



Name:		Date:	
Address:		Unit:	
City:	State:	Zip:	
PHONE	Home:	Mobile:	Work:
Email Address:			

Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Age:	Height:	Weight:
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Status:

- ☐ Married
☐ Separated
☐ Divorced

- ☐ Widowed
☐ Single
☐ Partnership

Live with:

- ☐ Spouse
☐ Partner
☐ Parents
☐ Children
☐ Friends
☐ Alone

Education:

Occupation: Hours per week: ☐ Retired

Employer	Work Address
<input type="text"/>	<input type="text"/>

In case of emergency, whom should we contact?

Name	Relationship	Address	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

How did you hear about our Wellness and Nutrition Program?

What is your major complaint? Please list when each symptom began and be as descriptive as possible:

What are your current medications?

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

What are your current vitamins and/or supplements?

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.):

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Is there anything else in your medical history that you consider to be relevant? (Even from childhood)

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What is your employment history? Please provide brief summary including dates if possible.

<hr/>
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Please list your past or present Hobbies that could be sources of toxicity or chemicals:

<hr/>
<hr/>
<hr/>

How often are you involved in these Hobbies currently?

<hr/>
<hr/>

Please list past or present allergies, including allergies to medications.

<hr/>
<hr/>
<hr/>

Please list all past surgeries and the condition each surgery was for, including dates.

Please explain your housing history (type of homes, where and when).

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have amalgam (silver) fillings in your teeth? If so, How many? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had an amalgam removed? If Yes, How many_____ Date? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you had amalgams removed, was it done by a biological dentist using a safe protocol?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did your mother have amalgam when pregnant with you?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever worked in a dental office? If so, how long? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any dental crowns? If yes, how many_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any bridges?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any root canals?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any tooth extractions?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any dental implants, retainers or other metal in your mouth? Explain:_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did you wear contact lenses during the 1980's or early 1990's?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did you take oral contraceptives during the 1980's or early 1990's?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you noticed any adverse reactions to these shots?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any tattoos with red ink?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your occupation involve soldering or metal salvage?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you done any old home repair or sandblasting? If so, When_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you do a lot of painting?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was your home built before 1978?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you around a lot of fake leather, or vinyl?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you get stomach aches in the morning?

General Toxicity

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have your house sprayed with pesticides for pest control? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you spray herbicide (weed killers) in or around your home? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you use conventional insect repellants on your self or family? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you use conventional sunscreen? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you use conventional perfume or cologne every day? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you get your hair colored? If so, is it on the scalp? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you use aerosol hairspray? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you get your nails done? If so, how often? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you use air freshener in your house, work or car? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you drink filtered water? If so, what type of filter do you have? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you drink bottle water if so what kind? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a water filtration system for your entire house or shower filtration? If so, what type? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your spouse or other family members work around chemicals? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Can you think of any other toxic exposures you may have had? |

Mold

How old is the house you are living in? _____ How long have you lived there? _____

Have you noticed any new symptoms since moving in? _____ If so, what? _____

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you see mold growing at home, work or school? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had water damage at home, work or school? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your home, workplace or school have a damp or mildew smell? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does spending time in your basement cause or worsen your symptoms? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your basement ever get wet? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a crawl space? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your basement or crawl space have a sump pump? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your car have a mildew smell? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does anyone in your home have asthma like symptoms? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does anyone in your family have chronic sinus infections or irritations? |

Lyme Disease

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been diagnosed with Lyme Disease? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had dry sockets or infected tooth extractions? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have small joint pain? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been bitten by a tick or recluse spider? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever seen a bulls-eye rash appear on any part of your body? |

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Was your mother ever diagnosed with Lyme Disease? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been diagnosed with Chronic Fatigues Syndrome, Fibromyalgia, Lupus, Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), or an Autoimmune condition? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)? |

Health History

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does anyone in your family experience similar symptoms to yours?
What is your birth order (i.e. first born, second, third, etc.)? _____. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any history of kidney dysfunction? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you or any immediate family member have a history with cancer? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any history of heart disease, myocardial infarction (heart attack), etc.? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you currently having any thoughts of suicide? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been diagnosed with bipolar disorder, schizophrenia or depression? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of strokes? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been diagnosed with diabetes, thyroiditis, or heart disease? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been in an auto accident, fallen or received a major physical injury? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you in menopause? |

Microbiome Health

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you get distention, bloating, feeling full and a noisy gut after eating healthy carbohydrates such as broccoli, Brussels sprouts or other vegetables? |
|------------------------------|-----------------------------|--|

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you often have gas that has a sulfur or foul smell? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you sensitive to supplements? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been vegan or vegetarian for any length of time? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Can you tolerate Meat? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you taken birth control or Hormone replacement therapy for any length of time? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have been on antibiotics for any extended period of time or often as a child or adult? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Were you caesarian delivered? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Were you breast fed? If so, How long _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your gut temporarily feel better after a round of antibiotics? |

How many times a day are you having a bowel movement? _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

- | | | |
|---------------------------------------|---|---------------------------------------|
| 0 = Never had the symptom | 2 = Occasionally have it, severe effect | 4 = Frequently have it, severe effect |
| 1 = Occasionally have it, mild effect | 3 = Frequently have it, mild effect | |

Column #1

Anxiety
Mood swings
Enraged behavior or anger for no reason
Excessive shyness, timidity, social phobia (not typical to your personality)
Irritability (not typical to your personality)
Low body temperature (below 97.5°)
Insomnia (can't get to sleep or return to sleep)
Dizziness
Sound in ears (ringing or hearing your heart beat)
Psychological symptoms, even thoughts of suicide
Sensitivity to sound

Column #2

Sensitivity to light
Fatigue after exercising (feeling worse)
Bad night vision or seeing halos around lights
Shortness of breath, with very little effort
Excessive thirst and/or frequent urination
Red eyes or tearing
Blurred vision at times
Morning stiffness
Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
Chronic fatigue or weakness
Non-restful sleep

Indecisiveness
Feeling of being overwhelmed or fearful
Metallic taste in your mouth
Bad breath
Bleeding gums
Sensitive teeth
Canker sores or other sores in the mouth
Floaters, shadows or swimmers when you read or look into the sky
Dyslexia or loss of place while reading, even as a child
Swelling eyelids
Peeling on top layer of skin (hands, feet)
Dry skin
Heart pain (angina) and you are under 45 years old
Depression
Gout (arthritic pain, especially in big toes)
Pain in shoulders or upper back
Twitching eyelids
Anemia (low iron/hemoglobin on blood test)
Wrist/ankle drop or weak extensor muscles
Hair falls out (not normal male pattern baldness)

Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
Trouble processing new information
Word reversal or trouble finding words
Sensitivity to touch
Short-term memory loss
Chronic sinus congestion
Dry non-productive cough
Muscle twitching
Excessive sweating, especially at night
Joint pain-not necessarily true arthritis-can move from joint to joint
Difficulty losing weight regardless of diet or exercise
Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
Frequent illness, prolonged illness or sick days
Numbness or weakness in arms and legs
Headaches
Trouble adding or dividing numbers in your head
Fluctuating constipation and diarrhea
Stomach pain for no apparent reason
Appetite swings
Frequent muscle aches, cramps, unusual sharp sudden pains
Rashes or rosacea
Cold extremities (hands and feet)

Total Columns 1 & 2