Rashel Tahzib DO
Advance Health Integrative Medicine
10365 E Crestridge Ln
Englewood CO, 80111
Tel(310)979-3434
Fax (310)907-5193

FUNCTIONAL MEDICINE HEALTH ASSESSMENT & INTAKE FORMS

Please ensure that these forms are **completely** filled out ***PRIOR*** to your scheduled appointment.

Welcome to Advance Health Integrative Medicine

Dear Patient

Welcome to Advance Health Integrative Medicine. I am honored to partner with you in the restoration and protection of your health and well-being.

My practice is an Integrative, Contemporary and Functional Medical Practice, with great focus on addressing the underlying root causes of disease and dysfunction in my patients. We will do our best to remove the problems found, the triggers and mediators of the disease process and support your body's natural ability to heal by replacing deficiencies and optimizing bodily functions. I call this process Advancing Health.

I have personally experienced the transformative power of Functional Medicine when I was faced with a rare autoimmune illness that was triggered by environmental factors. Witnessing first hand the power of Functional Medicine that provided answers where conventional medicine had none and rather fueled the disease process, I was fortunate to be led back on the path that led me back to wellness and optimal health.

With each individual patient there is a unique customized work up. I work with over 15 specialty laboratories to conduct investigational testing based on your unique needs when needed including advanced hormonal, nutrient, metabolic, immune, toxin, genetic, and cardiovascular testing.

Together we are a team and your improvement in health, vitality and well-being will be in direct proportion to the extent to which

you are fully engaged in, committed to, and compliant with this path.

To comprehensively assess your health and gather and organize necessary information we ask that you complete the thorough intake questionnaire as soon as possible even before your visit.

I look forward to partnering with you on your journey to optima health and well- being.

In Wellness
Rashel Tahzib DO AOBFP IFMCP

Understanding Our Stand for Your Health

Consent of Treatment

I ______________________________ seek the health improvement, restoration, protection services of Dr. Rashel J Tahzib and staff the philosophy of care which underlies the practice as follows:

———1. Health improvement and protection is best achieved in partnership between the patient and practitioner and staff. Trust, caring, mutual respect and understanding in a healing environment are essential to partnership.

———2. Health Improvement and protection focuses on enhancing **all dimensions of health** and respecting the the **interconnectedness of symptoms** in the body -the physical, emotional, mental, and spiritual rather than focusing on isolated symptoms in the body alone.

———3. A person's **Lifestyle,** including his or her diet, exercise patterns, sleep habits, stressors, interpersonal relationships**,** are directly related to the development and maintenance of health. I strive to evaluate these factors and seek to help my patients understand and embrace positive behaviors regardless of age or type of medical problem.

———4. I seek to use what is **Wise and what Works** for the benefit of my patients. This includes all modalities that are safe tolerable, and effective. I feel that the practice of medicine must be focused upon the PATIENT and strive to practice patient centered medicine vs disease centered medicine.

———5. Although prescription drugs as well as over the counter medications are used when the provider feels they are necessary, an attempt is first made to use products that are natural and or bio-identical to the body with **primary focus on health** production rather than disease treatment. These include targeted nutraceuticals, vitamins, minerals, enzymes, amino acids, essential fatty acids, herbs and bio- identical hormones.

According to the Federal Food, Drug, and Cosmetic Act as amended Section 201(g) (1) the term drug is defined as an article intended for use in diagnosis, cure, mitigation, treatment, or prevention of disease. " Technically vitamins, minerals, trace elements, amino acids, and herbs are not defined as drugs. However these substances can have significant effects on physiology and must be used rationally. In this practice nutritional counseling is provided and individualized recommendations are made regarding the use

of these substances in order to upgrade the quality of foods in the patient's diet and to supply nutrition to support

the physiological and biochemical processes of the human body. Although these products may be suggested with a therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of many nutritional supplements may be recommended for patients already using pharmaceutical drugs but some potentially harmful interactions may occur. For this reason it is important to keep all your healthcare providers fully informed about all medications and nutritional supplements, herbs, and or hormones you may be taking.

———6. In addition to recommending that a patient take nutritional supplements by mouth we may recommend that a patient receive a series of injections either intramuscularly, subcutaneously, or intravenously. Some of the reasons for recommending these procedures include:

a. The assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorption or digestive problems.

b. To achieve a concentration of the substance in the bloodstream that may be difficult to achieve if the substance is taken by mouth.

Additionally, it is important to understand these business aspects of Advance Health Integrative Medicine so that you can utilize it's services most effectively:

Sale of Nutritional Supplements:
As a service to you we make nutritional supplements available

through the practice. These are hand picked formulated products that have gained my confidence through considerable research and experience. The quality of the recommended supplements is determined by evaluating (1) The quality of the science and research behind the products (2) the quality of the ingredients (3) the quality of the manufacturing process (4) the synergism among the product components (5) the predictability of the results achieved by using the products (6) our clinical experience and clinical success with using the recommended products. The products recommended by the practice are those that meet our very high standards and produce predictable results.

Being that there is no FDA regulation on nutritional supplements and their quality, purity, actual ingredients or efficacy making these products available to you assures that you are getting the qualities outlined above rather than counterfeit products or products filled with fillers, impure ingredients, high amounts of toxins and impurities, that do not include active ingredients nor a concentration of an ingredient that can potentially be beneficial despite marketing schemes and advertisements.

The value of our recommended products includes your assurance of the products purity, quality, bioavailability (ability to be properly absorbed and utilized by the body) and likely effectiveness. One of the main reasons we make these products available is to ensure quality for favorable clinical results.

Purchasing supplements from the general market place, online, grocery stores, pharmacies you are not guaranteed quality, efficacy, purity or effectiveness due to the lack of stringent testing require-

ments for dietary supplements.
That being said you are not obligated to purchase supplements through our practice but are highly suggested to do so.

_____If you purchase supplements from the general market place we do not guarantee or expect clinical improvement at the same level or any level and note that there may be lack of improvement and lack of improvement of blood levels and deficiencies.

Information Regarding Insurance
_____Dr Rashel does not restrict her recommendations to the standard approach that is accepted by insurance carriers. Rather we seek to match treatment and wellness options with your unique health needs and goals regardless of wether insurance companies endorse these options for your health. Thus we do not accept insurance for Functional medicine anti-aging and contemporary medicine services as insurance companies do not pay for these services.

Information Regarding Primary Care Physician
_____Please note that Rashel Tahzib DO is not your primary care physician. It is recommended that you have a primary care physician. Dr. Rashel Tahzib does not provide primary care services. We will work with you closely as a consultant in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. We will confer with your primary care doctor and specialist physicians if required.

Understanding the above, I agree to the following noted by my initials and signature.
________ I agree that if I ever have a claim with respect to the services of Dr. Rashel J Tahzib DO Inc., its affiliates and or staff that

they shall be judged by the standards and principles of Complementary, and Functional Medicine and not by the standards of conventional medicine and that if such a claim should arise it will be addressed by arbitration only and not by court.

Signature:
____
Date:___________________ Printed Name
____

Prescription Dispensing Disclosure

Our practice offers as a service to our patients dispensing of some prescribed medications. Please note that you have a choice between obtaining the prescription from our office or have us provide you with a prescription that can be filled at the pharmacy of your choice.

AHIM Practice Policies and Office Policy Agreement

Phone calls, messages, faxes:

Business office hours are Mon-Fri 9am-4:30pm
To reach us by phone call 310-979-3434
Our fax is 310-907-5193
If you reach a recording we are busy attending to the needs of our patients please leave a clear message and we will return your call within one business day.

If you have an emergency call 911 and or go directly to the nearest emergency room. When leaving a message please leave the follow-

ing information:
Full name
Reason for call
Phone numbers you can be reached and email

It is important to read all of the enclosed information carefully and to complete, scan & email, mail, fax your intake forms at your earliest convenience.

Functional Medicine Appointments

_____There is a 72hour/ 3 business day cancellation policy (please see the CANCELLATION AND RESCHEDULING OF APPOINTMENTS section in this form).

Functional Medicine Appointment Fees
Initial Functional Medicine Consultation 60min is $695
Initial Functional Medicine Follow up Consultation 60min is $695.
Subsequent Follow ups 45 min $475
Functional Wellness Assessment 50min $525
Functional Wellness Follow Up 30min $375
Routine Follow up Concise for established patients 25 min $375
Phone Chat Supplement Review 15 min $85
*Appointment pricing is subject to change.

Laboratory Testing

——Laboratory tests as well as functional tests are usually recommended during your appointment.

PLEASE CALL YOUR INSURANCE CARRIER PRIOR TO YOUR APPOINTMENT TO KNOW WHAT YOUR COVERAGE IS. If you choose to run your recommended labs through your insurance, Advance Health Integrative Medicine is not responsible for any bills you receive from the laboratory. Some labs that involve stool, urine or saliva samples are done at home. You will be given all lab kits and step-by-step instructions for at-home tests at the time of your consult. All lab results will be reviewed with you at the time of your follow up appointment.

We do not email lab results to patients. The exception to this is if you have a follow up appointment by phone – we will email you your lab results prior to your appointment for your review.

Insurance Information

_____You will receive an invoice at the completion of your visit that you may submit to your insurance for reimbursement.
Payment for the office visit, phone consultation, or lab tests is expected at time of service.

All credit card payment will be processed the same day of the visit, or phone call. If test kits or supplements are sent to you, you will be charged the day they are mailed.
Advance health Integrative Medicine does not accept insurance for Functional Medicine and Anti-Aging medicine Services; however, if you wish you can submit your patient statement to your insurance carrier. We do not, however, assist in insurance claim filing, claim resolution or respond to insurance carrier requests for more information.

COPIES OF MEDICAL RECORDS & LABS FROM OUR OFFICE

You will be given a copy of your labs at each visit to keep for your records. Should you need additional copies of your medical records; a $25 fee will be charged for copies and postage.

MEDICAL RECORDS FROM OTHER DOCTORS/CLINICS/HOSPITALS

Medical records can only be released with your authorization. It is your responsibility to obtain previous medical records from other physicians or health care providers that you wish Dr. Rashel to review. If you feel your medical records are pertinent to your appointment with Dr. Rashel, please contact your physician or other health care provider to obtain these records and make sure that we have received them at least 7 days prior to your initial appointment.

Returns/Refunds of Supplements

_____Supplements (except probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase. Functional Lab kits must be completed within 1 year of purchase.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS

_____There is a 72 hour (3 business days) cancellation and rescheduling policy. Your appointment must be cancelled or rescheduled at least 72 hours (3 business days) prior to your consultation time or you will be charged for the visit, unless we are able to fill your appointment time. Please be aware that holidays and weekends do NOT constitute business days.

You may cancel your appointment by calling the office

(310) 979-3434 or emailing Appointments@drrashel.com

We reserve the right to charge your credit card on file for the full amount of the missed visit if it is not canceled or rescheduled 72 hours (2 business days) prior to your appointment. By signing below you agree to our cancelation policy and authorize Rashel Tahzib DO Advance Health Integrative Medicine to charge your credit card on file for any missed visits.
We ask that if you know that you need to cancel or reschedule, please let us know as soon as possible so that we may offer your appointment to someone else.

FOLLOW UP APPOINTMENTS

At the time of check out you will be scheduled for a follow up appointment. This date will be written on your check out paperwork. We will assume you will honor this appointment time unless you notify us otherwise at least 48 hours/ 2 business days prior to your scheduled appointment. Although you may get reminder phone calls or emails from our office about appointments, these reminders are a courtesy only. It is your responsibility to remember your appointment date and time.

PAYMENT OPTIONS

Cash or credit cards (MasterCard, Visa, Discover) are all accepted methods of payment for services. We do not accept American Express. When you schedule the
initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment
without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized and
payment is due on the day of service. Follow-up phone, or in-person consultations
will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account. Credit card on file will also be used for supplements mailed unless otherwise specified.

RECORDING APPOINTMENTS

——-Electronic recording of appointments and/or conversations with our providers is strictly prohibited, unless prior approval is obtained by Dr. Rashel. It is illegal and unethical to record a medical appointment without the knowledge of the medical provider. If such recording takes place, legal action may be taken.

PRESCRIPTION REFILL REQUESTS

———For prescription refills, we ask that you contact your pharmacy and have them fax over the medication refill request. Our fax number is (310) 907-5193. It may take up to 72 business hours to process a prescription refill. Please plan ahead to avoid interruptions in your treatment.

For our established patients medication refill requests can only be done with follow up visits of no longer than every 3 months. We cannot refill medications without appropriate follow up, please make sure that you stay current with your appointments. This is for your benefit so that we may evaluate your progress, symptoms, laboratory results and continue to optimize and titrate your treatment accordingly for you.

Any medication adjustment requests or new symptoms that arise must be addressed during a visit either in person or via telemedicine.

In the initial phases of your treatment when medications and supplements are still being adjusted to find the optimal dose, medication adjustments often require follow up of 6 week intervals.

Primary Care Physician Information

——-Please note that Rashel Tahzib DO is not your primary care physician. It is recommended that you have a primary care physician. Dr. Rashel Tahzib does not not provide primary care services. We will work with you closely as a consultant in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. We will confer with your primary care doctor and specialist physicians if required.

By Signing below you acknowledge and agree to our practice policies and are in agreement

Signature___________________________________

Date___________________

Printed Name________________________________

Welcome to Advance Health Integrative Medicine. Our goal is to provide you with the highest quality of personalized functional medical care. For your convenience, we provide free clinical support and Functional Wellness Coaching for the first 30 days of your enrollment when you schedule a Functional Medicine or Functional Wellness Consultation. After this initial 30-day period you have the option to enroll into membership as will be described below.

We know your time is valuable and understand that the journey to optimal health and well being, especially when properly addressed from a root cause perspective, can sometimes be challenging and those challenges must be overcome to achieve or regain optimal health and vitality. For this reason we would like to be there for you throughout this process and have the capability and necessary timing to address any of your questions or concerns and walk you along the way should you need it.

The nature of Functional Medicine is thorough, deep, individualized and customized and therefore we need the time and capacity to be provide you with this in depth customized level of care. Ongoing emails unregimented are not sustainable for the practice. Therefore we have created the Premium Access Plan below to be able to make ourselves available to you in an ongoing manner as needed in between appointments for sharing thoughts, questions and further guidance.

Premium Access-- $175/Month – (recommended for patients with chronic medical issues, multiple health concerns or a complex health problem requiring multiple points of contact) and anyone who desires ongoing close support in between appointments- Includes ongoing Email/patient portal questions as needed in between appointments, with response priority, prescription refillsand any requested letters.

Fee-for-service level – You will receive free clinical support between appointments for the first 30 days, after that, we ask that if questions or concerns are longer than one or two lines on Email, that you schedule a consultation to discuss. You can send us longer emails however there is a $45 Email Fee for Emails longer than 1-2 single concise lines that include one concise question. You can also schedule a 15 min phone chat $85.

Advance Health Integrative Medicine is here to serve your Functional Medicine needs.

I understand/agree to the above practice rules: ________________________________ Date: ________________
Signature/Printed Name

Yes I would like to enroll in Premium Access Membership:__________ Initial

Signature______________________________________ Date:__________________

Consent for Treatment

I, the undersigned, so hereby agree and give my consent to Advance Health Integrative Medicine, Rashel J Tahzib DO Inc to provide Telemedicine Services. I acknowledge understanding of the necessary interventions, associated risks, and expected benefits of treatment. I will be discussing with Dr. Rashel Tahzib the different outcomes that could occur and possible complications. I am aware that other complications could occur that we could not foresee. The above information has been read to me. Any questions I have regarding intervention have been answered to my satisfaction prior to my signing this consent form. I have made my decision and agree to the recommended treatment voluntarily and freely.

Initial: __________

Consent for Share of Information via Email

I give my consent to Rashel Tahzib DO to provide professional service via the following email address(es): __________________________ ___________________________. I understand that this way of communication may cause disclosure of the information related to my health.

Initial: __________

Credit Card Charge Agreement

I ______________________________, cardholder of (select one) __ Visa __ MasterCard__ Amex__ Discover

Ending in (last four digits) __________________
Expiration date ___________
Code __________

I __________________________ hereby authorize Rashel J Tahzib DO Inc to charge my card on file in the occurrence of any missed payments or balances on account. I have read this agreement and understand that I will be held fully responsible for its terms and charges and agree not to charge back Advance Health Integrative Medicine as long as I have received the products and services that are defined within the term of the invoice that I receive.
Initial: ____________

PATIENT'S SIGNATURE: _______________________________ DATE: _________________________________

PRIVACY POLICIES

Our office is dedicated to providing services with respect to human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in the law. This notice provides an explanation as to how we will collect information and what we will do with the "Protected Health Information" (all personal, financial and health information). This protected information is received from you, your healthcare provider or any other source in the normal course of health care operations.

This information is used for treatment, payment and other healthcare operations. Protected health information may not be disclosed for any purpose without prior written consent from the patient unless otherwise required by law.

Disclosure
This office may use or disclose your Protected Health Information only when required by law.

Patients Rights

- Upon request you have the right to access, review, or receive copies of your healthcare records.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
- You have the right to request that this office place additional restrictions on the disclosure of your Protected Health Information.
- You have the right to request that we amend your Protected Health Information.

RECEIPT OF NOTICE OF PRIVACY POLICIES

I ____, have read, reviewed and understand and agree to the statement of the Privacy Policy for healthcare services in this office as amended by the above.

This practice has attempted to provide each patient with a statement of privacy policies.

Patient Signature____ Date __________________

Cancellation Policy

At Advance Health Integrative Medicine, in order for us to give you the highest quality of customized individualized care, we do not overbook our schedule. When you make an appointment with us, that time slot is guaranteed to you and no one else. Additional time is blocked off before and after your appointment to prepare and for aftercare plan formulation for your consultation. Therefore, 72 hours notice is needed to reschedule or cancel a consultation.

The No Show fee is **charged at 100%** of any visit not canceled within 72 hours, unless we are able to fill the spot.

Your signature below verifies that you have read this policy and are willing to abide by it.

____
Name

____
Signature

____
Date

Welcome to the 30 day Health Coach Service and Clinical Support!

Congratulations on taking an important step toward a healthier you and subscribing to your complementary 30 days of Functional Wellness Coach Clinical Support System. During the next 30 days you will receive:

- As needed four weeks of weekly emails with Dr Rashel for your initial 30 days as needed for questions, guidance, coaching or concerns.
- Access to Dr. Rashel via ongoing Email to address any medical questions or concerns that may come up about your problem in between your appointments.
- Priority on appointment scheduling.

If you wish to continue the services after your complementary 30 days, you can do so at any time by contacting the office or by becoming a member below:

I________________________________, would like to enroll in Premium Access Membership with Advance Health Integrative Medicine, Dr Rashel Tahzib terms of which are described above.

I give my permission to Advance Health Integrative Medicine to charge my card on file for these services on a monthly basis at $175/Month.

I __________________________________ have read the above and agree to the terms and policies of this agreement.

Signature______________________________________ Date _______________________

Functional Medicine Health Questionnaire Intake Form

First Name: _________________Middle Name: _______________Last Name: ________________

Address:______________________________ City: _________________ State: ______ ZIP: ______

Home Phone: (________) ________-___________ Birth Date: _____/____/____ Age: _________

month day year

Work Phone: (________) ________-___________

Place of Birth:_____________________________

City or town & country if not US

Occupation: ______________________________

Referred by: ______________________________ Height: ___′ ____ ″ Weight: _______ Sex: _____

Today's Date ______________________________

1. Please check appropriate box(es):

- ☐ African American
- ☐ Hispanic
- ☐ Mediterranean
- ☐ Asian
- ☐ Native American
- ☐ Caucasian
- ☐ Northern European
- ☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 7, sister

____
____
____

4. Do you have any pets or farm animals? Yes____ No____
If yes, where do they live? 1. _____ indoors 2. _____ outdoors 3. _____ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes____ No____
If so, when and where? ____
____

6. Have you or your family recently experienced any major life changes? Yes____ No____
If yes, please comment: ____
____

7. Have you experienced any major losses in life? Yes____ No____
If so, please comment: ____
____

8. How important is religion (or spirituality) for you and your family's life?
a. _____ not at all important
b. _____ somewhat important
c. _____ extremely important

9. How much time have you lost from work or school in the past year?
a. _____ 0-2 days
b. _____ 3 –14 days
c. _____ > 15 days

10. Previous jobs:
____
____

11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

a. Did you feel safe growing up?
☐ Yes ☐ No

b. Have you been involved in abusive relationships in your life?
☐ Yes ☐ No

c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
☐ Yes ☐ No

d. Do you currently feel safe in your home?
☐ Yes ☐ No

e. Do you feel safe, respected and valued in your current relationship?
☐ Yes ☐ No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
☐ Yes ☐ No

g. Would you feel safer discussing any of these issues privately?
☐ Yes ☐ No

12. Past Medical and Surgical History:

	ILLNESSES	**WHEN**	**COMMENTS**
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
	ILLNESSES	**WHEN**	**COMMENTS**
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		

	INJURIES		COMMENTS
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

	< 5 Times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

16. What medications are you taking now? Include non-prescription drugs.

Medication Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications? Yes____ No____

If yes, please list: ____

____

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	**Yes**	**No**	**Don't Know**	**Comment**
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				

c. Bottle fed?			
2. As a child did you eat a lot of sugar and/or candy?			

19. As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes____ No____
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
____
____
____

20. 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**	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

21. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	

e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

22. Are you on a special diet? Yes____ No____
    _____ ovo-lacto _____ vegetarian _____ other (describe):
    _____ diabetic _____ vegan ____________________________
    _____ dairy restricted _____ blood type diet ____________________________

23. Is there anything special about your diet that we should know? Yes____ No____
    If yes, please explain:
    ____

24. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
    Yes____ No____
    b. If yes, are these symptoms associated with any particular food or supplement(s)?
    Yes____ No____
    c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
    ____
    ____

25. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

26. Do you feel much **worse** when you eat a lot of :
    _______high fat foods _______refined sugar (junk food)
    _______high protein foods _______fried foods
    _______high carbohydrate foods (breads, pastas, potatoes) _______ 1 or 2 alcoholic drinks
    _______other ______________________________

27. Do you feel much **better** when you eat a lot of :
    _______high fat foods _______refined sugar (junk food)
    _______high protein foods _______fried foods
    _______high carbohydrate foods (breads, pastas, potatoes) _______ 1 or 2 alcoholic drinks
    _______other ______________________________

28. Does skipping a meal greatly affect your symptoms? Yes____ No____

29. Have you ever had a food that you craved or really "binged" on over a period of time?
    Food craving may be an indicator that you may be allergic to that food. Yes____ No____
    If yes, what food(s)? ____
    ____

30. Do you have an aversion to certain foods? Yes____ No____

If yes, what foods? ____

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. 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	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

32. Intestinal gas: _______Daily _______Occasionally _______Excessive _____ Present with pain _____ Foul smelling _____ Little odor

33. a. Have you ever used alcohol? Yes____ No____
    b. If yes, how often do you now drink alcohol?
    ___ No longer drinking alcohol
    ___ Average 1-3 drinks per week
    ___ Average 4-6 drinks per week
    ___ Average 7-10 drinks per week
    ___ Average >10 drinks per week
    c. Have you ever had a problem with alcohol? Yes____ No____
    If yes, please indicate time period (month/year): from ________ to ___________.

34. Have you ever used recreational drugs? Yes____ No____

35. Have you ever used tobacco? Yes____ No____
    If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
    If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless _____Cigar _____Pipe _____Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes____ No____

37. Do you have mercury amalgam fillings? Yes____ No____

38. Do you have any artificial joints or implants? Yes____ No____

39. Do you feel worse at certain times of the year? Yes____ No____
    If yes, when? _______spring _______fall _______summer _______winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
If yes, which one(s)? ______
______
______

41. Do odors affect you? Yes____ No____

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

43. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from ______ to _______.
What kind? ____
Comments: ____

44. Are you currently, or have you ever been, married? Yes____ No____
If so, when were you married? __________ Spouse's occupation __________________
When were you separated? __________ Never _____
When were you divorced? __________ Never _____
When were you remarried? __________ Never _____ Spouse's occupation

Comments:____
____

45. Hobbies and leisure activities: ____
____

____

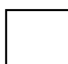
46. Do you exercise regularly? Yes No_
If so, how many times a week?
1.______1x
2.______2x
3.______3x
4.______4x or more

When you exercise, how long is each session?
1.______ ≤15 min
2.______ 16-30 min
3.______ 31-45 min
4.______ > 45 min

What type of exercise is it?
_______jogging/walking
_______basketball
_______home aerobics
_______tennis
_______water sports
_______other

FAMILY HISTORY

Check family members that apply.	MOTHER	FATHER	BROTHER(S)	SISTER(S)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNTS	UNCLES	OTHER
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Thyroid Problems Lupus												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease Other:												



48. Any other family history we should know about? ___
If so, please comment: ____

49. What is the attitude of those close to you about your illness?
_______Supportive
_______Non-supportive

FOR WOMEN ONLY (questions 50-58):

50. Have you ever been pregnant? (If no, skip to question 53.) Yes____ No____

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes____ No____

Have you had other problems with pregnancy? Yes____ No____

If so, please comment: ____
____

51. Age at first period _____ Date of last Pap Smear __________ Date of last Mammogram____________
Pap Smear: ____Normal Abnormal
Mammogram: ____Normal Abnormal

52. Have you ever used birth control pills? Yes No_ If yes, when _________

53. Are you taking the pill now? Yes No_

54. Did taking the pill agree with you? Yes No_ Not applicable _____

55. Do you currently use contraception? Yes No_
If yes, what type of contraception do you use? ____

56. Are you in menopause? No Yes If yes, age at last period
Do you take: Estrogen? __Ogen? ___Estrace? Premarin? Other (specify)
Progesterone? Provera? Other (specify) ___ ___________
___ ___ ________________

57. How long have you been on hormone replacement therapy (if applicable)?
____

58. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No____ Not applicable _____

59. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	**Mild**	**Mod**	**Severe**
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	**Mild**	**Mod-**	**Severe**
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			

FEMALE REPRODUCTIVE, Cont'd:	**Mild**	**Mod**	**Severe**
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

59. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	Mild	Mod-	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod-	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			

MOOD/NERVES, Cont'd:	Mild	Mod	Severe
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			

EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			

DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			

DIGESTION, Cont'd:	Mild	Mod -	Severe
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			

SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			

SKIN PROBLEMS, Cont'd:	Mild	Mod	Severe
Eczema			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	Mild	Mod-	Severe
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-	Severe
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY:	Mild	Mod-	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

Medical Symptoms Questionnaire

Name ______________________________ Date _________________

Rate each of the following symptoms based upon your typical health profile for:

Past 30 days Past 48 hours

Point Scale

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

HEAD
________ Headaches
________ Faintness
________ Dizziness
________ Insomnia

Total ________

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

Total ________

EARS
________ Itchy ears
________ Earaches, ear infections
________ Drainage from ear
________ Ringing in ears, hearing loss

Total ________

NOSE
________ Stuffy nose
________ Sinus problems
________ Hay fever
________ Sneezing attacks
________ Excessive mucus formation

Total ________

MOUTH/THROAT
________ Chronic coughing
________ Gagging, frequent need to clear throat
________ Sore throat, hoarseness, loss of voice
________ Swollen or discolored tongue, gums, lips
________ Canker sores

Total ________

DIGESTIVE TRACT
________ Nausea, vomiting
________ Diarrhea
________ Constipation
________ Bloated feeling
________ Belching, passing gas
________ Heartburn
________ Intestinal/stomach pain

Total ________

JOINTS/MUSCLE
________ Pain or aches in joints
________ Arthritis
________ Stiffness or limitation of movement
________ Pain or aches in muscles
________ Feeling of weakness or tiredness

Total ________

WEIGHT
________ Binge eating/drinking
________ Craving certain foods
________ Excessive weight
________ Compulsive eating
________ Water retention
________ Underweight

Total ________

SKIN
________ Acne
________ Hives, rashes, dry skin
________ Hair loss
________ Flushing, hot flashes
________ Excessive sweating

Total ________

HEART
________ Irregular or skipped heartbeat
________ Rapid or pounding heartbeat
________ Chest pain

Total ________

LUNGS
________ Chest congestion
________ Asthma, bronchitis
________ Shortness of breath
________ Difficulty breathing

Total ________

ENERGY/ACTIVITY
________ Fatigue, sluggishness
________ Apathy, lethargy
________ Hyperactivity
________ Restlessness

Total ________

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

Total ________

EMOTIONS
________ Mood swings
________ Anxiety, fear, nervousness
________ Anger, irritability, aggressiveness
________ Depression

Total ________

OTHER
________ Frequent illness
________ Frequent or urgent urination
________ Genital itch or discharge

Total ________

GRAND TOTAL _________
Please list your current supplements, dose and frequency.

Medications/Supplements	Dose	Freq.