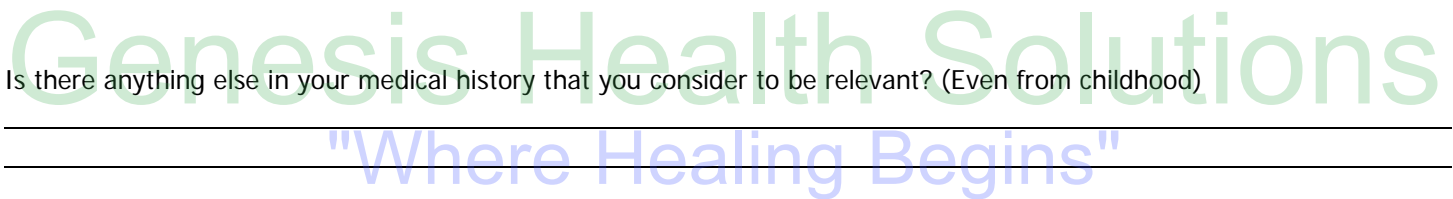
Is there anything else in your medical history that you consider to be relevant? (Even from childhood)

What is your employment history? Please provide brief summary including dates if possible.

Please list your past or present Hobbies that could be sources of toxicity or chemicals:

How often are you involved in these Hobbies currently?

Please list past or present allergies, including allergies to medications.



Please list all past surgeries and the condition each surgery was for, including dates.

Please explain your housing history (type of homes, where and when).

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

- | | | | | |
|--------------------------|-----|--------------------------|----|---|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you have amalgam (silver) fillings in your teeth? If so, How many? _____ |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you ever had an amalgam removed? If Yes, How many _____ Date? _____ |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | If you had amalgams removed, was it done by a biological dentist using a safe protocol? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Did your mother have amalgam when pregnant with you? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you ever worked in a dental office? If so, how long? _____ |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you had any dental crowns? If yes, how many _____ |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you had any bridges? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you had any root canals? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you had any tooth extractions? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you have any dental implants, retainers or other metal in your mouth? Explain: _____ |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Did you wear contact lenses during the 1980's or early 1990's? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Did you take oral contraceptives during the 1980's or early 1990's? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you noticed any adverse reactions to these shots? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you have any tattoos with red ink? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon? |

Lead

- | | | | | |
|--------------------------|-----|--------------------------|----|---|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Does your occupation involve soldering or metal salvage? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you done any old home repair or sandblasting? If so, When _____ |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you do a lot of painting? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Was your home built before 1978? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment) |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Are you around a lot of fake leather, or vinyl? |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Do you get stomach aches in the morning? |

General Toxicity

- Yes No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
- Yes No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
- Yes No Do you have your house sprayed with pesticides for pest control?
- Yes No Do you spray herbicide (weed killers) in or around your home?
- Yes No Do you use conventional insect repellants on your self or family?
- Yes No Do you use conventional sunscreen?
- Yes No Do you use conventional perfume or cologne every day?
- Yes No Do you get your hair colored? If so, is it on the scalp?
- Yes No Do you use aerosol hairspray?
- Yes No Do you get your nails done? If so, how often? _____
- Yes No Do you use air freshener in your house, work or car?
- Yes No Do you drink filtered water? If so, what type of filter do you have? _____
- Yes No Do you drink bottle water if so what kind?
- Yes No Do you have a water filtration system for your entire house or shower filtration? If so, what type? _____
- Yes No Does your spouse or other family members work around chemicals?
- Yes No Can you think of any other toxic exposures you may have had?

Mold

How old is the house you are living in? _____ How long have you lived there? _____

Have you noticed any new symptoms since moving in? _____ If so, what? _____

- Yes No Do you see mold growing at home, work or school?
- Yes No Have you ever had water damage at home, work or school?
- Yes No Does your home, workplace or school have a damp or mildew smell?
- Yes No Does spending time in your basement cause or worsen your symptoms?
- Yes No Does your basement ever get wet?
- Yes No Do you have a crawl space?
- Yes No Does your basement or crawl space have a sump pump?
- Yes No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
- Yes No Does your car have a mildew smell?
- Yes No Does anyone in your home have asthma like symptoms?
- Yes No Does anyone in your family have chronic sinus infections or irritations?

Lyme Disease

- Yes No Have you ever been diagnosed with Lyme Disease?
- Yes No Have you had dry sockets or infected tooth extractions?
- Yes No Do you have small joint pain?
- Yes No Have you ever been bitten by a tick or recluse spider?
- Yes No Have you ever seen a bulls-eye rash appear on any part of your body?
- Yes No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
- Yes No Was your mother ever diagnosed with Lyme Disease?
- Yes No Have you ever been diagnosed with Chronic Fatigues Syndrome, Fibromyalgia, Lupus, Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), or an Autoimmune condition?
- Yes No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

- Yes No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
- Yes No Does anyone in your family experience similar symptoms to yours?
What is your birth order (i.e. first born, second, third, etc.)? _____.
- Yes No Do you have any history of kidney dysfunction?
- Yes No Do you or any immediate family member have a history with cancer?
- Yes No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
- Yes No Are you currently having any thoughts of suicide?
- Yes No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
- Yes No Do you have a history of strokes?
- Yes No Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?
- Yes No Have you ever been in an auto accident, fallen or received a major physical injury?
- Yes No Are you in menopause?

Microbiome Health

- Yes No Do you get distention, bloating, feeling full and a noisy gut after eating healthy carbohydrates such as broccoli, Brussels sprouts or other vegetables?

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- Yes No Do you often have gas that has a sulfur or foul smell?
- Yes No Are you sensitive to supplements?
- Yes No Have you ever been vegan or vegetarian for any length of time?
- Yes No Can you tolerate Meat?
- Yes No Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?
- Yes No Have you taken birth control or Hormone replacement therapy for any length of time?
- Yes No If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?
- Yes No Have been on antibiotics for any extended period of time or often as a child or adult?
- Yes No Were you caesarian delivered?
- Yes No Were you breast fed? If so, How long _____
- Yes No Does your gut temporarily feel better after a round of antibiotics?

How many times a day are you having a bowel movement? _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom 2 = Occasionally have it, severe effect 4 = Frequently have it, severe effect
 1 = Occasionally have it, mild effect 3 = Frequently have it, mild effect

Column #1

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|--|
| Anxiety |
| Mood swings |
| Enraged behavior or anger for no reason |
| Excessive shyness, timidity, social phobia (not typical to your personality) |
| Irritability (not typical to your personality) |
| Low body temperature (below 97.5°) |
| Insomnia (can't get to sleep or return to sleep) |
| Dizziness |
| Sound in ears (ringing or hearing your heart beat) |
| Psychological symptoms, even thoughts of suicide |
| Sensitivity to sound |

Column #2

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| Sensitivity to light |
| Fatigue after exercising (feeling worse) |
| Bad night vision or seeing halos around lights |
| Shortness of breath, with very little effort |
| Excessive thirst and/or frequent urination |
| Red eyes or tearing |
| Blurred vision at times |
| Morning stiffness |
| Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners |
| Chronic fatigue or weakness |
| Non-restful sleep |

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| Indecisiveness |
| Feeling of being overwhelmed or fearful |
| Metallic taste in your mouth |
| Bad breath |
| Bleeding gums |
| Sensitive teeth |
| Canker sores or other sores in the mouth |
| Floaters, shadows or swimmers when you read or look into the sky |
| Dyslexia or loss of place while reading, even as a child |
| Swelling eyelids |
| Peeling on top layer of skin (hands, feet) |
| Dry skin |
| Heart pain (angina) and you are under 45 years old |
| Depression |
| Gout (arthritic pain, especially in big toes) |
| Pain in shoulders or upper back |
| Twitching eyelids |
| Anemia (low iron/hemoglobin on blood test) |
| Wrist/ankle drop or weak extensor muscles |
| Hair falls out (not normal male pattern baldness) |

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| Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.) |
| Trouble processing new information |
| Word reversal or trouble finding words |
| Sensitivity to touch |
| Short-term memory loss |
| Chronic sinus congestion |
| Dry non-productive cough |
| Muscle twitching |
| Excessive sweating, especially at night |
| Joint pain-not necessarily true arthritis-can move from joint to joint |
| Difficulty losing weight regardless of diet or exercise |
| Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis |
| Frequent illness, prolonged illness or sick days |
| Numbness or weakness in arms and legs |
| Headaches |
| Trouble adding or dividing numbers in your head |
| Fluctuating constipation and diarrhea |
| Stomach pain for no apparent reason |
| Appetite swings |
| Frequent muscle aches, cramps, unusual sharp sudden pains |
| Rashes or rosacea |
| Cold extremities (hands and feet) |

Total Columns 1 & 2