INITIAL PATIENT HISTORY AND PROFILE

Name ____Date _____________________

Home Phone (______)________________ Cell Phone (______)______________________

Address_____________________________________State______Zip Code___________

Social Security Number____

Date of Birth_________________ Email____

Please briefly describe your health problems____________________________________

____

____

____

When was the last time you really felt good (date)? _____________. Were you healthy as a child? ____

If not please list health problems you had as a child _______________________________

____

____

What caused your PRESENT illness? Significant Event at Onset:

Health Problem; Family Problem; Job Stressors; Surgery; Accident; not sure? Please briefly explain: ____

____

____

Have you been diagnosed with Fibromyalgia or Chronic Fatigue Syndrome? __Yes__No
Which one ____

Date of Diagnosis______ Who Diagnosed you?___________________________________

What type of doctor made diagnosis (family doctor, rheumatologist, OBGYN, orthopedic doctor, etc.)? ____

What makes your health problems worse? Stress, weather changes, poor sleep, exertion, etc____

____

Sleep

Do you have trouble falling asleep? ___Yes ___No

Do you have trouble Staying Asleep? ___Yes ___No

When did you first start having trouble sleeping (months, years)? ___________________

Neurotransmitters

What over the counter or prescription medications have you taken for sleep?

____ Ambien ____ Zanaflex ___Trazadone ____Sonata _____Tylenol P.M. ____Elavil
____ Neurontin ___Doxepin ____Flexeril ____Xanax _____ Klonopin ______Ativan
____Melatonin _____5HTP ___Benadryl ____Others? Please list here: _____________
____

Are you taking anti-depressants? ___Yes ___No

Which ones? ____

Have you taken any anti-depressants in the past? ___Yes___ No

Which ones?
Prozac_____Paxil_____Celexa____Lexapro_____Wellbutrin___Effexor____Zoloft____

Other:
____

Where they helpful? Please describe (didn't help, had side –effects, stopped working, etc.)____

____

Do you crave carbohydrates or sugar? ___Yes ___No

Do you have normal, daily bowel movements (at least one bowel movement a day)? ___Yes ____No

If no - Do you have loose bowels (diarrhea), constipation, or both?__________________

Have you been diagnosed with Irritable Bowel Syndrome (IBS)? ____Yes ____No

What other medications are you taking? Please list here: _______________________

____

____

Immune Function

DO YOU HAVE PROBLEMS WITH: (Please mark all that apply)

____ Chronic Sinus Congestion ____ Chronic Sinus Infections (2 or more a year) ___ Chronic Sore Throats ____Chronic Colds or Flu infections each year ____Chronic Upper Respiratory Infections (Bronchitis, Pneumonia)

Liver Function

Have you ever had elevated or high liver enzymes on laboratory blood work?

__Yes __ No __Not Sure

Do you have any funny reactions if you drink alcohol (little goes a long way, can't drink red wine, etc.)?

If so please describe:____

____

Do you have any problems eating raw onions? ____ Yes ____No

The day after eating asparagus do you get a very strong odor when urinating (the next day?)

Do you have hepatitis? ___Yes ___ No Do you have a fatty liver? __ Yes __ No

Do you have funny reactions to medications? ___Yes ___No

Do strong odors (gasoline, smoke, cleaning supplies, perfume, etc.) bother you?

___Yes ___No

<u>Adrenal Function</u>

If you skip a meal do you feel bad (have headaches, become irritable, get jittery, tired, etc.) ___ Yes __No

Do you have low blood pressure? ___Yes ___ No __Don't Know

Do you crave salty foods? ___Yes ___No

Does increased stress or stressful situations make your symptoms worse?___Yes ____No

How's your energy level? Scale of 1-5, with 5 being the best. ______

How is your concentration and memory on a scale of 1-5, with 5 being best? ________

How do you feel in the morning? ____Refreshed_____ Hung over___ Exhausted

_____ Nauseated _____ Achy All Over

Are you hungry in the morning? ___Yes ___No

<u>DIGESTION</u> How is your digestion?

Bloating ___Yes ___No **Gas** ___Yes ___No **Indigestion** ___Yes ___No

Are there certain foods that give you problems (sugar, spicy foods, fruits, meats, fats, dairy, etc.)? Please list: ____

____

<u>Diet</u>

What do you eat for breakfast? Please (honestly) describe here: ____________________

____

What do you eat for Lunch? ____

____

What do you eat for dinner? ____

____

What are your usually snack foods (popcorn, ice cream, cookies, potato chips, candies)? Please be honest and specific: ____

____

Do you drink coffee? If so, how many cups a day and when: ______________________

Do you drink sodas? If so, how many and when? ______________________________

Do you drink tea? If so, how many glasses and when? __________________________

<u>Pain</u> (Please mark all that apply)

Where do you have pain? ____Joints ____Muscles ____Neck ____Shoulder ____ Mid Back ____Low Back ___Chest ___ Hips____ Arms ____Back of Legs ____ Front of legs ___Knees ____ Feet____ Ankles_____ Hands ___Fingers___ Head

<u>History</u>

Please place a check mark by any that apply below.

Do you ever have-

HEENT: ____Headaches ____Vision Problems ____Frequent Colds/Sore Throats

____ Dizziness ____ Hearing Problems

Chemical Sensitivities/Allergies: ____________________________________

CVS: ____Chest Pain ____ Palpitations ____High Cholesterol ____ High Blood Pressure

LUNGS: ____Coughing ____Wheezing ____Breathing Problems ___ Frequent Respiratory Infections

GI: ____Swallowing Problems ____Stomach Pains ____Nausea ____Vomiting

____Diarrhea ____Constipation ____Digestive Difficulties

Food allergies __Yes ___No

GU: ____Urinary Frequency ____Urinary Hesitancy ____Irregular Periods ____ Decreased Sex Drive

SKIN: ____Rashes ____Dry Skin ____Fungus Infections ____Eczema ____Psoriasis

Social History: Do You Smoke? ____Yes ____No

Family History: ____Cancer ____Diverticulitis ____Thyroid ____Heart Disease ____ Stroke ____Diabetes ____High Cholesterol

Intestinal Dysbiosis

Have you ever been on long term (more than 2 weeks) antibiotic therapy? __ Yes__ No

Have you ever had vaginal yeast infections? __Yes __No

If yes, when was last infection? ____

Do you have chronic vaginal yeast infections (more than 2 a year)? ___Yes __No

Are you bothered by memory or concentration problems? _________________________

Do you sometimes feel spaced-out? ____

Do you feel "sick all over", yet in spite of visits to different physicians, the causes haven't been found? ____

Have you been pregnant TWO or more times? ____________________________________

Have you taken birth control pills? _______ for more than 2 years?_____ for more than 1 year?___________6 months to 1 year?___________

Are your symptoms worse on damp, muggy days or in moldy places? _______________

Do you ever have itchy ears? __Yes __No Itchy nose? __Yes __No

Rectal Itching? ____Yes __No

Do you crave Sugar? ____ Yes ___No

Does eating sugar make your symptoms worse? __Yes __No

Do you have rectal itching after eating sugar, fruit, or a lot of starches? ___Yes ___No

Have you EVER been on long term (weeks) steroid therapy (prednisone, cortisone)? _____Yes ___No

Have you EVER been on long term (month or more) non-steroidal anti-inflammatory medications (Vioxx, Celebrex, Naprosyn, Advil, Bextra, Mobic, etc.)? __Yes __No

Yeast Questionnaire

Please mark your symptoms as follows: MI-mild **M-**moderate **S-**severe

- Feeling of being "drained" _____
- Abdominal pain _____
- Constipation and/or diarrhea _____
- Bloating, belching or intestinal gas_____
- Indigestion or heartburn _____
- Prostatitis_____
- Endometriosis or infertility _____
- Cramps and/or menstrual irregularities ______
- Premenstrual tension (PMS) _____
- Sore throat _____
- Recurrent sinus infections _____
- Chronic hives _____

- Cough or recurrent bronchitis _____
- Nasal congestion or postnasal drip _____
- Nasal itching _____
- Eczema
- Psoriasis ______
- Cystitis or interstitial cystitis ________
- Pressure in the ears_____
- Troublesome vaginal burning, itching or discharge _____
- Rectal itching _____
- Dry mouth or Throat _____
- Mouth rashes, Including " white" tongue ____
- Bad breath _____
- Foot, hair or body odor not relieved by washing _____
- Wheezing or shortness of breath _____
- Urinary frequency or urgency _____
- Burning on urination _____
- Burning or tearing eyes _____

Thyroid

Symptom Checklist:

___ Fatigue
___ Headaches
___ Migraines
___ PMS
___ Irritability
___ Fluid retention
___ Dry hair
___ Dry skin
___ Hair loss
___ Depression
___ Decreased memory
___ Decreased concentration
___ Decreased sex drive
___ Unhealthy nails
___ Constipation
___ Irritable Bowel Syndrome
___ Inappropriate weight gain
___ Hypoglycemia

___ High Cholesterol
___ Cold hands/feet
___ Changes in skin pigmentation
___ Changes in skin pigmentation
___ Irregular periods
___ Severe menstrual cramps
___ Low blood pressure
___ Frequent colds and sore throats
___ Heat and/or cold intolerance
___ Lightheadedness
___ Ringing in the ears
___ Infertility
___ Asthma
___ Low motivation
___ Frequent infections
___ Allergies
___ Falling asleep during the day

Parasite Check List

____ Have you traveled outside the United States?
_____Do you have foul smelling stools?
_____Do you experience any stomach bloating, gas, or pain?
____ Any rectal itching?
_____Unexpected weight loss with increased appetite?
_____Food allergies that continue to get worse despite treatment.
_____Do you feel hungry all the time?
_____Have you been diagnosed with irritable bowel syndrome?
_____What about inflammatory bowel disease?
_____Do you have sore mouth and gums?
_____Do you experience chronic low back pain that's unresponsive to treatment?
_____Do you have digestive disturbances?
_____Do you grind your teeth at night?
_____Do you own a dog, cat or other pet? Or are frequently around animals?

Brain Function Questionnaire

The "O" Group

Do ANY of these apply to your present feelings?

- Your life seems incomplete.
- You feel shy with all but your close friends.
- You have feelings of insecurity.
- You often feel unequal to others.
- When things go right you sometimes feel undeserving.
- You feel something is missing in your life.
- You occasionally feel a low self worth or esteem.
- You feel inadequate as a person.
- You frequently feel fearful when there is nothing to fear.

The "G" Group

Please note the items which apply to your present feelings.

- You often feel anxious for no reason.
- You sometimes feel "free floating" anxiety.
- You frequently feel "edgy" and its difficult relax.
- You often feel a "knot" in your stomach.
- Falling asleep is sometimes difficult.
- It's hard to turn your mind off when you want to relax.
- You occasionally experience feelings of panic for no reason.
- You often use alcohol or other sedatives to calm down.

The "D" Group

Please note the items which apply to your present feelings.

- You lack pleasure in life.
- You feel there are no real rewards in life.
- You have unexplained lack of concern for others, even loved ones.
- You experience decreased parental feelings.
- Life seems less "colorful" or "flavorful."
- Things that used to be "fun" aren't any longer enjoyable.
- You have become a less spiritual or socially concerned person.

The "N" Group

Please note the items which apply to your present feelings.

- You suffer from a lack of energy.
- You often find it difficult to "get going."
- You Suffer From Decreased Drive.
- You Often Start Projects and Then Don't Finish Them.
- You Frequently Feel A Need To Sleep Or "Hibernate."
- You Feel Depressed A Good Deal Of The Time.
- You Occasionally Feel Paranoid.
- Your Survival Seems Threatened.
- You Are Bored A Great Deal Of The Time.

The "S" Group

Please note the items which apply to your present feelings.

- It's hard for you to go to sleep.
- You Can't Stay Asleep.
- You Often Find Yourself Irritable.
- You're Emotions Often Lack Rationality.
- You Occasionally Experience Unexplained Tears.
- Noise bothers You More than It Used To. It seems louder than normal.
- You "Flare Up" At Others More Easily Than You Used To.
- You Experience Unprovoked Anger.
- You Feel Depressed Much Of The Time.
- You Find You Are More Susceptible To Pain.
- You Prefer To Be Left Alone.