Name: ______________________________ Date: __________________

Address: ____ Unit: _____________

City: _______________________________________ State: ___________ Zip: ______________

Phone | Home: _______________________ Mobile: _______________________ Work: ______________________

Email Address: ____

Date of Birth: ______/_______/__________ Gender: ☐ Male ☐ Female

Age: ___________ Height: ______________ Weight: ____________

Status:

☐ Married ☐ Widowed

☐ Separated ☐ Single

☐ Divorced ☐ Partnership

Live With:

☐ Spouse ☐ Children ☐ Pets? Which kind?

☐ Partner ☐ Friends _________________

☐ Parents ☐ Alone _________________

Education: ____

Occupation: __________________________________ Hours per week: _______________ ☐ Retired

Employer: _________________________________ Work Address: _______________________________________

In case of emergency, whom should we contact?

Name: ____________________________________ Relationship: ______________________________

Address: ____ Phone: _________________________

How did you hear about our Wellness and Nutrition Program?

____

____

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

____

____

____

____

What are your current medications?

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

What are your current vitamins and/or supplements?

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Please list your current and past health conditions, diagnosed or suspected? (i.e. Diabetes, Hypothyroidism, cancer, etc.)

____

____

____

____

____

____

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

____

____

____

____

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

____

____

____

____

____

Please list your past or present Hobbies or Work related exposures that could be sources of toxicity or chemicals.

____

____

____

How often are you involved in these Hobbies or Work related exposures currently?

____

____

Please list past or present known allergies, including allergies to medications, pets, foods.

____

____

____

Please list all past surgeries and hospitalizations and the conditions requiring those, including approximate dates.

____

____

____

____

____

____

Have you suffered any noteworthy traumatic events in childhood or recent times? Give approximate dates.

____

____

____

____

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

____

____

____

____

Patient History

Answer the following questions as completely as you are able. Accurate answers are important.

Mercury

 Yes **No** Do you have silver amalgam fillings in your teeth? If so, how many? _____________

 Yes **No** Have you ever had a silver amalgam removed? If yes, how many? ____________ When? _____________

 Yes **No** If you had silver amalgams removed, was it done by a biological dentist using a safe protocol?

 Yes **No** Did your mother already have silver amalgams when pregnant with you?

 Yes **No** Have you ever worked in a dental office? If so, how long? ________________

 Yes **No** Have you ever had any dental crowns? If yes, how many? ____________ When? _____________

 Yes **No** Have you had any bridges? How many? __________ When? ________________

 Yes **No** Do you have any dental implants, retainers or other metal in your mouth? Explain: _________________

 Yes **No** Did you wear contact lenses during 1980's or early 1990's?

 Yes **No** Did you take oral contraceptives during the 1980's or early 1990's?

 Yes **No** Did you receive yearly flu shots, or have you recently received a flu shot, allergy shot or a vaccination?

 Yes **No** Have you noticed any adverse reactions to these shots?

 Yes **No** Do you have any tattoos with red ink?

 Yes **No** Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

 Yes **No** Do you have breast implants? When was this surgery? __________________ Are they removed? ______

Lead

 Yes **No** Does your occupation involve soldering or metal salvage?

 Yes **No** Have you done any old home repair or sandblasting? If so, when ____________

 Yes **No** Have you done a lot of painting?

 Yes **No** Was your current or previous home built before 1978?

 Yes **No** Have you ever worn cosmetics containing kohl? (Make-up with dark black or deep red pigment)

 Yes **No** Are you around a lot of fake leather, or vinyl?

 Yes **No** Do you get stomach aches in the morning?

 Yes **No** Do you interact with any black pigments in pottery, leather soles, etc.?

 Yes **No** Have you had imaging (MRIs) requiring contrast mediums? Which ones? ___________________________

General Toxicity

 Yes No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain?

 Yes No Do you have Wi-Fi in your home? Where is the main panel in your home? ___________________

 Yes No Do you have cordless phones, baby monitors or smart meters in your home? Circle which ones.

 Yes No Do you hold your cellphone to your head often when talking?

 Yes No Do you keep your cellphone on your body during the day?

 Yes No Do ever fall asleep with your cellphone or iPad device near you?

 Yes No Do you sleep with your cellphone or iPad on airplane mode or at least 10 feet from you?

 Yes No Do you use a Blue Tooth device with your phone or iPad or other Blue Tooth devices in your home?

 Yes No Do you spent a lot of time on a computer that is near a router?

 Yes No Have you ever had any chemical exposure? (i.e. cleaning chemical spills, working in a beauty salon, etc.)

 Yes No Do you have your house sprayed with pesticides for pest control?

 Yes No Do you spray herbicide (weed killers) like Round Up in or around your home?

 Yes No Do you use conventional insect repellants on yourself or family?

 Yes No Do you use conventional sunscreen?

 Yes No Do you use frequently use conventional perfume, cologne or hairspray? (Circle which ones.)

 Yes No Do you get your hair colored? Does it touch the scalp? ____ How often & how many years? __________

 Yes No Do you use artificial sweeteners? Which ones? ____

 Yes No Do you get your nails done? (Sculptured nails? Circle: Yes or No) If so, how often? _____________

 Yes No Do you use air freshener in your house, work or car? Circle which ones.

 Yes No Do you drink filtered water? If so, what type of filter do you have? ___________________________

 Yes No Do you drink bottled water? If so, what kind? _______________________

 Yes No Do you have water filtration system for entire house or shower filtration? What type? __________

 Yes No Does your spouse or other family members work around chemicals?

 Yes No Can you think of any other toxic exposures you may have had? _______________________________

What kind of laundry detergent do you use? ____________________________ Do you use bleach? ______________

What kind of shampoo and conditioner do you use? ____

What kind of deodorant do you use? ________________________ Toothpaste? _______________________________

What kind of cleaning products do you use at home? ____

Mold

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

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

☐ **Yes** ☐ **No** Do you see mold growing at home, work or school? Circle which ones.

☐ **Yes** ☐ **No** Have you ever had water damage at home, work or school? Circle which ones.

☐ **Yes** ☐ **No** Does your home, workplace or school have a damp or mildew smell? Circle which ones.

☐ **Yes** ☐ **No** Does spending time in your basement or any other room cause or worsen your symptoms?

☐ **Yes** ☐ **No** Does your basement ever get wet? How often? ________________

☐ **Yes** ☐ **No** Do you have a crawl space?

☐ **Yes** ☐ **No** Does your basement or crawl space have a sump pump?

☐ **Yes** ☐ **No** Does spending time away from home cause a noticeable decrease in your symptoms?

☐ **Yes** ☐ **No** Does your car have a mildew smell?

☐ **Yes** ☐ **No** Does anyone (including pets) in your home have asthma like symptoms?

☐ **Yes** ☐ **No** Does anyone in your family have chronic sinus infections or irritations?

Lyme Disease

☐ **Yes** ☐ **No** Have you ever been diagnosed with Lyme Disease? Any treatment? _________________________

☐ **Yes** ☐ **No** Have you had any dental extractions? How many? _________ When? _______________________

☐ **Yes** ☐ **No** Have you had dry sockets or <u>infected</u> teeth that had to be extracted? Circle which ones.

☐ **Yes** ☐ **No** Have you had any root canals? How many? _________ When? _____________________________

☐ **Yes** ☐ **No** Do you have small joint pain? Which ones? ____

☐ **Yes** ☐ **No** Have you (or your pets) ever been bitten by a tick or recluse spider? Circle which ones.

☐ **Yes** ☐ **No** Have you ever seen a bulls-eye rash appear on any part of your body? When? _________________

☐ **Yes** ☐ **No** Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?

☐ **Yes** ☐ **No** Was your mother ever diagnosed with Lyme disease? When? _______________________________

☐ **Yes** ☐ **No** Have you ever been diagnosed with Chronic Fatigue Syndrome, Fibromyalgia, Lupus, Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), or an Autoimmune condition? Circle which ones.

☐ **Yes** ☐ **No** Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

☐ **Yes** ☐ **No** Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? Who? ____

☐ **Yes** ☐ **No** Does anyone in your family experience similar symptoms to yours? Who? _________________________

What is your birth order? (I.e. first, second, third, etc.) ________________

☐ **Yes** ☐ **No** Do you have any history of kidney disfunction? How long? ____________________

☐ **Yes** ☐ **No** Do you or any immediate family members have a history with cancer? Who? __________________

☐ **Yes** ☐ **No** Do you have any history of heart disease, myocardial infraction (heart attack), etc.? Circle which ones.

☐ **Yes** ☐ **No** Have you recently had thoughts of suicide, not typical to your personality?

☐ **Yes** ☐ **No** Have you ever been diagnosed with bipolar disorder, schizophrenia or depression? Circle which ones.

☐ **Yes** ☐ **No** Do you have a history of strokes? When? ________________________

☐ **Yes** ☐ **No** Have you ever been diagnosed with diabetes, thyroiditis, or heart disease? Circle which ones.

☐ **Yes** ☐ **No** Have you ever been in an auto accident, fallen or received a major physical injury? Circle which ones.

☐ **Yes** ☐ **No** Are you in menopause? Symptoms? ____

Microbiome Health

☐ **Yes** ☐ **No** Do you get distention, bloating, feeling full, noisy gut after eating healthy carbohydrates such as broccoli, Brussels sprouts or other vegetables?

☐ **Yes** ☐ **No** Do you often have gas that has a sulfur or foul smell?

☐ **Yes** ☐ **No** Are you sensitive to supplements? Which ones? ____

☐ **Yes** ☐ **No** Have you ever been vegan or vegetarian for any length of time? How long? ______________________

☐ **Yes** ☐ **No** Can you tolerate meat? If no, describe. ____

☐ **Yes** ☐ **No** Are you missing your gall bladder or other body parts? Which? _________________________________

☐ **Yes** ☐ **No** Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?

☐ **Yes** ☐ **No** Have you taken birth control or Hormone replacement therapy for any length of time? How long? ______

☐ **Yes** ☐ **No** If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?

☐ **Yes** ☐ **No** Have you been on antibiotics for any extended period of time recently or often, as a child or adult?

☐ **Yes** ☐ **No** Were you delivered by Caesarian section?

☐ **Yes** ☐ **No** Were you breast fed? If so, for how long? ___________________________________

☐ **Yes** ☐ **No** Does your gut temporarily feel better after a round of antibiotics?

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

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

Point Scale

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

3 = Occasionally have it, severe effect | **4 = Frequently have it, severe effect**

Column #1

	Anxiety
	Mood swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5)
	Insomnia (can't get to sleep or return to sleep)
	Dizziness
	Sound in ears (ringing or hearing your heartbeat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound
	SubTotal
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read a book or look up to the sky
	Dyslexia or loss of place when reading, even as a child
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)
	SubTotal

Total Columns 1 & 2: _______________

Column #2

	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Bad night vision or seeing halos around lights
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red yes and tearing
	Blurred vision at times
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep
	SubTotal
	Receive static shock more often and w/ more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain - not necessarily true arthritis - can move from joint to joint
	Difficulty losing weight, regardless of diet and exercise
	Persistent fungal or viral infection, including athletes' foot, warts, jock itch, candidiasis.
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)
	SubTotal

SYMPTOM SURVEY FORM

Birth date: ___________________ Approx. weight: ______________ Sex: Male ☐ Female ☐

Pulse: Lying down ___________________ Standing: _________________ Vegetarian: Yes ☐ No ☐

Blood Pressure: Lying down: ________/_________ Standing: _______/_______ Ragland's Test is Positive ☐

INSTRUCTIONS: Rate each symptom by filling in the blanks as they apply to you.

0= Does NOT apply to you
1= MILD symptoms (occurred once or twice last 6 months)
2= MODERATE symptoms (occurring once or twice last month)
3= SEVERE symptoms (chronic, occurring once or twice last week)

Group 1

____ Acid foods upset
____ Get chilled often
____ "Lump" in throat
____ Dry mouth-eyes-nose
____ Pulse speeds after meal
____ Keyed up - fail to calm down
____ Cut heals slowly
____ Gag easily
____ Unable to relax – startle easily
____ Extremities cold, clammy
____ Strong light irritates
____ Urine amount reduced
____ Heart sounds after retiring
____ "Nervous" stomach
____ Appetite reduced
____ Cold sweats often
____ Fever easily raised
____ Neuralgia-like pains
____ Staring, blinks little
____ Sour stomach often
_________ TOTAL

Group 2

____ Joint stiffness on arising
____ Muscle/leg/toe cramps at night
____ "Butterfly" stomach, cramps
____ Eyes or nose watery
____ Eye blink often
____ Eyelids swollen, puffy
____ Indigestion soon after meals
____ Always seems hungry; feels "lightheaded" often
____ Digestion rapid
____ Vomiting frequent
____ Hoarseness frequent
____ Breathing irregular
____ Pulse slow; feels "irregular"
____ Gagging reflex reduced
____ Difficulty swallowing
____ Constipation, diarrhea alternating
____ "Slow starter"
____ Get "chilled" infrequently
____ Perspire easily
____ Circulation poor, sensitive to cold
____ Subject to colds, asthma, bronchitis
_________ TOTAL

Group 3

____ Eat when nervous
____ Excessive appetite
____ Hungry between meals
____ Irritable before meals
____ Get "shaky" if hungry
____ Fatigue, eating relieves
____ "Lightheaded" if meals delayed
____ Heart palpitates if meals missed or delayed
____ Afternoon headaches
____ Overeating sweets upsets
____ Awaken a few hours after sleep - hard to get back to sleep
____ Crave candy or coffee in afternoons
____ Moods of depression - "blues" or melancholy
____ Abnormal craving for sweets and snacks
_________ TOTAL

Group 4

____ Hands and feet go to sleep easily, numbness
____ Sigh frequently, "air hunger"
____ Aware of "breathing heavily"
____ High altitude discomfort
____ Opens windows in closed rooms
____ Susceptible to colds and fevers
____ Afternoon "yawner"
____ Get "drowsy" often
____ Swollen ankles, worse at night
____ Muscle cramps, worse during exercise; get "charley horses"
____ Shortness of breath on exertion
____ Dull pain in chest or radiating into left arm, worse on exertion
____ Bruise easily, "black and blue" spots
____ Tendency to anemia
____ "Nose bleeds" frequently
____ Noises in head, or "ringing in ears"
____ Tension under breastbone, or feeling of "tightness" worse on exertion
_________ TOTAL

Group 5

____ Dizziness
____ Dry Skin
____ Burning feet
____ Blurred Vision
____ Itching skin and feet
____ Excessive hair falling out
____ Frequent skin rashes
____ Bitter, metallic taste in mouth in mornings
____ Bowel movements painful or difficult
____ Worrier, feels insecure
____ Feeling queasy; headache over eyes
____ Greasy foods upset
____ Stools light colored
____ Skin peels on foot soles
____ Pain between shoulder blades
____ Use laxatives
____ Stools alternate from soft to watery
____ History of gallbladder attacks or gallstones
____ Sneezing attacks
____ Dreaming, nightmare type bad dreams
____ Bad breath (halitosis)
____ Milk products cause distress
____ Sensitive to hot weather
____ Burning or itching anus
____ Crave sweets
_________ TOTAL

Group 6

____ Loss of taste for meat
____ Lower bowel gas several hours after eating
____ Burning stomach sensations, eating relieves
____ Coated tongue
____ Pass large amounts of foul-smelling gas
____ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours.
____ Mucous colitis or “irritable bowel”
____ Gas shortly after eating
____ Stomach “bloating” after eating
_________ TOTAL

Group 7A

____ Insomnia
____ Nervousness
____ Can’t gain weight
____ Intolerance to heat
____ Highly emotional
____ Flush easily
____ Night sweats
____ Thin, moist skin
____ Inward trembling
____ Heart palpitates
____ Increased appetite without weight gain
____ Pulse fast at rest
____ Eyelids and face twitch
____ Irritable and restless
____ Can’t work under pressure
_________ TOTAL

Group 7B

____ Increase in weight
____ Decrease in appetite
____ Fatigue easily
____ Ringing in ears
____ Sleepy during day
____ Sensitive to cold
____ Dry or scaly skin
____ Constipation
____ Mental sluggishness
____ Hair coarse, falls out
____ Headaches upon arising, wear off during the day
____ Slow pulse, below 65
____ Frequency of urination
____ Impaired hearing
____ Reduced initiative
_________ TOTAL

Group 7C

____ Failing memory
____ Low blood pressure
____ Increased sex drive
____ Headaches, “splitting or rendering” type
____ Decreased sugar tolerance
_________ TOTAL

Group 7D

____ Abnormal thirst
____ Bloating of abdomen
____ Weight gain around hips or waist
____ Sex drive reduced or lacking
____ Tendency or ulcers, colitis
____ Increased sugar tolerance
____ Women; mental disorders
____ Young girls: lack of menstrual function
_________ TOTAL

Group 7E

____ Dizziness
____ Headaches
____ Hot flashes
____ Increased blood pressure
____ Hair growth on face or body (female)
____ Sugar in urine (not diabetes)
____ Masculine tendencies (female)
_________ TOTAL

Group 7F

____ Weakness, dizziness
____ Chronic fatigue
____ Low blood pressure
____ Nails weak, ridged
____ Tendency to hives
____ Arthritic tendencies
____ Perspiration increase
____ Bowel disorder
____ Poor circulation
____ Swollen ankles
____ Crave salt
____ Brown spots or bronzing of skin
____ Allergies - tendency to asthma
____ Weakness after colds, influenza
____ Exhaustion - muscular and nervous
____ Respiratory disorders
_________ TOTAL

Group 8

____ Apprehension
____ Irritability
____ Morbid fears
____ Never seems to get well
____ Forgetfulness
____ Indigestion
____ Poor appetite
____ Craving of sweets
____ Muscular soreness
____ Depression; feelings of dread
____ Noise sensitivity
____ Acoustic hallucinations
____ Tendency to cry without reason
____ Hair is course and/or thinning
____ Weakness
____ Fatigue
____ Skin sensitive to touch
____ Tendency toward hives
____ Nervousness
____ Headache
____ Insomnia
____ Anxiety
____ Anorexia
____ Inability to concentrate; confusion
____ Frequent stuffy nose; sinus infection
____ Allergy to some foods
____ Loose joints
_________ TOTAL

FEMALE ONLY

____ Very easily fatigued
____ Premenstrual tension
____ Painful menses
____ Depressed feelings before menstruation
____ Menstruation excessive and prolonged
____ Painful breasts
____ Menstruate too frequently
____ Vaginal discharge
____ Hysterectomy / ovaries removed
____ Menopausal hot flashes
____ Menses scanty or missed
____ Acne, worse at menses
____ Depression of long standing
_________ TOTAL

MALE ONLY

____ Prostate trouble
____ Urination difficult or dribbling
____ Night urination frequent
____ Depression
____ Pain on inside of legs or heels
____ Feeling of incomplete bowel evacuation
____ Lack of energy
____ Migrating aches and pains
____ Tire too easily
____ Avoids activity
____ Leg nervousness at night
____ Diminished sex drive
_________ TOTAL

List your five main complaints in the order of their importance:

1. ____

2. ____

3. ____

4. ____

5. ____

Please recheck all items to be sure each is accurately answered to give us the best potential to help you.

Your help in this is greatly appreciated.

To your health!