# Dr. Henderson, DC, CCSP

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Brentwood Functional Medicine

**Dr. Henderson, DC, CCSP**
**785 Old Hickory Blvd. STE 200**
**Brentwood, TN 37027**
**Phone: 615-371-1091 ext 13**

# 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) | | |

| 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____

## 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 | | | | | | | | | |


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# 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.______________________

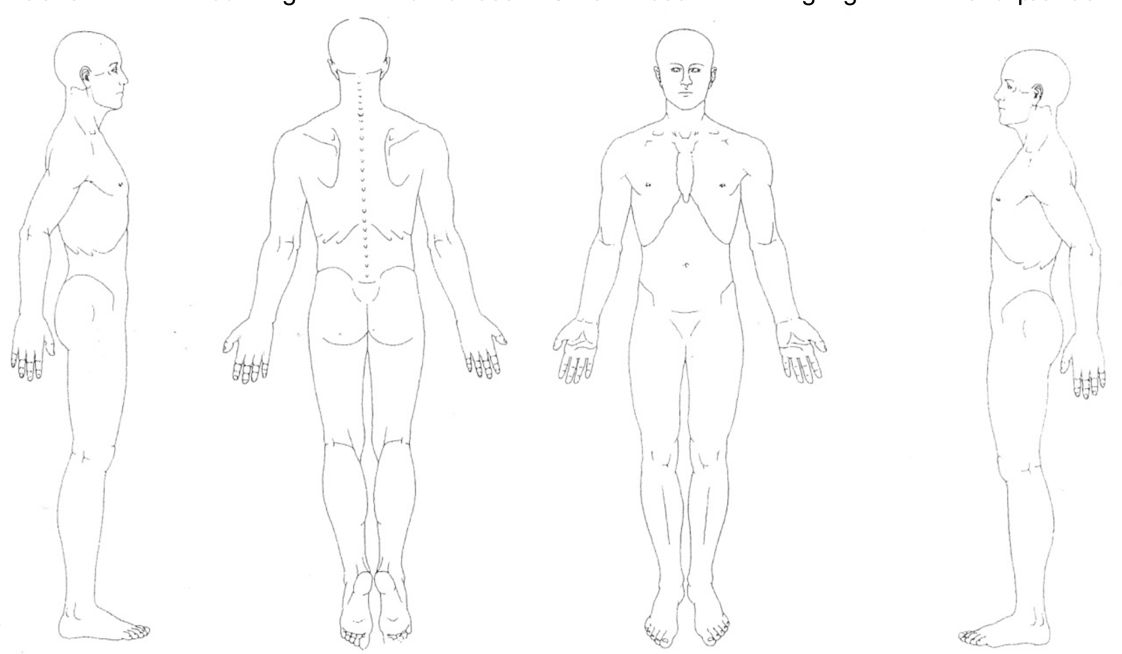
1 2 3 4 5 6 7 8 9 10

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 | |

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:

| Type of exercise | Times/week | | | | Length of session | | | |
|---|---|---|---|---|---|---|---|---|
| | 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 ❑ Famil y ❑ 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. 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 | 098 | Abdominal Gas/Bloating R14.0 | 002 | Acne L70.8 |
| 005 | ADD/ADHD F90.1/F90.9 | 006 | Allergies (unspecified) J30.9 | 007 | Allergic Rhinitis from food J30.5 |
| 144 | ALS (Lou Gehrig's Disease) G12.21 | 009 | Alzheimer's G30.9 | 099 | Amenorrhea M91.2 |
| 012 | Anemia D64.9 | 027 | Anxiety Disorder F41.9 | 028 | Autism F84.0 |
| 013 | Arthritic Disorder M12.9 | 015 | Asthma J45.909 | 096 | Bladder Disorder N32.9 |
| 181 | Brain Aneurysm I61.9 | 025 | Brain Tumor, malignant C71.9 | 018 | Breast Cancer (female) C50.919 |
| 094 | Breast Cancer (male) C50.929 | 017 | Cancer | 080 | Canker Sores K12.0 |
| 053 | Cataracts H26.9 | 026 | Cervical Cancer C53.9 | 035 | Chronic Fatigue R53.82 |
| 036 | Circulatory Disorder I99.9 | 021 | Colon/Rectal Cancer C18.9 | 043 | Constipation K59.00 |
| 088 | Crohn's disease K50.90 | 092 | Currently Pregnant Z33.1 | 046 | Depression F32.9 |
| 091 | Desires Nutritional and Metabolic Analysis | 047 | Diabetes Mellitus E11.9 | 049 | Dizziness/Balance problems R42 |
| 050 | Ear Infection H65.90 | 034 | Eczema L25.9 | 033 | Edema R60.9 |
| 016 | Emphysema J43.9 | 051 | Epstein Barr B27.90 | 052 | Eye Problems H57.13 |
| 056 | Fever R50.9 | 057 | Fibromyalgia M79.7 | 058 | Gallbladder Disorder K82.9 |
| 090 | General Good Health | 086 | GERD K21.9 | 054 | Glaucoma H40.9 |
| 171 | Goiter E04.9 | 059 | Gout M10.9 | 060 | Headaches R51 |
| 061 | Hearing Loss H91.90 | 037 | Heart Disease I51.9 | 179 | Hemochromatosis E83.119 |
| 065 | Hepatitis K71.6 | 066 | Hepatitis B B16.9 | 067 | Hepatitis C B17.10 |
| 087 | HIV Infection B20 | 076 | Hot flashes N95.1 | 038 | Hypercholesterolemia (High Cholesterol) E78.0 |
| 029 | Hyperglycemia (high blood sugar) R73.09 | 720 | Hypertension (High Blood Pressure) I10 | 069 | Hyperthyroid E05.90 |
| 148 | Hypocholesterolemia (Low Cholesterol) E78.6 | 048 | Hypoglycemia (low blood sugar) E16.2 | 721 | Hypotension (Low Blood Pressure) I95.9 |
| 070 | Hypothyroid E03.9 | 044 | Indigestion K30 | 072 | Infertility, Female N97.9 |
| 062 | Infertility, male N46.9 | 078 | Insomnia G47.00 | 073 | Interstitial Cystitis N30.11 |
| 074 | Irregular Menstrual Cycle N92.6 | 089 | Irritable Bowel Syndrome K58.9 | 068 | Kidney Disorder N28.9 |
| 023 | Leukemia w/o remission C95.90 | 095 | Leukemia w/ remission C95.91 | 064 | Liver Disease K76.9 |
| 040 | Low blood pressure I95.9 | 020 | Lung Cancer C34.90 | 071 | Lupus, systemic M32.10 |
| 142 | Lupus, non-systemic L93.0 | 024 | Lymphoma, malignant C85.89 | 055 | Macular Degeneration H35.30 |
| 722 | Malaise | 075 | Menopausal Symptoms N95.1 | 723 | Menorrhagia |
| 077 | Mental Disorder F99 | 140 | Migraines G43.909 | 724 | Motion Sickness |
| 079 | Mouth/Throat/Tongue | 143 | Multiple Sclerosis G35 | 725 | Myalgia |
| 726 | Myopia | 727 | Nasal Polyp | 728 | Nephritis |
| 729 | Nephrolithiasis (Kidney Stones) | 095 | Nosebleed | 042 | Numbness/Paresthesia R20.9 |
| 085 | Obesity E66.9 | 730 | Orgasm, poor/infrequent | 731 | Osteoarthritis |
| 014 | Osteoporosis M81.0 | 026 | Other Cancers | 081 | Overweight E66.3 |
| 732 | Pain in Limbs | 733 | Painful Urination | 011 | Parkinson's Disease G20 |
| 145 | Polymyalgia Rheumatica M35.3 | 010 | Poor Concentration/Memory F07.8 | 181 | Post stroke/brain aneurysm |

- 613 ☐ Premenstrual Syndrome
- 734 ☐ Presbyopia
- 019 ☐ Prostate Cancer C61
- 735 ☐ Prostate Cancer - screening
- 063 ☐ Prostate Disorder N42.9
- 003 ☐ Psoriasis L40.8
- 178 ☐ Raynaud's syndrome I73.00
- 736 ☐ Rheumatism
- 141 ☐ Rheumatoid Arthritis M06.9
- 737 ☐ Salivary Secretions
- 146 ☐ Scleroderma M34.9
- 738 ☐ Scoliosis
- 083 ☐ Sexual Disorder F66
- 739 ☐ Shortness of Breath
- 093 ☐ Shingles B02.9
- 008 ☐ Sinusitis J01.90
- 022 ☐ Skin Cancer C44.90
- 001 ☐ Skin Disorder L25.9
- 94 ☐ Skin Rash
- 096 ☐ Sneezing
- 740 ☐ Sore Throat
- 084 ☐ Spinal Problems M53.9
- 463 ☐ Stammering/Stuttering
- 741 ☐ Stress Incontinence, female
- 742 ☐ Stress Incontinence, male
- 097 ☐ Swollen Joints
- 743 ☐ Syncope
- 041 ☐ Tachycardia (High Heart Rate) R00.0
- 744 ☐ Tender Breasts
- 180 ☐ Thalassemia D56.8
- 745 ☐ Thoracicalgia
- 746 ☐ Toothache
- 747 ☐ Tympanic Membrane (Ear Ache)
- 030 ☐ Type 1 Diabetes E10.9
- 031 ☐ Type 2 Diabetes E11.65
- 045 ☐ Ulcerative Colitis K51.90
- 082 ☐ Underweight R63.6
- 748 ☐ Urethra Discharge
- 749 ☐ Urinary Frequency
- 004 ☐ Urticaria (Hives) L50.9
- 750 ☐ Vaginal Discharge
- 751 ☐ Vaginal Yeast Infection
- 098 ☐ Variscosities
- 752 ☐ Vertigo
- 753 ☐ Viral Warts
- 099 ☐ Wheezing

**If necessary, please state your most significant concern…**

______________________________

______________________________

## General Health

- 226 ☐ Breast Cancer - Screening
- 138 ☐ Anti Rejection Drugs
- 108 ☐ Balance Problems
- 100 ☐ Base of fingernails are pink
- 101 ☐ Base of fingernails are purple
- 107 ☐ Blacks out easily
- 111 ☐ Brittle hair
- 219 ☐ Breast Cancer - History
- 117 ☐ Currently on Chemotherapy
- 118 ☐ Currently on Radiation treatments
- 109 ☐ Difficulty walking
- 115 ☐ Drinks alcoholic beverage(s) every day
- 116 ☐ Drinks less than 8 glasses of water per day
- 112 ☐ Dry hair
- 755 ☐ Energy level is better than it was 5 years ago
- 756 ☐ Energy level is the same as it was 5 years ago
- 125 ☐ Energy level is worse than it was 5 years ago
- 102 ☐ Fingernails have ridges or white spots
- 103 ☐ Fingernails are soft
- 104 ☐ Fingernails are splitting
- 105 ☐ Fingernails peel
- 121 ☐ Gained over 20 lbs within in the last 12 months
- 114 ☐ Hair loss
- 119 ☐ Has had Chemotherapy in the past
- 758 ☐ Has had Chemotherapy within the last 3 months
- 120 ☐ Has had Radiation treatments in the past
- 132 ☐ Had a major accident or injury
- 130 ☐ Had Blood Transfusion in the Past
- 131 ☐ Had Transplant in the Past
- 110 ☐ Has tattoos
- 148 ☐ Is overweight
- 754 ☐ Is underweight
- 124 ☐ Lost over 20 lbs within the last 4 months
- 106 ☐ Pale fingernail beds
- 757 ☐ Pink fingernail beds
- 126 ☐ Rarely exercises
- 129 ☐ Sensitive to chemicals, paint, exhaust fumes, cologne
- 127 ☐ Sleeps less than 6 hours per night
- 122 ☐ Somewhat Overweight
- 123 ☐ Somewhat Underweight
- 113 ☐ Thin hair
- 128 ☐ Unable to recall dreams the next day
- 187 ☐ Family history of Alcoholism
- 184 ☐ Family history of Cancer
- 188 ☐ Family history of Depression
- 186 ☐ Family history of Diabetes
- 185 ☐ Family history of Heart Disease
- 189 ☐ Family history of Obesity
- 149 ☐ Had Chemotherapy in the last year
- 176 ☐ Had childhood vaccinations
- 148 ☐ Had Radiation therapy in the last year
- 175 ☐ Has been out of the country recently
- 177 ☐ Has been vaccinated in the last 12 months
- 147 ☐ Has had a flu shot in the last year
- 183 ☐ Has had a Hepatitis vaccine within the last 2 years
- 182 ☐ Has had a pneumonia vaccine in the last year
- 137 ☐ Sleep Apnea
- 139 ☐ Toxic Chemical Exposure

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

## Neuromuscular

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

## Respiratory

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

## Women Only

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

## Skin

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

***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*** |
|---|---|---|
| | | |
| | | |
| | | |
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# 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 voicemail 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: (PLEASE PRINT) Date of Birth:

Address of Patient: (STREET) Phone:

(CITY, STATE, ZIP CODE) Email:

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