



Steps for your appointment:

- 1) Please fill out all New Patient forms in their entirety.
- 2) If you have any recent labs (within 12 months), please bring them to your appointment.
- 3) If you are married or in a relationship, please **bring your spouse or significant other** with you to your appointment. *(There will be a lot of information covered concerning your unique condition as well as the fundamentals of the program).*
- 4) Please arrive on time.
- 5) **We require a 24-hour notice to change or cancel your appointment. Cancellations with less than a 48-hour notice are not eligible for a refund.**
- 6) **Appointments rescheduled within 48-hours of the scheduled time will be charged an additional consult fee.**

Note: If these steps are not followed, it may compromise the full value of your consultation and therefore we will have to reschedule your appointment.

Main Complaints:

1. _____ 3. _____
2. _____ 4. _____

How long have you suffered with these problems? _____

Current and Past Medical Problems:

Diabetics only: Current A1c: _____ Please check any complications below:
Heart disease: _____ Kidney Disease: _____ Neuropathy: _____ Poor Circulation: _____ Retinopathy: _____

Surgical History:

Would you like improvement with any of the following? (Check all that apply)

- _____ Digestion: Reflux, Gas, Constipation
_____ Sleep: Problems falling asleep or staying asleep
_____ Sense of well-being
_____ Energy

Social & Lifestyle History:

Do you Smoke? () Yes () No

How Long: _____ Year Quit: _____

Pack/Day: _____

2nd Hand Smoke Exposure? _____

Do You Drink?

Alcohol, what, how often and how much _____

Caffeine, what, how often and how much _____

Recreational Drugs? _____

Occupational Exposures: _____

Other Chemical Exposures: _____

Silver Dental Fillings. How many? _____

Routine Screenings:

Annual Physical Exam: _____

Bi-annual Dental exam-cleaning: _____

Colonoscopy: _____

Bone Density: _____

Females only: Mammography: _____ Pelvic/PAP: _____ Self breast exam: _____

Males only: PSA _____ Prostate exam: _____

Screening Chest CT in smoker: _____

Typical Diet:

Breakfast: _____

Snack: _____

Lunch: _____

Dinner: _____

Snack: _____

How many times a week do you eat out and where? _____

Weekly Exercise: _____

Family History: Relationship?

() Allergies _____ () Bleeding problems _____

() Diabetes _____ () Thyroid problems _____

() Heart Disease _____ () Cancer _____

() Arthritis _____ () Autoimmune _____

() Breast cancer _____ () Ovarian or Uterine cancer _____

What have you tried doing in the past to resolve these problems, but they DID NOT work?

Have you become discouraged or stressed about handling these problems?

When your problems are at their worst, how does it make you feel?

How do these problems interfere with the following areas in your life?

Family: _____

Work: _____

Hobbies: _____

Life: _____

When your symptoms are at their worst, how much older do they make you feel?

Do you know how these problems may have started?

Are you here visiting us to:

- a) Resolve your immediate problem
- b) Undergo a lifestyle program for optimized living
- c) Both
- d) Other: _____

How have you taken care of your health in the past? (circle all that apply)

Medications
Routine medical exams
Exercise
Diet & Nutrition Changes

Holistic Approach
Vitamins
Chiropractic Care
Other: _____

How did the previous methods work for you?

Please circle the aspects of your life you fear are going to be impacted if your current state of health does not improve.

Job
Kids
Marriage
Sleep

Freedom
Future abilities
Finances
Time

Are there any health conditions you are afraid your symptoms may turn into? (circle all that apply)

Disability
Weight Gain
Heart Disease
Depression

Arthritis
Cancer
Diabetes
Other: _____

Where do you picture yourself being in the next 3-5 years if these problems are not taken care of? Please be specific.

What would be different or better without these problems? (circle all that apply)

Stress Level
Energy Level
Self Esteem
Confidence

Sleep
Work
Outlook
Family

If we were to sit down and discuss your life 3 years from now and look back at it today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness; i.e. health, family, work, finances, travel, marriage, or bucket list items).

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and would enjoy working with a mentor?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

How would you describe your family support?

_____ My spouse fully supports my decision concerning a lifestyle program.

_____ My spouse is not really involved, but wants me to get the help I need.

_____ My spouse needs more information to be supportive.

_____ I am single, but do have a support system with friends.

_____ I am single and do not have a support system.

Patient Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale **0-*Never or almost never*** have the symptom **3-*Frequently*** have it, effect is ***not severe***
 1-*Occasionally* have it, effect is ***not severe*** **4-*Frequently*** have it, effect is ***severe***
 2-*Occasionally* have it, effect is ***severe***

HEAD:

_____	Headaches	_____	Dizziness
_____	Faintness	_____	Insomnia
Total _____			

EYES:

_____	Watery or itchy eyes	_____	Bags or dark circles under eyes
_____	Blurred or tunnel vision (Does not include near or far-sighted)	_____	Swollen, reddened or sticky eyelids
Total _____			

EARS:

_____	Itchy ears	_____	Earaches, ear infections
_____	Drainage from ears	_____	Ringing in ears, hearing loss
Total _____			

NOSE:

_____	Stuffy nose	_____	Sinus problems
_____	Hay fever	_____	Excessive mucus formation
_____	Sneezing attacks		
Total _____			

MOUTH/THROAT:

_____	Chronic coughing	_____	Sore throat, hoarseness, voice loss
_____	Canker sores	_____	Gagging, frequent throat clearing
_____	Swollen or discolored tongue, gums, lips		
Total _____			



SKIN:

_____	Acne	_____	Hair loss
_____	Hives, rashes, dry skin	_____	Flushing, hot flashes
_____	Excessive sweating		
			Total _____

HEART:

_____	Chest pain	_____	Irregular or skipped heartbeat
_____	Rapid or pounding heartbeat		
			Total _____

LUNGS:

_____	Chest congestion	_____	Asthma, bronchitis
_____	Shortness of breath	_____	Difficulty breathing
			Total _____

DIGESTIVE TRACT:

_____	Nausea, vomiting	_____	Diarrhea
_____	Constipation	_____	Bloated feeling
_____	Belching, passing gas		
_____	Heartburn	_____	Intestinal/stomach pain
			Total _____

JOINTS/MUSCLE:

_____	Pain or joint aches	_____	Arthritis
_____	Stiffness or limited mobility	_____	Pain or muscle aches
_____	Feeling of weakness		
			Total _____

WEIGHT:

_____	Binge eating/drinking	_____	Craving certain foods
_____	Excessive weight	_____	Compulsive eating
_____	Water retention	_____	Underweight
			Total _____

ENERGY:

_____	Fatigue, sluggishness	_____	Apathy, lethargy
_____	Hyperactivity	_____	Restlessness

Total _____

MIND:

_____	Poor memory	_____	Slurred speech
_____	Confusion, poor comprehension	_____	Poor concentration
_____	Poor physical coordination	_____	Difficulty making decisions
_____	Stuttering or stammering	_____	Learning disabilities

Total _____

EMOTIONS:

_____	Anger, irritability, aggressiveness	_____	Depression
_____	Anxiety, fear, nervousness	_____	Mood swings

Total _____

OTHER:

_____	Frequent or urgent urination	_____	Frequent illness
_____	Genital itch or discharge		

Total _____

GRAND TOTAL _____