Dr. Henderson, DC, CCSP

Brentwood Functional Medicine

Dr. Henderson, DC, CCSP
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & COMPREHENSIVE HEALTH HISTORY FORMS

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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:_____

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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 American ❑ Hispanic ❑ Mediterranean ❑ Asian
❑ Native American ❑ Caucasian ❑ Northern European ❑ Other

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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

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		

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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)		

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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

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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:_____

_____

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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___

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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____

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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									

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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

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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

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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._____

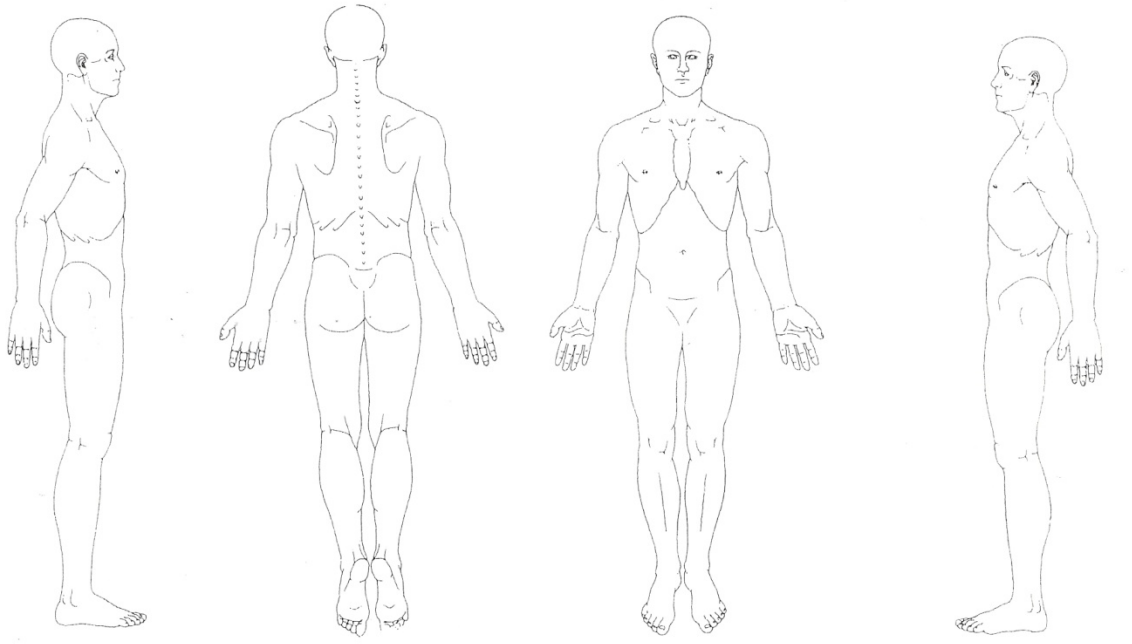
1 2 3 4 5 6 7 8 9 10

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

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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)

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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	

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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
- ❑ Other (describe)_____
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet

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_____

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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

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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?

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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?_____

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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_____

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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. Henderson, DC, CCSP

PATIENT SYMPTOM SURVEY

DATE_____

PATIENT'S NAME_____ AGE_____

WEIGHT_____ HEIGHT_____ BLOOD PRESSURE_____ PULSE_____ O2_____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time…

Primary Complaints

097 ☐ Abdominal Pain R10.9
005 ☐ ADD/ADHD F90.1/F90.9
144 ☐ ALS (Lou Gehrig's Disease) G12.21
012 ☐ Anemia D64.9
013 ☐ Arthritic Disorder M12.9
181 ☐ Brain Aneurysm I61.9
094 ☐ Breast Cancer (male) C50.929
053 ☐ Cataracts H26.9
036 ☐ Circulatory Disorder I99.9
088 ☐ Crohn's disease K50.90
091 ☐ Desires Nutritional and Metabolic Analysis
050 ☐ Ear Infection H65.90
016 ☐ Emphysema J43.9
056 ☐ Fever R50.9
090 ☐ General Good Health
171 ☐ Goiter E04.9
061 ☐ Hearing Loss H91.90
065 ☐ Hepatitis K71.6
087 ☐ HIV Infection B20
029 ☐ Hyperglycemia (high blood sugar) R73.09
148 ☐ Hypocholesterolemia (Low Cholesterol) E78.6
070 ☐ Hypothyroid E03.9
062 ☐ Infertility, male N46.9
074 ☐ Irregular Menstrual Cycle N92.6
023 ☐ Leukemia w/o remission C95.90
040 ☐ Low blood pressure I95.9
142 ☐ Lupus, non-systemic L93.0
722 ☐ Malaise
077 ☐ Mental Disorder F99
079 ☐ Mouth/Throat/Tongue
726 ☐ Myopia
729 ☐ Nephrolithiasis (Kidney Stones)
085 ☐ Obesity E66.9
014 ☐ Osteoporosis M81.0
732 ☐ Pain in Limbs
145 ☐ Polymyalgia Rheumatica M35.3

098 ☐ Abdominal Gas/Bloating R14.0
006 ☐ Allergies (unspecified) J30.9
009 ☐ Alzheimer's G30.9
027 ☐ Anxiety Disorder F41.9
015 ☐ Asthma J45.909
025 ☐ Brain Tumor, malignant C71.9
017 ☐ Cancer
026 ☐ Cervical Cancer C53.9
021 ☐ Colon/Rectal Cancer C18.9
092 ☐ Currently Pregnant Z33.1
047 ☐ Diabetes Mellitus E11.9
034 ☐ Eczema L25.9
051 ☐ Epstein Barr B27.90
057 ☐ Fibromyalgia M79.7
086 ☐ GERD K21.9
059 ☐ Gout M10.9
037 ☐ Heart Disease I51.9
066 ☐ Hepatitis B B16.9
076 ☐ Hot flashes N95.1
720 ☐ Hypertension (High Blood Pressure) I10
048 ☐ Hypoglycemia (low blood sugar) E16.2
044 ☐ Indigestion K30
078 ☐ Insomnia G47.00
089 ☐ Irritable Bowel Syndrome K58.9
095 ☐ Leukemia w/ remission C95.91
020 ☐ Lung Cancer C34.90
024 ☐ Lymphoma, malignant C85.89
075 ☐ Menopausal Symptoms N95.1
140 ☐ Migraines G43.909
143 ☐ Multiple Sclerosis G35
727 ☐ Nasal Polyp
095 ☐ Nosebleed
730 ☐ Orgasm, poor/infrequent
026 ☐ Other Cancers
733 ☐ Painful Urination
010 ☐ Poor Concentration/Memory F07.8

002 ☐ Acne L70.8
007 ☐ Allergic Rhinitis from food J30.5
099 ☐ Amenorrhea M91.2
028 ☐ Autism F84.0
096 ☐ Bladder Disorder N32.9
018 ☐ Breast Cancer (female) C50.919
080 ☐ Canker Sores K12.0
035 ☐ Chronic Fatigue R53.82
043 ☐ Constipation K59.00
046 ☐ Depression F32.9
049 ☐ Dizziness/Balance problems R42
033 ☐ Edema R60.9
052 ☐ Eye Problems H57.13
058 ☐ Gallbladder Disorder K82.9
054 ☐ Glaucoma H40.9
060 ☐ Headaches R51
179 ☐ Hemochromatosis E83.119
067 ☐ Hepatitis C B17.10
038 ☐ Hypercholesterolemia (High Cholesterol) E78.0
069 ☐ Hyperthyroid E05.90
721 ☐ Hypotension (Low Blood Pressure) I95.9
072 ☐ Infertility, Female N97.9
073 ☐ Interstitial Cystitis N30.11
068 ☐ Kidney Disorder N28.9
064 ☐ Liver Disease K76.9
071 ☐ Lupus, systemic M32.10
055 ☐ Macular Degeneration H35.30
723 ☐ Menorrhagia
724 ☐ Motion Sickness
725 ☐ Myalgia
728 ☐ Nephritis
042 ☐ Numbness/Paresthesia R20.9
731 ☐ Osteoarthritis
081 ☐ Overweight E66.3
011 ☐ Parkinson's Disease G20
181 ☐ Post stroke/brain aneurysm

613 ☐ Premenstrual Syndrome
735 ☐ Prostate Cancer - screening
178 ☐ Raynaud's syndrome I73.00
737 ☐ Salivary Secretions
083 ☐ Sexual Disorder F66
008 ☐ Sinusitis J01.90
94 ☐ Skin Rash
084 ☐ Spinal Problems M53.9
742 ☐ Stress Incontinence, male
041 ☐ Tachycardia (High Heart Rate) R00.0
745 ☐ Thoracicalgia

030 ☐ Type 1 Diabetes E10.9
082 ☐ Underweight R63.6
004 ☐ Urticaria (Hives) L50.9
098 ☐ Variscosities
099 ☐ Wheezing

734 ☐ Presbyopia
063 ☐ Prostate Disorder N42.9
736 ☐ Rheumatism
146 ☐ Scleroderma M34.9
739 ☐ Shortness of Breath
022 ☐ Skin Cancer C44.90
096 ☐ Sneezing
463 ☐ Stammering/Stuttering
097 ☐ Swollen Joints
744 ☐ Tender Breasts

746 ☐ Toothache

031 ☐ Type 2 Diabetes E11.65
748 ☐ Urethra Discharge
750 ☐ Vaginal Discharge
752 ☐ Vertigo

019 ☐ Prostate Cancer C61
003 ☐ Psoriasis L40.8
141 ☐ Rheumatoid Arthritis M06.9
738 ☐ Scoliosis
093 ☐ Shingles B02.9
001 ☐ Skin Disorder L25.9
740 ☐ Sore Throat
741 ☐ Stress Incontinence, female
743 ☐ Syncope
180 ☐ Thalassemia D56.8

747 ☐ Tympanic Membrane (Ear Ache)

045 ☐ Ulcerative Colitis K51.90
749 ☐ Urinary Frequency
751 ☐ Vaginal Yeast Infection
753 ☐ Viral Warts

If necessary, please state your most significant concern…

General Health

226 ☐ Breast Cancer - Screening
100 ☐ Base of fingernails are pink
111 ☐ Brittle hair
118 ☐ Currently on Radiation treatments
116 ☐ Drinks less than 8 glasses of water per day
756 ☐ Energy level is the same as it was 5 years ago
103 ☐ Fingernails are soft
121 ☐ Gained over 20 lbs within in the last 12 months
758 ☐ Has had Chemotherapy within the last 3 months
130 ☐ Had Blood Transfusion in the Past
148 ☐ Is overweight

106 ☐ Pale fingernail beds
129 ☐ Sensitive to chemicals, paint, exhaust fumes, cologne
123 ☐ Somewhat Underweight

187 ☐ Family history of Alcoholism
186 ☐ Family history of Diabetes
149 ☐ Had Chemotherapy in the last year
175 ☐ Has been out of the country recently
183 ☐ Has had a Hepatitis vaccine within the last 2 years
139 ☐ Toxic Chemical Exposure

138 ☐ Anti Rejection Drugs
101 ☐ Base of fingernails are purple
219 ☐ Breast Cancer - History
109 ☐ Difficulty walking

112 ☐ Dry hair

125 ☐ Energy level is worse than it was 5 years ago
104 ☐ Fingernails are splitting
114 ☐ Hair loss

120 ☐ Has had Radiation treatments in the past
131 ☐ Had Transplant in the Past

754 ☐ Is underweight

757 ☐ Pink fingernail beds
127 ☐ Sleeps less than 6 hours per night
113 ☐ Thin hair

184 ☐ Family history of Cancer
185 ☐ Family history of Heart Disease
176 ☐ Had childhood vaccinations

177 ☐ Has been vaccinated in the last 12 months
182 ☐ Has had a pneumonia vaccine in the last year

108 ☐ Balance Problems
107 ☐ Blacks out easily
117 ☐ Currently on Chemotherapy
115 ☐ Drinks alcoholic beverage(s) every day

755 ☐ Energy level is better than it was 5 years ago
102 ☐ Fingernails have ridges or white spots
105 ☐ Fingernails peel
119 ☐ Has had Chemotherapy in the past
132 ☐ Had a major accident or injury

110 ☐ Has tattoos

124 ☐ Lost over 20 lbs within the last 4 months
126 ☐ Rarely exercises
122 ☐ Somewhat Overweight

128 ☐ Unable to recall dreams the next day

188 ☐ Family history of Depression
189 ☐ Family history of Obesity
148 ☐ Had Radiation therapy in the last year
147 ☐ Has had a flu shot in the last year
137 ☐ Sleep Apnea

Allergies

206 ☐ Dairy
207 ☐ Eggs
208 ☐ Garlic
209 ☐ Gluten
210 ☐ Mold
211 ☐ Peanut
212 ☐ Ragweed
213 ☐ Shellfish
214 ☐ Soy
215 ☐ Sulfa Drugs
216 ☐ Tree Nuts
217 ☐ Wheat
218 ☐ Other allergies

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
170 ☐ Brain Fog
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
165 ☐ Poor memory
162 ☐ Recurrent bad dreams
166 ☐ Scared to be alone
163 ☐ Sometimes wishes to be dead or away from it all
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when others are happy
164 ☐ Upset by criticism

Cardiovascular

197 ☐ At Times Low Blood Pressure
190 ☐ Cold feet
191 ☐ Cold hands
192 ☐ Experiences shortness of breath while sitting still
199 ☐ Frequent swollen ankles
193 ☐ Heart skips beats
205 ☐ Heart palpitations
039 ☐ High blood pressure
195 ☐ Leg cramps during bedtime
196 ☐ Leg cramps during daytime
198 ☐ Pain in leg/hips when walking
200 ☐ Pains in the heart or chest
201 ☐ Spells of rapid heart rate
194 ☐ Tendency of High Blood Pressure
202 ☐ Troubled with blood clots
203 ☐ Unusually slow heart rate (Bradycardia)
204 ☐ Varicose veins

Ears

220 ☐ Discharge from ears
221 ☐ Hard of hearing
222 ☐ Punctured ear drum
223 ☐ Recurrent ear infections
224 ☐ Ringing or noises in the ears
225 ☐ Tinnitus

Endocrine

245 ☐ Coarse hair
246 ☐ Coarse skin
247 ☐ Diabetic
248 ☐ Excessive thirst
249 ☐ Frequently feels cold
250 ☐ Frequently feels hot
251 ☐ Gets lightheaded when standing quickly
252 ☐ Heals slowly
255 ☐ Swollen Lymph glands
253 ☐ Unusually jumpy or nervous
254 ☐ Unusually tired most of the time

Eyes

320 ☐ Bloodshot eyes
321 ☐ Blurred Vision
322 ☐ Cross eyes
332 ☐ Dry Eyes
323 ☐ Eye pain
324 ☐ Eyes feel gritty
325 ☐ Eyes water
327 ☐ Far sighted
759 ☐ Has or has had cataracts
330 ☐ Itchy eyes
328 ☐ Mild Cataracts
326 ☐ Mild Glaucoma
329 ☐ Mild Macular Degeneration
331 ☐ Near sighted

Feet

350 ☐ Corns
351 ☐ Frequent foot cramps
357 ☐ Fungal Infection
352 ☐ Heel spurs
353 ☐ Painful feet
356 ☐ Plantar Fascitis
354 ☐ Plantar warts
355 ☐ Swelling in the feet and/or ankles

Gastrointestinal

- 266 ☐ 3 or less bowel movements per week
- 265 ☐ 4-5 bowel movements per week
- 267 ☐ 6 or more bowel movements per week
- 277 ☐ Abdominal gas
- 278 ☐ Belching and burping after eating
- 268 ☐ Black tarry stools
- 279 ☐ Bloated after eating
- 270 ☐ Bloody Stools
- 287 ☐ Difficulty swallowing
- 300 ☐ Diverticulitis
- 301 ☐ Diverticulosis
- 288 ☐ Eating relieves fatigue
- 289 ☐ Eats when nervous
- 290 ☐ Excessive hunger
- 292 ☐ Experiences fainting spells when hungry
- 293 ☐ Feels shaky when hungry
- 274 ☐ Frequent diarrhea
- 275 ☐ Frequent nausea
- 276 ☐ Frequent vomitting
- 294 ☐ Frequently drowsy after eating a meal
- 295 ☐ Gall bladder disease
- 302 ☐ Greasy foods cause indigestion
- 760 ☐ Has constipation
- 296 ☐ Has had intestinal worms
- 272 ☐ Hemorrhoids (piles)
- 284 ☐ Immediate indigestion upon eating
- 285 ☐ Indigestion in 2 hours or more after meals
- 286 ☐ Indigestion within 1 hour after meals
- 299 ☐ Irritable Bowel
- 298 ☐ Liver disease
- 273 ☐ Loose bowel movements
- 269 ☐ Pale or yellow colored stool
- 291 ☐ Poor appetite
- 297 ☐ Reflux/Hiatal Hernia
- 280 ☐ Severe abdominal pains
- 281 ☐ Stomach ulcers
- 271 ☐ Tends to constipation
- 282 ☐ Uses digestive aids
- 283 ☐ Uses laxatives

Lifestyle Habits

- 389 ☐ Anorexia R63.0
- 390 ☐ Bulemia
- 391 ☐ Craves Sugars/starches
- 382 ☐ Currently smokes
- 370 ☐ Drinks alcohol
- 371 ☐ Drinks caffeinated coffee
- 372 ☐ Drinks caffeinated pop/soda
- 373 ☐ Drinks caffeinated tea
- 375 ☐ Drinks Decaffeinate Pop/Soda
- 392 ☐ Drinks coffee
- 374 ☐ Drinks decaffeinated coffee
- 376 ☐ Drinks decaffeinated tea
- 388 ☐ Drinks diet pop/soda
- 377 ☐ Drinks more than 3 cups of coffee per day
- 378 ☐ Drinks more than 3 cups of tea per day
- 379 ☐ Drinks 1 or more pop/sodas per day
- 380 ☐ Drinks beverages from a can
- 393 ☐ Drinks tea
- 136 ☐ Eats no meat, no dairy
- 135 ☐ Eats no red meat
- 387 ☐ Frequent use of Artificial Sweeteners
- 174 ☐ Had 4 alcoholic drinks in one day less than 3 months ago
- 173 ☐ Had 4 alcoholic drinks in one day more than 3 months ago
- 381 ☐ Has more than 5 alcoholic drinks per week
- 172 ☐ Never had 4 alcoholic drinks in one day
- 383 ☐ Quit smoking in the last 5 years
- 133 ☐ Regularly exercises
- 384 ☐ Smoked for more than 5 years
- 385 ☐ Smokes more than 1 pack per day
- 386 ☐ Takes vitamins
- 134 ☐ Vegetarian
- 340 ☐ Home has well water
- 341 ☐ Home has city water
- 342 ☐ Home water is filtered
- 343 ☐ Home pipes are steel
- 344 ☐ Home pipes are PVC
- 345 ☐ Home pipes are copper
- 346 ☐ Home pipes are PEX
- 347 ☐ Home built prior to 1978
- 348 ☐ Home renovations within the last year
- 349 ☐ Uses chlorine bleach or other heavy duty chemicals
- 360 ☐ Has worked in plumbing, automotive or metallurgic industry
- 361 ☐ Has worked around industrial solvents, chemicals or pesticides

Mouth and Throat

- 418 ☐ Amalgam dental fillings
- 400 ☐ Bad breath
- 401 ☐ Bitter taste in the mouth in the morning
- 420 ☐ Dental Fillings (gold, composite etc.)
- 402 ☐ Dry mouth
- 403 ☐ Excessive saliva
- 406 ☐ Frequent canker sores
- 407 ☐ Frequent fever blisters
- 408 ☐ Frequent sore throats
- 409 ☐ Frequently has a sore tongue
- 405 ☐ Glands often swell
- 416 ☐ Gums bleed when brushing teeth

419 ☐ Have had root canals
404 ☐ Sores or cracks in the corners of the mouth
413 ☐ Tongue burns
417 ☐ Toothaches
420 ☐ Other dental fillings
411 ☐ Swollen gums
414 ☐ Tongue has grooves or fissures
410 ☐ Sore gums
412 ☐ Swollen tongue
415 ☐ Tongue is coated

Neuromuscular

440 ☐ Bites nails
447 ☐ Frequently feels faint
450 ☐ Has Osteoarthritis
455 ☐ Leg pain at rest
443 ☐ Muscle weakness
461 ☐ Numbness/tingling in the body
452 ☐ Rheumatoid Arthritis
456 ☐ Spinal curvature
444 ☐ Tremors/Shakes
445 ☐ Frequent headaches
448 ☐ Has Epilepsy
451 ☐ Has Rheumatism
457 ☐ Low back pain
458 ☐ Neck pain
446 ☐ Often dizzy
460 ☐ Shoulder/arm pain
761 ☐ Stutters or stammers
441 ☐ Frequent muscle soreness
449 ☐ Has Motion Sickness
453 ☐ Joint stiffness in the morning
442 ☐ Muscle spasms
464 ☐ Nerve Pain
459 ☐ Pain between the shoulders
462 ☐ Sleep walks
454 ☐ Swollen joints

Respiratory

485 ☐ Catches severe colds
488 ☐ Constant runny nose
491 ☐ Frequent colds
494 ☐ Frequent stuffy nose
496 ☐ Nasal polyps
500 ☐ Spits up blood
486 ☐ Chronic chest condition
489 ☐ COPD
492 ☐ Frequent nose bleeds
503 ☐ Has asthma
498 ☐ Post nasal drip
501 ☐ Spits up phlegm
487 ☐ Chronic cough
490 ☐ Difficulty breathing
493 ☐ Frequent sinus infections
495 ☐ Hay fever
499 ☐ Sneezing spells
502 ☐ Wheezes

Women Only

497 ☐ Night sweats
616 ☐ Acne worse at menstruation
647 ☐ Breast Fibroids
648 ☐ Currently breastfeeding
643 ☐ D & C
617 ☐ Excessive menstrual flow
621 ☐ Has taken birth control medication for more than one year
637 ☐ Herpes infection
609 ☐ Mastitis
646 ☐ Ovarian Fibroids
629 ☐ Poor or infrequent orgasm
638 ☐ Sexual diseases
644 ☐ Tubal Pregnancy
762 ☐ Vagina dryness
612 ☐ Abnormal cycle >29 days and/or <26 days
634 ☐ Bloody spotting discharge
707 ☐ Breast Implants
620 ☐ Currently taking birth control medication
627 ☐ Diminished sexual desire
636 ☐ External genital sores
622 ☐ Has taken birth control medication within the last year
632 ☐ Hysterectomy
614 ☐ Menstrual cramps
628 ☐ Painful intercourse
619 ☐ Pre-menstrual depression
625 ☐ Takes hormone replacement medication
645 ☐ Uterine Fibroids
635 ☐ Yeast infections
642 ☐ Abortion
641 ☐ Breast Augmentation
640 ☐ Breast Reduction
611 ☐ Cycles are every 27-29 days
639 ☐ Endometriosis
623 ☐ Has had miscarriage
610 ☐ Heavy hair growth on face or body
630 ☐ Lumps in the breasts
624 ☐ Mild to Moderate Hot Flashes
615 ☐ Painful periods
618 ☐ Retains fluid during periods
631 ☐ Tender breasts
633 ☐ Vaginal discharge

Skin

534 ☐ Dry Skin
522 ☐ Frequent goose bumps
524 ☐ Has Psoriasis
527 ☐ Problems with Eczema
531 ☐ Skin is tender
520 ☐ Bruises easily
523 ☐ Has Acne
525 ☐ Hives
529 ☐ Skin eruptions
532 ☐ Sores that heal slowly
521 ☐ Excessive perspiration
528 ☐ Has moles which are changing in size and/or color
526 ☐ Itchy skin
530 ☐ Skin is rough, especially on the back of the arms
533 ☐ Troubled with boils

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
560 ☐ Frequent urination
562 ☐ Incontinence when sneezing or laughing
566 ☐ Kidney stones
563 ☐ Loses bladder control
559 ☐ Painful urination
561 ☐ Troubled by urgent urination

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
594 ☐ Herpes
584 ☐ Inflammation of Testis
596 ☐ Low sex drive
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
595 ☐ Sexual Diseases
593 ☐ Sores on external genitalia

Surgeries

701 ☐ Appendix removed
718 ☐ Bariatric/Weight loss surgery
708 ☐ Cancer surgery
716 ☐ Cataract Surgery
709 ☐ Coronary Bypass
711 ☐ Extremity Surgery
702 ☐ Gallbladder removed
717 ☐ Hemorrhoid Surgery
712 ☐ Hip Replacement
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
713 ☐ Knee Replacement
715 ☐ Radiated Thyroid
710 ☐ Spinal Surgery
714 ☐ Spleen Removed (Splenectomy)
703 ☐ Thyroid removed
700 ☐ Tonsils and/or Adenoids removed
706 ☐ Tubal Ligation (fallopian tubes tied)

Medications

Please list all drugs you are currently taking on a daily basis.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	***BRAND***	***DOSAGE***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may have to disclose your health information to Science Based Nutrition™ to obtain test results and reports.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.

I authorize Brentwood Functional Medicine to contact me with information related to my personal health needs and interests. The physician's office may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative treatments, presentations or events
- Other health related information that may be of interest to me

To contact me, I authorize Brentwood Functional Medicine to use and disclose the following information:

- My Name, Address, Email and Phone Numbers
- The Name of my Physician and the Clinic where I was treated

NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.

Patient Name: Date of Birth:
(PLEASE PRINT)

Address of Patient: Phone:
(STREET)

Email:

(CITY, STATE, ZIP CODE)

Brentwood Functional Medicine fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA, this authorization allows us to access only the above authorized information for contact purposes.

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing Brentwood Functional Medicine, 785 Old Hickory Blvd STE 200 Brentwood, TN 37027. In this case, every effort will be made to discontinue future communications.

Signature (PATIENT OR PERSON AUTHORIZED) Date