GENERAL INFORMATION

Name _____

Preferred Name_____ Date _____

Address _____ City _____ State _____ Zip Code ____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Age _____ Date of Birth _____ Place of birth_____ Gender: female __ male___

Married _____ Separated _____ Divorced _____ Widowed _____ Single ____ Partnership _____

Right Handed: ____ Left Handed: ____ Mixed Dominance: _____

Number of Sisters: ____ (# deceased: ____) # of Brothers: ____ (# deceased: ____) Birth Order: ____

Occupation _____ Hours per week _____ Retired _____

Nature of Business_____

How did you hear about our clinic? Book _____ Website _____ Media_____ Friend/ family member_____

Other _____

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

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

Address _____

Genetic Background: Please check appropriate box(es):

- ❑ African American
- ❑ Hispanic
- ❑ Mediterranean
- ❑ Asian
- ❑ Native American
- ❑ Caucasian
- ❑ Northern European
- ❑ Other

Who is your primary medical physician?_____

Primary medical physician address & office phone # _____

Functional Diagnostic Medicine Questionnaire

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

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

Please print or write legibly.

COMPLAINTS/CONCERNS

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

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

What diagnosis or explanation have been given to you?_____

_____

_____

_____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

What makes you feel **worse**? _____

_____

What makes you feel **better**? _____

_____

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

1. 4.
2. 5.
3. 6.

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

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

PAST MEDICAL & SURGICAL HISTORY

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

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 Ultrasound				
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)				

FAMILY HISTORY

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

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

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

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 thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

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

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

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

_____

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

1. _____
2. _____
3. _____

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

Yes_____ **No**_____

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

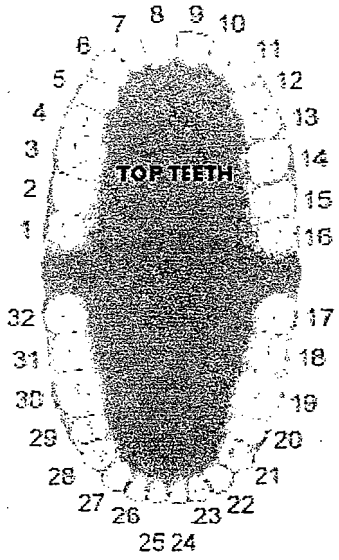
Most people I ask tell me they're made the decision to change. But how many people have truly decided to change? Very few! Why? Because there is a big difference between deciding something and having "reasons" to actually do it.

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

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please circle the tooth or teeth you have had or still have problems with. Please state what type of problem you have had, for example: root canal, crown, abscessed tooth, partials, etc. and indicate which teeth have fillings.



RIGHT SIDE

RECORD ANSWERS:

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
- ❑ 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

- ❑ Chemotherapy
- ❑ Cholesterol lowering medications
- ❑ Cortisone/steroids
- ❑ Diabetic medications/insulin
- ❑ 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

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**