

## 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 Up-  
per 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

### **Adrenal Function**

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

### **DIGESTION** 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: \_\_\_\_\_  
\_\_\_\_\_

### **Diet**

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? \_\_\_\_\_

**Pain** (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

**History**

**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:

- |  |  |
|--|--|
| <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> High Cholesterol                |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Cold hands/feet                 |
| <input type="checkbox"/> Migraines                 | <input type="checkbox"/> Changes in skin pigmentation    |
| <input type="checkbox"/> PMS                       | <input type="checkbox"/> Changes in skin pigmentation    |
| <input type="checkbox"/> Irritability              | <input type="checkbox"/> Irregular periods               |
| <input type="checkbox"/> Fluid retention           | <input type="checkbox"/> Severe menstrual cramps         |
| <input type="checkbox"/> Dry hair                  | <input type="checkbox"/> Low blood pressure              |
| <input type="checkbox"/> Dry skin                  | <input type="checkbox"/> Frequent colds and sore throats |
| <input type="checkbox"/> Hair loss                 | <input type="checkbox"/> Heat and/or cold intolerance    |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Lightheadedness                 |
| <input type="checkbox"/> Decreased memory          | <input type="checkbox"/> Ringing in the ears             |
| <input type="checkbox"/> Decreased concentration   | <input type="checkbox"/> Infertility                     |
| <input type="checkbox"/> Decreased sex drive       | <input type="checkbox"/> Asthma                          |
| <input type="checkbox"/> Unhealthy nails           | <input type="checkbox"/> Low motivation                  |
| <input type="checkbox"/> Constipation              | <input type="checkbox"/> Frequent infections             |
| <input type="checkbox"/> Irritable Bowel Syndrome  | <input type="checkbox"/> Allergies                       |
| <input type="checkbox"/> Inappropriate weight gain | <input type="checkbox"/> Falling asleep during the day   |
| <input type="checkbox"/> Hypoglycemia              |  |

## **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.