CARBONE CHIROPRACTIC CENTER, LLC

# FUNCTIONAL MEDICINE HEALTH HISTORY FORM

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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records of Dr._____

Address:_____

Telephone number (  ) ___ - _____ Fax number (  ) ___ - _____

## THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to _____

_____

all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse*:* O Yes O No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: O Yes O No

Genetic Testing O Yes O No

*Please note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.*

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release_____

(Name of physician, clinic name, or health organization)

employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand the there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name:_____ D.O.B._____

*Please Print*

Signature: _____ Date_____

**Records Requested by:**

Doctor's Name: _____

Signature:_____

## COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date:_____

First Name:_____ Middle:_____Last:_____

Address _____ City _____ State _____ Zip Code_____

Home Phone (____) _____-_____ Work (____) _____-_____ Cell (____) ____-_____

Email _____

Age _____ Date of Birth ____/____/_____ Place of birth_____ Gender: Female__Male___

City or town & country, if not US

Referred by:_____

Name, address, & phone number of primary care physician:_____

_____

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: _____

Relationship Name Phone

_____

Address

Occupation _____ Hours per week _____ Retired _____

Nature of Business_____

Genetic Background: Please check appropriate box(es):

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

## CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

| Problem | Date of Onset | Severity/Frequency | Treatment Approach | Success |
|---|---|---|---|---|
| **Example:** Headaches | May 2006 | 2 times per week | Acupuncture/Aspirin | Mild improvement |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

When was the last time that you felt well?_____

What seems to trigger your symptoms?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

_____

_____

How much time have you lost from work or school in the past year due to these conditions?_____

## PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

| ILLNESSES | WHEN /ONSET | COMMENTS |
|---|---|---|
| Anemia | | |
| Arthritis | | |
| Asthma | | |
| Bronchitis | | |
| Cancer | | |
| Chicken Pox | | |
| Chronic Fatigue Syndrome | | |
| Crohn's Disease or Ulcerative Colitis | | |
| Diabetes | | |

| ILLNESS | WHEN/ONSET | COMMENTS |
|---|---|---|
| Emphysema | | |
| Epilepsy, convulsions, or seizures | | |

| | | |
|---|---|---|
| Gallstones | | |
| German Measles | | |
| Gout | | |
| Heart Attack, Angina | | |
| Heart Failure | | |
| Hepatitis | | |
| Herpes Lesions/Shingles | | |
| High blood fats (cholesterol, triglycerides) | | |
| High blood pressure (hypertension) | | |
| Irritable bowel (or chronic diarrhea) | | |
| Kidney stones | | |
| Measles | | |
| Mononucleosis | | |
| Mumps | | |
| Pneumonia | | |
| Rheumatic Fever | | |
| Sinusitis | | |
| Sleep Apnea | | |
| Stroke | | |
| Thyroid disease | | |
| Whooping Cough | | |
| Other (describe) | | |
| Other (describe) | | |
| **INJURIES** | **WHEN** | **COMMENTS** |
| Back injury | | |
| Broken bones or fractures (describe) | | |
| Head injury | | |
| Neck injury | | |
| Other (describe) | | |
| Other (describe) | | |

| **DIAGNOSTIC STUDIES** | **WHEN** | **COMMENTS** |
|---|---|---|
| Blood Tests | | |
| Bone Density Test | | |
| Bone Scan | | |
| Carotid Artery Ultrasound | | |

| | | |
|---|---|---|
| CAT Scan (Please indicate type) | | |
| Colonoscopy | | |
| EKG | | |
| Liver Scan | | |
| Mammogram | | |
| Neck X-Ray | | |
| MRI | | |
| X-Ray (Please indicate type) | | |
| Other (describe) | | |
| Other (describe) | | |
| **SURGERIES** | **WHEN** | **COMMENTS** |
| Appendectomy | | |
| Dental Surgery | | |
| Gall Bladder | | |
| Hernia | | |
| Hysterectomy | | |
| Tonsillectomy | | |
| Tubes in Ears | | |
| Other (describe) | | |
| Other (describe) | | |

## HOSPITALIZATIONS

| WHERE HOSPITALIZED | WHEN | REASON |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## MEDICATIONS

| How often have you taken antibiotics? | Less than 5 times | More than 5 times | Comments |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

| How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc) | Less than 5 times | More than 5 times | Comments |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

**List all medications. Include all over the counter non-prescription drugs.**

| Medication Name | Date started | Date stopped | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.**

| Type | Date Started | Date Stopped | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:_____

_____

## CHILDHOOD HISTORY

Please answer to the best of your knowledge.

| | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| Where you a full term baby? | | | | |
| A premature birth? ('preemie') | | | | |
| Breast fed? | | | | |

| | | | | |
|---|---|---|---|---|
| Bottle fed? | | | | |
| When pregnant with you, did your mother: | | | | |
| Smoke tobacco? | | | | |
| Use recreational drugs? | | | | |
| Drink alcohol? | | | | |
| Use estrogen? | | | | |
| Other prescription or non-prescription medications? | | | | |

## IMMUNIZATION HISTORY

| Please indicate if you have been vaccinated against any of the following diseases: | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| Smallpox | | | | |
| Tetanus | | | | |
| Diphtheria | | | | |
| Pertussis | | | | |
| Polio (oral) | | | | |
| Polio (injection) | | | | |
| Mumps | | | | |
| Measles | | | | |
| Rubella (German Measles) | | | | |
| Typhoid | | | | |
| Cholera | | | | |

## CHILDHOOD DIET

| Was your childhood diet high in: | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| Sugar? (Sweets, Candy, Cookies, etc) | | | | |
| Soda? | | | | |
| Fast food, pre-packaged foods, artificial sweeteners? | | | | |
| Milk, cheeses, other dairy products? | | | | |
| Meat, vegetables, & potato diet? | | | | |
| Vegetarian diet? | | | | |
| Diet high in white breads? | | | | |

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: milk – diarrhea)_____

_____

_____

## CHILDHOOD ILLNESSES

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

| | YES | AGE |
|---|---|---|
| ADD (Attention Deficient Disorder) | | |
| Asthma | | |
| Bronchitis | | |
| Chicken Pox | | |
| Colic | | |
| Congenital problems | | |
| Ear infections | | |
| Fever blisters | | |
| Frequent colds or flu | | |
| Frequent headaches | | |
| Hyperactivity | | |
| Jaundice | | |

| | YES | AGE |
|---|---|---|
| Mumps | | |
| Pneumonia | | |
| Seasonal allergies | | |
| Skin disorders (e.g. dermatitis) | | |
| Strep infections | | |
| Tonsillitis | | |
| Upset stomach, digestive problems | | |
| Whooping cough | | |
| Other (describe) | | |
| Other (describe) | | |
| Measles | | |
| | | |

As a child did you: Have a high absence from school? Yes___ No___

If yes, why?_____

Experience chronic exposure to second hand smoke in your home? Yes___ No___

Experience abuse Yes___ No___

Have alcoholic parents? Yes___ No___

# FEMALE MEDICAL HISTORY

*(For women only)*

## OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____
- ❑ Caesarean _____
- ❑ Vaginal deliveries_____
- ❑ Miscarriage _____
- ❑ Abortion _____
- ❑ Living Children_____
- ❑ Post partum depression___
- ❑ Toxemia _____
- ❑ Gestational diabetes_____

## GYNECOLOGICAL HISTORY

Age at first menses?_____ Frequency:_____ Length:_____

Painful: Yes_____ No_____ Clotting: Yes____ No____

Date of last menstrual period:____/____/_____

Do you currently use contraception? Yes____ No____ If yes, what please indicate which form:

Non-hormonal

- ❑ Condom

- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant._____

_____

_____

Are you menopausal? Yes_____ No_____ If yes, age of menopause_____

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

❑ Other _____

## DIAGNOSTIC TESTING

Last PAP test:_____/_____/_____ Normal:_____Abnormal_____

Last Mammogram_____/_____/_____ Breast biopsy? Date:_____/_____/_____

Date of last bone densitiy_____/_____/_____ Results: High____ Low____ Within normal range____

## FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

| Check Family Members that Apply | Father | Mother | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|---|---|
| Age (if still living) | | | | | | | | | |
| 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 | | | | | | | | | |
| **Check Family Members that Apply** | **Father** | **Mother** | **Brother(s)** | **Sister(s)** | **Children** | **Maternal Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** |
| Epilepsy | | | | | | | | | |
| Flu | | | | | | | | | |
| Genetic Disorders | | | | | | | | | |
| Glaucoma | | | | | | | | | |
| Headache | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| High Cholesterol | | | | | | | | | |
| 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 | | | | | | | | | |

## REVIEW OF SYMPTOMS

**Check (√)** those items that applied to you in the ***past***. **Circle** those that ***presently*** apply

### GENERAL

- ❑ Fever
- ❑ Chills/Cold all over
- ❑ Aches/Pains
- ❑ General Weakness
- ❑ Difficulty sweating
- ❑ Excessive Sweating
- ❑ Swollen Glands
- ❑ Cold hands & Feet
- ❑ Fatigue
- ❑ Difficulty falling asleep
- ❑ Sleepwalker
- ❑ Nightmares
- ❑ No dream recall
- ❑ Early waking
- ❑ Daytime sleepiness
- ❑ Distorted vision

### SKIN:

- ❑ Cuts heal slowly
- ❑ Bruise easily
- ❑ Rashes
- ❑ Pigmentation
- ❑ Changing Moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness/cracking skin
- ❑ Oiliness
- ❑ Itching
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on Nails
- ❑ Peeling Skin
- ❑ Shingles
- ❑ Nails Split
- ❑ White Spots/Lines on Nails
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot
- ❑ Cellulite
- ❑ Bugs love to bite you
- ❑ Bumps on back of arms & front of thighs
- ❑ Skin cancer
- ❑ Strong body odor

**Is your skin sensitive to:**

- ❑ Sun
- ❑ Fabrics
- ❑ Detergents
- ❑ Lotions/Creams

### HEAD:

- ❑ Poor Concentration
- ❑ Confusion
- ❑ Headaches:
  - ❑ After Meals
  - ❑ Severe

- ❑ Migraine
- ❑ Frontal
- ❑ Afternoon
- ❑ Occipital
- ❑ Afternoon
- ❑ Daytime
- ❑ Relieved by:
  - ❑ Eating Sweets

- ❑ Concussion/Whiplash
- ❑ Mental sluggishness
- ❑ Forgetfulness
- ❑ Indecisive
- ❑ Face twitch
- ❑ Poor memory
- ❑ Hair loss

## EYES:

- ❑ Feeling of sand in eyes
- ❑ Double vision
- ❑ Blurred vision
- ❑ Poor night vision
- ❑ See bright flashes
- ❑ Halo around lights
- ❑ Eye pains
- ❑ Dark circles under eyes
- ❑ Strong light irritates
- ❑ Cataracts
- ❑ Floaters in eyes
- ❑ Visual hallucinations

## EARS:

- ❑ Aches
- ❑ Discharge/Conjunctivitis
- ❑ Pains
- ❑ Ringing
- ❑ Deafness/Hearing loss
- ❑ Itching
- ❑ Pressure
- ❑ Hearing aid
- ❑ Frequent infections
- ❑ Tubes in ears
- ❑ Sensitive to loud noises
- ❑ Hearing hallucinations

## NOSE/SINUSES

- ❑ Stuffy
- ❑ Bleeding
- ❑ Running/Discharge
- ❑ Watery nose
- ❑ Congested
- ❑ Infection
- ❑ Polyps
- ❑ Acute smell
- ❑ Drainage
- ❑ Sneezing spells
- ❑ Post nasal drip
- ❑ No sense of smell
- ❑ Do the change of seasons tend to make your symptoms worse? Yes/No

**If yes, is it worse in the:**

- ❑ Spring
- ❑ Summer
- ❑ Fall
- ❑ Winter

## MOUTH:

- ❑ Coated tongue
- ❑ Sore tongue
- ❑ Teeth problems
- ❑ Bleeding gums
- ❑ Canker sores
- ❑ TMJ
- ❑ Cracked lips/ corners
- ❑ Chapped lips
- ❑ Fever blisters
- ❑ Wear dentures
- ❑ Grind teeth when sleeping
- ❑ Bad breath
- ❑ Dry mouth

## THROAT:

- ❑ Mucus
- ❑ Difficulty swallowing
- ❑ Frequent hoarseness
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Constant clearing of throat
- ❑ Throat closes up

## NECK:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell

## CIRCULATION/RESPIRATION:

- ❑ Swollen ankles
- ❑ Sensitive to hot
- ❑ Sensitive to cold
- ❑ Extremities cold or clammy
- ❑ Hands/Feet go to sleep/numbness/tingling
- ❑ High blood pressure
- ❑ Chest pain
- ❑ Pain between shoulders
- ❑ Dizziness upon standing
- ❑ Fainting spells
- ❑ High cholesterol
- ❑ High triglycerides
- ❑ Wheezing
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Low exercise tolerance

- ❑ Frequent coughs
- ❑ Breathing heavily
- ❑ Frequently sighing
- ❑ Shortness of breath
- ❑ Night sweats
- ❑ Varicose veins/spider veins
- ❑ Mitral valve prolapse
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/Pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Prior heart attack ? When___/___/_____
- ❑ Phlebitis

## GASTROINTESTINAL

- ❑ Peptic/Duodenal Ulcer
- ❑ Poor appetite
- ❑ Excessive appetite
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Nervous stomach
- ❑ Full feeling after small meal
- ❑ Indigestion
- ❑ Heartburn
- ❑ Acid Reflux
- ❑ Hiatal Hernia
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Abdominal Pains/Cramps
- ❑ Gas
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in bowels
- ❑ Rectal bleeding
- ❑ Tarry stools
- ❑ Rectal itching
- ❑ Use laxatives
- ❑ Bloating
- ❑ Belch frequently
- ❑ Anal itching
- ❑ Anal fissures
- ❑ Bloody stools
- ❑ Undigested food in stools

## KIDNEY/URINARY TRACT:

- ❑ Burning
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Night time urination
- ❑ Problem passing urine
- ❑ Kidney pain
- ❑ Kidney stones
- ❑ Painful urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Syphilis
- ❑ Bedwetting
- ❑ Have trichomonas

## WOMEN'S HISTORY (for women only)

- ❑ Fibrocystic breasts
- ❑ Lumps in breast
- ❑ Fibroid Tumors/Breast
- ❑ Spotting
- ❑ Heavy periods
- ❑ Fibroid Tumors/Uterus

## WOMEN'S HISTORY (for women only)

- ❑ Painful periods
- ❑ Change in period
- ❑ Breast soreness before period
- ❑ Endometriosis
- ❑ Non-period bleeding
- ❑ Breast soreness during period
- ❑ Vaginal dryness
- ❑ Vaginal discharge
- ❑ Partial/total hysterectomy
- ❑ Hot flashes
- ❑ Mood swings
- ❑ Concentration/Memory Problems
- ❑ Breast cancer
- ❑ Ovarian cysts
- ❑ Pregnant
- ❑ Infertility
- ❑ Decreased libido
- ❑ Heavy bleeding
- ❑ Joint pains
- ❑ Headaches
- ❑ Weight gain
- ❑ Loss of bladder control
- ❑ Palpitations

## MEN'S HISTORY (for men only)

Have you had a PSA done?
Yes _____ No _____

PSA Level:

- ❑ 0 – 2
- ❑ 2 – 4
- ❑ 4 – 10
- ❑ >10

- ❑ Prostate enlargement
- ❑ Prostate infection
- ❑ Change in libido
- ❑ Impotence
- ❑ Diminished/poor libido
- ❑ Infertility

- ❑ Lumps in testicles
- ❑ Sore on penis
- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer
- ❑ Low sperm count
- ❑ Difficulty obtaining erection
- ❑ Difficulty maintaining an erection
- ❑ Nocturia (urination at night)
    - ❑ How many times at night? ____
- ❑ Urgency/Hesitancy/Change in Urinary Stream
- ❑ Loss of bladder control

## JOINT/MUSCLES/TENDONS

- ❑ Pain wakes you
- ❑ Weakness in legs and arms
- ❑ Balance problems
- ❑ Muscle cramping
- ❑ Head injury
- ❑ Muscle stiffness in morning
- ❑ Damp weather bothers you

## EMOTIONAL:

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Blackouts/Amnesia
- ❑ Had prior shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Startled by sudden noises
- ❑ Anxiety/Feeling of panic
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless/groggy
- ❑ Withdrawn feeling/Feeling ‘lost’
- ❑ Had nervous breakdown
- ❑ Unable to concentrate/short attention span
- ❑ Vision changes
- ❑ Unable to reason
- ❑ Considered a nervous person by others
- ❑ Tends to worry needlessly
- ❑ Unusual tension

## EMOTIONAL (CONTINUED)

- ❑ Frustration
- ❑ Emotional numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Previously admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Misunderstood by others
- ❑ Irritable/
- ❑ Feeling of hostility/volatile or aggressive
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness
- ❑ Am a workaholic
- ❑ Have had hallucinations
- ❑ Have considered suicide
- ❑ Have overused alcohol
- ❑ Family history of overused alcohol
- ❑ Cry often
- ❑ Feel insecure
- ❑ Have overused drugs
- ❑ Been addicted to drugs
- ❑ Extremely shy

# PAIN ASSESSMENT

Are you currently in pain? Yes ___ No___

Is the source of your pain due to an injury? Yes___ No___

***If yes***, please describe your injury and the date in which it occurred:_____

_____

***If no***, please describe how long you have experienced this pain and what you believe it is attributed to:_____

Please use the area(s) and illustration below to describe the severity of your pain.

(0= no pain, 10= severe pain)

Example:_____**Neck**_____

0 1 2 3 4 5 6 7 8 9 10

Area 1._____

1 2 3 4 5 6 7 8 9 10

Area 2._____

1 2 3 4 5 6 7 8 9 10

Area 3._____

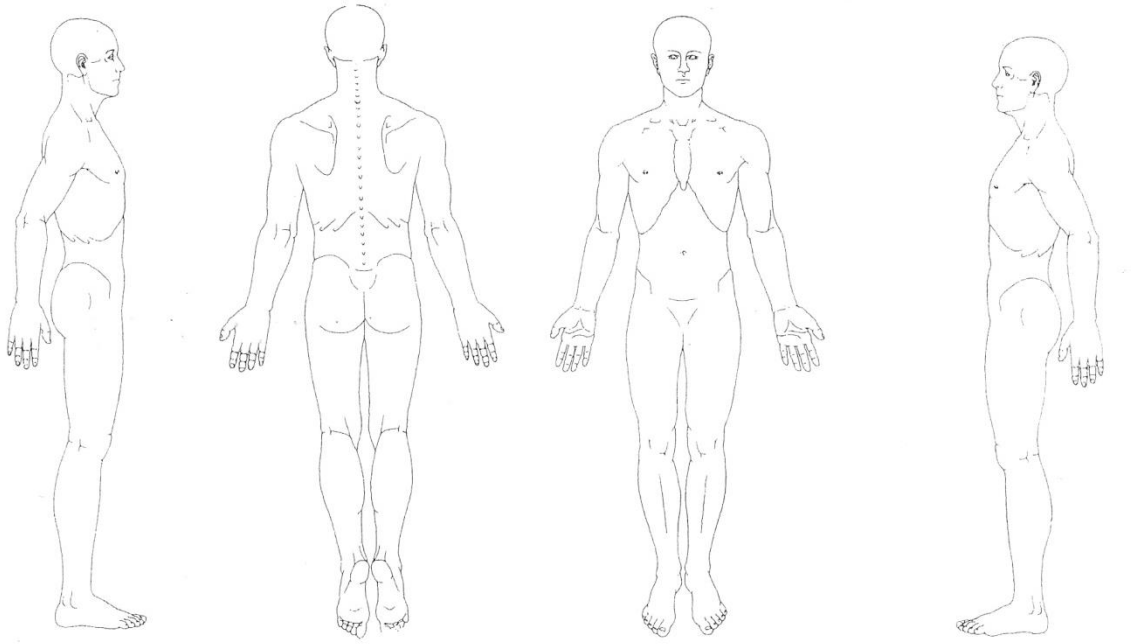
1 2 3 4 5 6 7 8 9 10

Area 4._____

1 2 3 4 5 6 7 8 9 10

Use the letters provided to mark your area(s) of pain on the illustration.

**A** = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting



Right Side Back Front Left side

# DENTAL HISTORY

| | Yes | No |
|---|---|---|
| Problem with sore gums (gingivitis)? | | |
| Ringing in the ears (tinnitus)? | | |
| Have TMJ (temporal mandibular joint) problems? | | |
| Metallic taste in mouth? | | |
| Problems with bad breath (halitosis) or white tongue (thrush)? | | |
| Previously or currently wear braces? | | |
| Problems chewing? | | |
| Floss regularly? | | |
| Do you have amalgam dental fillings? How many? | | |
| Did you receive these fillings as a child? | | |

List your approximate age and the type of dental work done from childhood until present:

| Age | Type of dental work: | Health Problems following dental work? (describe) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____

## FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

| Usual Breakfast | Usual Lunch | Usual Dinner |
|---|---|---|
| ❑ None | ❑ None | ❑ None |
| ❑ Bacon/Sausage | ❑ Butter | ❑ Beans (legumes) |
| ❑ Bagel | ❑ Coffee | ❑ Brown rice |
| ❑ Butter | ❑ Eat in a cafeteria | ❑ Butter |
| ❑ Cereal | ❑ Eat in restaurant | ❑ Carrots |
| ❑ Coffee | ❑ Fish sandwich | ❑ Coffee |
| ❑ Donut | ❑ Fried foods | ❑ Fish |
| ❑ Eggs | ❑ Hamburger | ❑ Green vegetables |
| ❑ Fruit | ❑ Hot dogs | ❑ Juice |
| ❑ Juice | ❑ Juice | ❑ Margarine |
| ❑ Margarine | ❑ Leftovers | ❑ Milk |
| ❑ Milk | ❑ Lettuce | ❑ Pasta |
| ❑ Oat bran | ❑ Margarine | ❑ Potato |
| ❑ Sugar | ❑ Mayo | ❑ Poultry |
| ❑ Sweet roll | ❑ Meat sandwich | ❑ Red meat |
| ❑ Sweetener | ❑ Milk | ❑ Rice |
| ❑ Tea | ❑ Pizza | ❑ Salad |
| ❑ Toast | ❑ Potato chips | ❑ Salad dressing |
| ❑ Water | ❑ Salad | ❑ Soda |
| ❑ Wheat bran | ❑ Salad dressing | ❑ Sugar |
| ❑ Yogurt | ❑ Soda | ❑ Sweetener |
| ❑ Oat meal | ❑ Soup | ❑ Tea |
| ❑ Milk protein shake | ❑ Sugar | ❑ Vinegar |
| ❑ Slim fast | ❑ Sweetener | ❑ Water |
| ❑ Carnation shake | ❑ Tea | ❑ White rice |
| ❑ Soy protein | ❑ Tomato | ❑ Yellow vegetables |
| ❑ Whey protein | ❑ Vegetables | ❑ Other: (List below) |
| ❑ Rice protein | ❑ Water | |
| ❑ Other: (List below) | ❑ Yogurt | |
| | ❑ Slim fast | |
| | ❑ Carnation shake | |
| | ❑ Protein shake | |

How much of the following do you consume each week?

| | |
|---|---|
| Candy | |
| Cheese | |
| Chocolate | |
| Cups of coffee containing caffeine | |
| Cups of decaffeinated coffee or tea | |
| Cups of hot chocolate | |
| Cups of tea containing caffeine | |
| Diet soda | |
| Ice cream | |
| Salty foods | |
| Slices of white bread (rolls/bagels, etc) | |
| Soda with caffeine | |
| Soda without caffeine | |

Do you currently follow a special diet or nutritional program? Yes____ No_____

- ❑ Ovo-lacto
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet
- ❑ Other (describe)_____

Please tell us if there is anything special about your diet that we should know._____

_____

Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc?
Yes___ No____
If yes, are these symptoms associated with any particular food or supplement?
Yes___ No____
If yes, please name the food or supplement and symptom(s). _____

_____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals greatly affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes _____ No _____ If yes, what food(s) _____

_____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) _____

_____

Please complete the following chart as it relates to your bowel movements:

| **Frequency** | √ | **Color** | √ |
|---|---|---|---|
| More than 3x/day | | Medium brown consistently | |
| 1-3x/ day | | Very dark or black | |
| 4-6x/week | | Greenish color | |
| 2-3x/week | | Blood is visible | |
| 1 or fewer x/week | | Varies a lot | |
| | | Dark brown consistently | |
| **Consistency** | √ | Yellow, light brown | |
| Soft and well formed | | Greasy, shiny appearance | |
| Often floats | | | |
| Difficult to pass | | | |
| Diarrhea | | | |
| Thin, long or narrow | | | |
| Small and hard | | | |
| Loose but not watery | | | |
| Alternating between hard and loose/watery | | | |

Intestinal gas:

- ❑ Daily
- ❑ Occasionally
- ❑ Excessive
- ❑ Present with pain
- ❑ Foul smelling
- ❑ Little odor

# LIFESTYLE HISTORY

## TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much?_____

Number of years?_____If not a current user, year quit_____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain:_____

_____

## ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From_____ to _____

## OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____

If yes, what type(s) and method? (IV, inhaled, smoked, etc)_____

_____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___No___

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

## SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?

## EXERCISE HISTORY

Do you exercise regularly? Yes____ No____

| If yes, please indicate: | Times/week | | | | Length of session | | | |
|---|---|---|---|---|---|---|---|---|
| **Type of exercise** | 1x | 2x | 3x | 4x/+ | ≤15 | 16-30 min | 31-45 min | >45 |
| Jogging/Walking | | | | | | | | |
| Aerobics | | | | | | | | |
| Strength Training | | | | | | | | |
| Pilates/Yoga/Tai Chi | | | | | | | | |
| Sports (tennis, golf, water sports, etc) | | | | | | | | |
| Other (please indicate) | | | | | | | | |

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

_____

_____

## SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

### STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? _____ When was the last time?_____

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc)_____

Did it help?_____

How well have things been going for you?

| | Very well | Fine | Poorly | Very poorly | Does not apply |
|---|---|---|---|---|---|
| At school | | | | | |
| In your job | | | | | |
| In your social life | | | | | |
| With close friends | | | | | |
| With sex | | | | | |
| With your attitude | | | | | |
| With your boyfriend/girlfriend | | | | | |
| With your children | | | | | |
| With your parents | | | | | |
| With your spouse | | | | | |

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _____

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

Hobbies and leisure activities:

_____

_____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes_____ No_____

## READINESS ASSESSMENT

*Rate on a scale of: 5 (very willing) to 1 (not willing).*

In order to improve your health, how willing are you to:

| | |
|---|---|
| Significantly modify your diet | 5 _____ 4 _____ 3 _____ 2 _____ 1 _____ |
| Take nutritional supplements each day | 5 _____ 4 _____ 3 _____ 2 _____ 1 _____ |
| Keep a record of everything you eat each day | 5 _____ 4 _____ 3 _____ 2 _____ 1 _____ |
| Modify your lifestyle (e.g. work demands, sleep habits) | 5 _____ 4 _____ 3 _____ 2 _____ 1 _____ |
| Practice relaxation techniques | 5 _____ 4 _____ 3 _____ 2 _____ 1 _____ |
| Engage in regular exercise | 5 _____ 4 _____ 3 _____ 2 _____ 1 _____ |
| Have periodic lab tests to assess progress | 5 _____ 4 _____ 3 _____ 2 _____ 1 _____ |

Comments _____

_____

_____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and well being.

Sincerely,
Dr. Guy Carbone & Dr. Melissa Tulisano