AdvancedHealth
Functional and Regenerative Medicine

NEW PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY:

Name _____ Date _____ Home (____)____-_____

Address _____ Apt. # _____ Work (____)____-_____

City _____ State _____ Zip _____ SS# _____ - ____ - _____

E-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex: M / F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room is needed)

_____

Previous treatments for this complaint: _____

_____

Other complaints or problems: (use separate sheet if needed)

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

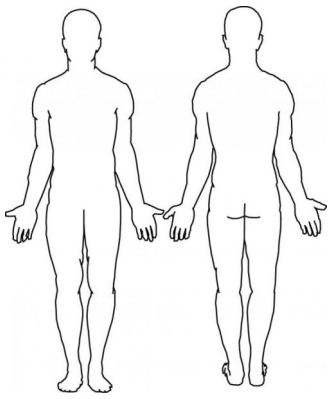
Are you currently under the care of a physician or other health care professionals? YES / NO

(If yes, please give name and date of last visit) _____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? YES / NO

(IF yes indicate how much) Cigarettes _____ Coffee _____ Alcohol _____



When did your symptoms appear? _____

Is this condition getting progressively worse? YES / NO / UNKNOWN

Mark an "x" on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scal from 1 (least pain) to 10 (severe pain) _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □Shooting

□ Burning □Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your □ Work □ Sleep □Daily Routine □ Recreation

Activities or movements that are painful to perform □ Sitting □Standing □Walking □Bending □ Lying Down

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I give Advanced Health Natural Health Improvement Center permission to bill my insurance company for chiropractic services.

SIGNED: _____ **DATE:** _____

NEW PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY:

Name _____ Date _____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx . Date: _____

_____

Past Accidents or injuries: _____

_____

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Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	AGE	SEX	Any physical conditions or concerns?
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Hearth / Other: _____

_____

Any household pets or other animals you or family members are in close contact with: _____

_____

What can we do to make you happier? _____

_____

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SIGNED: _____ **DATE:** _____

OFFICE USE ONLY:

Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name: _____ Date: _____

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

Digestive Tract	Nausea, vomiting	⓪ ① ② ③ ④
	Diarrhea	⓪ ① ② ③ ④
	Constipation	⓪ ① ② ③ ④
	Bloated feeling	⓪ ① ② ③ ④
	Heartburn	⓪ ① ② ③ ④
	Intestinal, stomach pain	⓪ ① ② ③ ④
	Digestive Total:	
Joints / Muscles	Pain or aches in joints	⓪ ① ② ③ ④
	Arthritis, joint swelling	⓪ ① ② ③ ④
	Stiff or limitation of movement	⓪ ① ② ③ ④
	Pain or aches in muscles	⓪ ① ② ③ ④
	Feeling of weakness or tired	⓪ ① ② ③ ④
	Joints / Muscles Total:	
Emotional	Mood swings	⓪ ① ② ③ ④
	Anxiety, fear, nervousness	⓪ ① ② ③ ④
	Anger, irritability, aggression	⓪ ① ② ③ ④
	Depression	⓪ ① ② ③ ④
	Emotional Total:	
Weight / Food	Binge eating, drinking	⓪ ① ② ③ ④
	Craving certain foods	⓪ ① ② ③ ④
	Excessive weight	⓪ ① ② ③ ④
	Compulsive eating, food addictions	⓪ ① ② ③ ④
	Water retention	⓪ ① ② ③ ④
	Underweight	⓪ ① ② ③ ④
	Weight / Food Total:	
Energy / Sleep	Fatigue, sluggishness	⓪ ① ② ③ ④
	Apathy, lethargy	⓪ ① ② ③ ④
	Hyperactivity	⓪ ① ② ③ ④
	Restlessness, achiness	⓪ ① ② ③ ④
	Sleep disturbances	⓪ ① ② ③ ④
	Energy / Sleep Total:	
Skin	Acne	⓪ ① ② ③ ④
	Hives, rashes, dry skin, redness	⓪ ① ② ③ ④
	Hair loss	⓪ ① ② ③ ④
	Flushing, hot flashes	⓪ ① ② ③ ④
	Excessive sweating	⓪ ① ② ③ ④
	Skin Total:	
Heart	Irregular or skipped heartbeat	⓪ ① ② ③ ④
	Rapid or pounding heartbeat	⓪ ① ② ③ ④
	Chest pain	⓪ ① ② ③ ④
	Heart Total:	
Other	Frequent illness	⓪ ① ② ③ ④
	Frequent or urgent urination	⓪ ① ② ③ ④
	Genital itch or discharge	⓪ ① ② ③ ④
	Other Total:	

Respiratory	Chest congestion	⓪ ① ② ③ ④
	Asthma, bronchitis	⓪ ① ② ③ ④
	Shortness of breath	⓪ ① ② ③ ④
	Difficulty breathing	⓪ ① ② ③ ④
	Respiratory Total:	
Eyes	Watery or itchy eyes	⓪ ① ② ③ ④
	Swollen, red, or sticky eyelids	⓪ ① ② ③ ④
	Bags or dark circles under eyes	⓪ ① ② ③ ④
	Blurred or restricted vision	⓪ ① ② ③ ④
	Eyes Total:	
Nose	Stuffy nose	⓪ ① ② ③ ④
	Sinus problems or dripping nose	⓪ ① ② ③ ④
	Hay fever	⓪ ① ② ③ ④
	Sneezing attacks	⓪ ① ② ③ ④
	Excessive mucus	⓪ ① ② ③ ④
	Nose Total:	
Mouth / Throat	Frequent, consistent coughing	⓪ ① ② ③ ④
	Gagging, need to clear throat	⓪ ① ② ③ ④
	Sore throat, hoarse, loss of voice	⓪ ① ② ③ ④
	Swollen or discolored tongue, gums, or lips	⓪ ① ② ③ ④
	Canker sores, other mouth sores	⓪ ① ② ③ ④
	Mouth / Throat Total:	
Ears	Itchy ears	⓪ ① ② ③ ④
	Earaches, ear infections	⓪ ① ② ③ ④
	Drainage from ear, waxy buildup	⓪ ① ② ③ ④
	Ringing in ears, hearing loss	⓪ ① ② ③ ④
	Ears Total:	
Head	Headaches	⓪ ① ② ③ ④
	Faintness or lightheadedness	⓪ ① ② ③ ④
	Dizziness	⓪ ① ② ③ ④
	Head Total:	
Cognitive	Poor memory, recall	⓪ ① ② ③ ④
	Confusion, poor comprehension	⓪ ① ② ③ ④
	Poor concentration	⓪ ① ② ③ ④
	Poor physical coordination	⓪ ① ② ③ ④
	Difficulty in making decisions	⓪ ① ② ③ ④
	Stuttering, stammering	⓪ ① ② ③ ④
	Slurred speech	⓪ ① ② ③ ④
	Learning disabilities	⓪ ① ② ③ ④
	Cognitive Total:	

Grand Total _____

For Practitioner Use Only:

Urinary pH_____

Metagenics®

Metabolic Detoxification Questionnaire

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
◯ Yes (1 pt.) ◯ No (0 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?
◯ Cimetidine (2 pts.) ◯ Acetaminophen (2 pts.) ◯ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
◯ Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
◯ Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
◯ Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
◯ Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently (within the last 6 months) or have you regularly used tobacco products?
◯ Yes (2 pts.) ◯ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
◯ Yes (1 pt.) ◯ No (0 pt.)

7. Do you develop symptoms with exposure to fragrances, exhaust fumes, or strong odors?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

10. Do you have a personal history of:
◯ Environmental and/or chemical sensitivities (5 pts.)
◯ Chronic fatigue syndrome (5 pts.)
◯ Multiple chemical sensitivity (5 pts.)
◯ Fibromyalgia (3 pts.)
◯ Parkinson's type symptoms (3 pts.)
◯ Alcohol or chemical dependence (2 pts.)
◯ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
◯ Yes (1 pt.) ◯ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

Total _____

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction?
◯ Yes (1 pt.) ◯ No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?
◯ Yes (1 pt.) ◯ No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?
◯ Yes (1 pt.) ◯ No (0 pt.)

Total _____

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total _____ (High ›50; moderate 15-49; low ‹14)
Part 2: XTT Total _____ (High ›10; moderate 5-9; low ‹4)
Part 3: Alkalizing Assessment Total _____ (High ≥1)
Urinary pH _____

Notes:

- Patients with high symptoms but low XTT may be exhibiting reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergy, gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.

DATE: _____ Morning pH: _____

Doctor Driven Goals:

Breakfast / Time:
Snack / Time:
Lunch / Time:
Snack / Time:
Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks: _____

Exercise (on scale of 1=no exercise to 10=a lot of exercise):

1 2 3 4 5 6 7 8 9 10

Relaxation (on scale of 1=no relaxation to 10=a lot of relaxation):

1 2 3 4 5 6 7 8 9 10

Hours of Sleep: _____ Quality of Sleep: _____

Additional Supplements, Prescription and/or OTC medications taken:

_____

_____

DATE: _____ Morning pH: _____

Doctor Driven Goals:

Breakfast / Time:
Snack / Time:
Lunch / Time:
Snack / Time:
Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks: _____

Exercise (on scale of 1=no exercise to 10=a lot of exercise):

1 2 3 4 5 6 7 8 9 10

Relaxation (on scale of 1=no relaxation to 10=a lot of relaxation):

1 2 3 4 5 6 7 8 9 10

Hours of Sleep: _____ Quality of Sleep: _____

Additional Supplements, Prescription and/or OTC medications taken:

_____

_____

DATE: _____ Morning pH: _____

Doctor Driven Goals:

Breakfast / Time:
Snack / Time:
Lunch / Time:
Snack / Time:
Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks: _____

Exercise (on scale of 1=no exercise to 10=a lot of exercise):

1 2 3 4 5 6 7 8 9 10

Relaxation (on scale of 1=no relaxation to 10=a lot of relaxation):

1 2 3 4 5 6 7 8 9 10

Hours of Sleep: _____ Quality of Sleep: _____

Additional Supplements, Prescription and/or OTC medications taken:

_____

_____

DATE: _____ Morning pH: _____

Doctor Driven Goals:

Breakfast / Time:
Snack / Time:
Lunch / Time:
Snack / Time:
Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks: _____

Exercise (on scale of 1=no exercise to 10=a lot of exercise):

1 2 3 4 5 6 7 8 9 10

Relaxation (on scale of 1=no relaxation to 10=a lot of relaxation):

1 2 3 4 5 6 7 8 9 10

Hours of Sleep: _____ Quality of Sleep: _____

Additional Supplements, Prescription and/or OTC medications taken:

_____

_____