NORTH FLORIDA
SPINE AND WELLNESS

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Designed Clinical Nutrition Intake Forms

THESE FORMS & YOUR LAB WORK FOR THE LAST 6 MONTHS MUST BE SUBMITTED UPON YOUR ARRIVAL 30 MINUTES PRIOR TO YOUR NEW PATIENT APPOINTMENT

Dear Patient,

Welcome to North Florida Spine and Wellness. We look forward to helping you achieve optimum health, naturally!

WHAT TO EXPECT DURING YOUR INTIAL CONSULTATION AND EVALUATION

YOU ARRIVE TO THE OFFICE

All included intake forms and office policy forms are completed and processed at the front desk. All previous labs and relevant medical history is obtained from other providers.

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT TIME TO PROCESS YOUR PAPERWORK AND TO WATCH A SHORT VIDEO INTRODUCTION TO OUR PRACTICE

DESIGNED CLINICAL NUTRITION CONSULTATION AND EVALUATION:

-A complete timeline health history will be conducted by Dr. Zaideman.
-A complete review of all intake questionnaires, previous medical records and labs.
-Non-invasive computerized diagnostic studies including: Heart Rate Variability, BMI, and/or other evaluation tools that are deemed medically necessary to evaluate your condition.
-Functional medicine physical exam.
-Neuromuscular biofeedback examination of all body systems and organs.
-Functional Analysis of previous and current blood work and labs.

****Expect to reserve 60-90 minutes for your initial visit.***

Advanced Specialty Lab Tests:

Bloodwork done in the past 6 months by other providers may provide adequate information to evaluate your condition; however, depending on your specific condition and exam findings additional labs may be ordered by the doctors and will incur an **additional charge outside of your evaluation fee**. Those charges will be discussed before any labs are ordered.

Checkout Procedure:

-All fees for evaluation and advanced specialty labs will be collected.
-Schedule follow-up appointment for a report of findings to discuss findings and treatment plan recommendations.

This report is given at no charge. No supplements are given until after care recommendations are discussed and agreed upon by both doctor and patient.

Evaluation Fees Schedule :

The **Designed Clinical Nutrition** consultation, evaluation, and report of findings is **$200.**

Advanced specialty labs are not included in the evaluation cost and will be an additional cost, if necessary.

NORTH FLORIDA SPINE AND WELLNESS
DESIGNED CLINICAL NUTRITION
NEW PATIENT INFORMATION FORM

Name:_____ DOB:_____

Address _____

City _____ State_____ ZIP _____

Home Phone (____) ____-_____Cell (____) ____-_____ Work (____) ____-_____

E-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Marital Status: S M D W Social Sec. No: _____

Children:	Age	Sex	Any Health Issues?
1. _____	___	M/F	_____
2. _____	___	M/F	_____
3. _____	___	M/F	_____
4. _____	___	M/F	_____

Family History: Diabetes ( ) Cancer ( ) Heart Disease ( ) Other: _____

_____

Your major complaint(s): _____

_____

How long have you had this? _____Weeks _____ Months _____ Years

Previous treatments for this complaint _____

Surgeries/Accidents _____

Currently under Physician's care for 1._____ 2. _____

3._____4._____5._____

Name of Dr(s). 1._____2._____3._____

Supplements Currently Taking:

1._____4._____7._____

2._____5._____8._____

3._____6._____9._____

Do you **smoke**? Yes/No How many per day? _____

Do you drink **Alcohol?** Yes/No How much per week? _____

Do you drink **Coffee**? Yes/No How many per day? _____

I understand that Designed Clinical Nutrition is not a method for diagnosing or treatment of any disease including conditions of cancer, AIDS, infections or other medical conditions, and that these conditions are not being tested for, or treated. I understand the DCN is a means by which the neurological reflexes can be used to determine possible nutritional imbalances, bringing the body to a more optimum state of health.

SIGNED: _____ DATE_____

ALLERGIES

Medication/ Supplement/Food: _____

_____

Reaction: _____

_____

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us?_____

_____

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 you felt well?_____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes 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?_____

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

PAST MEDICAL AND SURGICAL HISTORY

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	WHEN	REASON

FEMALE MEDICAL HISTORY (*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 (ie copper ParaGard)
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ IUD (ie Mirena)
- ❑ Other (please describe)_____

Even if you are *not* currently using contraception, 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 ❑ Other_____
- ❑ Premarin ❑ Porvera ❑ Progesterone

DIAGNOSTIC TESTING

Last PAP test:_____/_____/_____ Normal:_____Abnormal_____

Last Mammogram_____/_____/_____ Breast biopsy? Date:_____/_____/_____

Date of last bone densitiy_____/_____/_____ Results: High____ Low____ Within normal range____

MALE MEDICAL HISTORY (*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
- ❑ Nocturia (urination at night)
  - ❑ How many times at night? ____
- ❑ Urgency/Hesitancy/Change in Urinary Stream
- ❑ Loss of bladder control
- ❑ Infertility
- ❑ Lumps in testicles
- ❑ Sore on penis
- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer
- ❑ Low sperm count
- ❑ Difficulty obtaining erection
- ❑ Difficulty maintaining an erection

CHILDHOOD HISTORY

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___
Fully Vaccinated? Yes___ No___
How would you describe your diet as a child? _____

DENTAL HISTORY

	Yes	No
Problem with sore gums (gingivitis)?	_____	_____
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?	_____	_____

NUTRITONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____

How many times per week do you consume the following types of food?

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 any type of nutritional program or diet? Yes ____ No_____

Please tell us if there is anything special about your diet (ie diabetic diet, paleo, vegan, etc) _____

_____

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_____

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) _____

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	
2-3x/week		Greenish color	
1 or fewer x/week		Blood is visible	
		Varies a lot	
Consistency	√	Dark brown consistently	
Soft and well formed		Yellow, light brown	
Often floats		Greasy, shiny appearance	
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

Intestinal gas (check all that apply):

- ❑ Daily
- ❑ Occasionally
- ❑ Excessively
- ❑ Painful
- ❑ 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/chemicals in your job or at home? Yes___No___

If yes, Explain _____

Occupation _____

SLEEP AND 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:	Times/week				Length of session			
Type of exercise	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

_____

_____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? _____ When was the last time?_____

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc)_____

Did it help?_____

How are the following aspects of your life going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _____

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

Hobbies and leisure activities:

_____

_____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here?

Yes_____ No_____

PAIN HISTORY

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._____

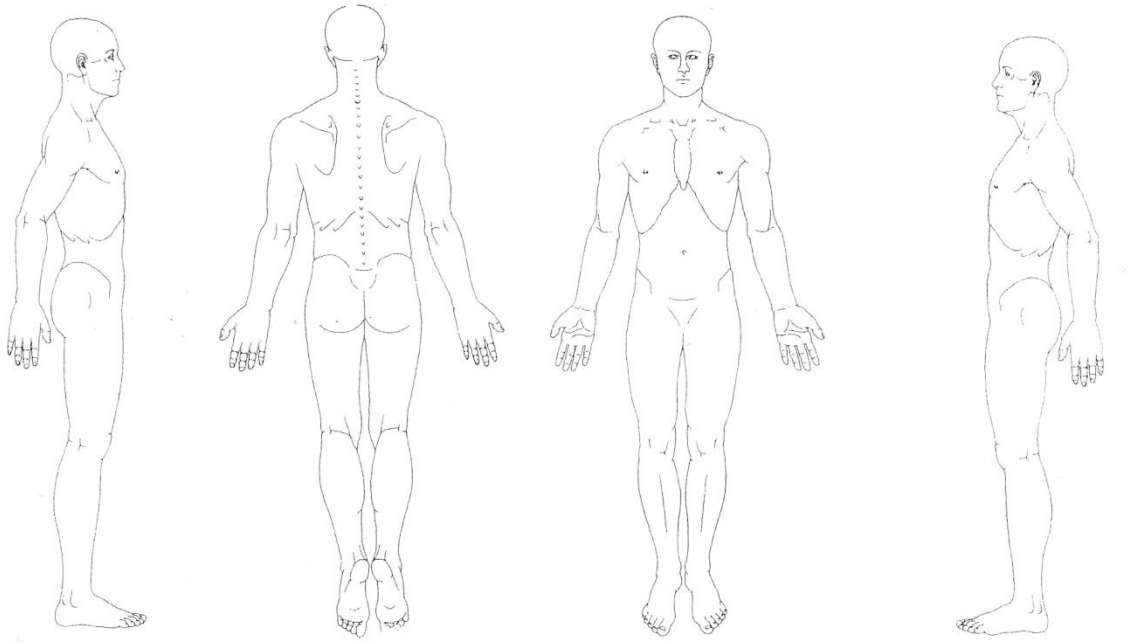
1 2 3 4 5 6 7 8 9 10

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



Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** ____ **Date:** _____

PART I

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II Please circle the appropriate number 0 - 3 on all questions below.
0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relief by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard, dry, or small stool	**0**	**1**	**2**	**3**
Coated tongue of fuzzy debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
Use laxatives frequently	**0**	**1**	**2**	**3**

Category II

Excessive belching, burping, or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movements	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested foods found in stools	**0**	**1**	**2**	**3**

Category III

Stomach pain, burning, or aching 1- 4 hours after eating	**0**	**1**	**2**	**3**
Do you frequently use antacids?	**0**	**1**	**2**	**3**
Feeling hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief from antacids, food, milk, carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	**0**	**1**	**2**	**3**

Category IV

Roughage and fiber cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness lasts 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category V

Greasy or high fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates from clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed	**Yes**			**No**

Category VI

Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep yourself going or started	**0**	**1**	**2**	**3**
Get lightheaded if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory, forgetful	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**

Category VII

Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst & appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category VIII

Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**0**	**1**	**2**	**3**
Afternoon headaches	**0**	**1**	**2**	**3**
Headaches with exertion or stress	**0**	**1**	**2**	**3**
Weak nails	**0**	**1**	**2**	**3**

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Category IX

Cannot fall asleep	**0**	**1**	**2**	**3**
Perspire easily	**0**	**1**	**2**	**3**
Under high amounts of stress	**0**	**1**	**2**	**3**
Weight gain when under stress	**0**	**1**	**2**	**3**
Wake up tired even after 6 or more hours of sleep	**0**	**1**	**2**	**3**
Excessive perspiration or perspiration with little or no activity	**0**	**1**	**2**	**3**

Category X

Tired, sluggish	**0**	**1**	**2**	**3**
Feel cold hands, feet, all over	**0**	**1**	**2**	**3**
Require excessive amounts of sleep to function properly	**0**	**1**	**2**	**3**
Increase in weight gain even with low-calorie diet	**0**	**1**	**2**	**3**
Gain weight easily	**0**	**1**	**2**	**3**
Difficult, infrequent bowel movements	**0**	**1**	**2**	**3**
Depression, lack of motivation	**0**	**1**	**2**	**3**
Morning headaches that wear off as the day progresses	**0**	**1**	**2**	**3**
Outer third of eyebrow thins	**0**	**1**	**2**	**3**
Thinning of hair on scalp, face or genitals or excessive falling hair	**0**	**1**	**2**	**3**
Dryness of skin and/or scalp	**0**	**1**	**2**	**3**
Mental sluggishness	**0**	**1**	**2**	**3**

Category XI

Heart palpations	**0**	**1**	**2**	**3**
Inward trembling	**0**	**1**	**2**	**3**
Increased pulse even at rest	**0**	**1**	**2**	**3**
Nervous and emotional	**0**	**1**	**2**	**3**
Insomnia	**0**	**1**	**2**	**3**
Night sweats	**0**	**1**	**2**	**3**
Difficulty gaining weight	**0**	**1**	**2**	**3**

Category XII

Diminished sex drive	**0**	**1**	**2**	**3**
Menstrual disorders or lack of menstruation	**0**	**1**	**2**	**3**
Increased ability to eat sugars without symptoms	**0**	**1**	**2**	**3**

Category XIII

Increased sex drive	**0**	**1**	**2**	**3**
Tolerance to sugars reduced	**0**	**1**	**2**	**3**
Splitting type headaches	**0**	**1**	**2**	**3**

Category XIV

Urination difficulty or dribbling	**0**	**1**	**2**	**3**
Urination frequent	**0**	**1**	**2**	**3**
Pain inside of legs or heels	**0**	**1**	**2**	**3**
Feeling of incomplete bowel evacuation	**0**	**1**	**2**	**3**
Leg nervousness at night	**0**	**1**	**2**	**3**

Category XV (Males Only)

Decrease in libido	**0**	**1**	**2**	**3**
Decrease in spontaneous morning erections	**0**	**1**	**2**	**3**
Decrease in fullness of erections	**0**	**1**	**2**	**3**
Difficulty in maintain morning erections	**0**	**1**	**2**	**3**
Spells of mental fatigue	**0**	**1**	**2**	**3**
Inability to concentrate	**0**	**1**	**2**	**3**
Episodes of depression	**0**	**1**	**2**	**3**
Muscle soreness	**0**	**1**	**2**	**3**
Decrease in physical stamina	**0**	**1**	**2**	**3**
Unexplained weight gain	**0**	**1**	**2**	**3**
Increase in fat distribution around chest and hips	**0**	**1**	**2**	**3**
Sweating attacks	**0**	**1**	**2**	**3**
More emotional than in the past	**0**	**1**	**2**	**3**

Category XVI (Menstruating Females Only)

Are you perimenopausal	**Yes**		**No**	
Alternating menstrual cycle lengths	**Yes**		**No**	
Extended menstrual cycle, greater than 32 days	**Yes**		**No**	
Shortened menses, less than every 24 days	**Yes**		**No**	
Pain and cramping during periods	**0**	**1**	**2**	**3**
Scanty blood flow	**0**	**1**	**2**	**3**
Heavy blood flow	**0**	**1**	**2**	**3**
Breast pain and swelling during menses	**0**	**1**	**2**	**3**
Pelvic pain during menses	**0**	**1**	**2**	**3**
Irritable and depressed during menses	**0**	**1**	**2**	**3**
Acne break outs	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Hair loss/thinning	**0**	**1**	**2**	**3**

Category XVII (Menopausal Females Only)

How many years have you been menopausal?	_____			
Since menopause, do you ever have uterine bleeding?	**Yes**		**No**	
Hot flashes	**0**	**1**	**2**	**3**
Mental fogginess	**0**	**1**	**2**	**3**
Disinterest in sex	**0**	**1**	**2**	**3**
Mood swings	**0**	**1**	**2**	**3**
Depression	**0**	**1**	**2**	**3**
Painful intercourse	**0**	**1**	**2**	**3**
Shrinking breasts	**0**	**1**	**2**	**3**

How many alcohol beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Environmental Influences Questionnaire

Name:_____ **Date**____/____/____

There are over 70,000 chemicals commercially produced in the United States. The long-term effects of many of these chemicals have never been investigated. But many chemicals are harmful in very low doses. Unless generated by the body (formaldehyde, pentane), the body's level for chemicals should be non-detectable, and not "low level". Chemicals are widespread in our environment, and constant exposure to low levels can cause dysfunction in many systems of the body. The purpose in the following questions is to determine if any of your health problems can be result of chemical toxicity and to measure your TOTAL TOXIN LOAD.

Electromagnetic Factors

- ❑ Live or have you lived within 200 yards form high voltage wires or transformers
- ❑ Live or have lived near an electric distribution substation
- ❑ Bed is close to the main electrical current
- ❑ Have a fan directly over your bed
- ❑ Have an alarm clock or radio close to your bed (plugged in)
- ❑ Live or have you lived near a television transmitter
- ❑ Sleep with an electric blanket, heating pad
- ❑ Sleep with an electric blanket, heating pad
- ❑ Sleep on a waterbed

Position of your head of your bed is facing

- ❑ North
- ❑ South
- ❑ East
- ❑ West

- ❑ Work on a computer for longer than six hours/day
- ❑ Use a screening shield over your computer screen
- ❑ Live or have lived near a power generating station
- ❑ Live near a radio tower
- ❑ You use a cellular phone more than 2 hours per day
- ❑ Use microwave ovens
- ❑ Bed has a wooden backboard
- ❑ Have fluorescent light fixtures

Occupation: _____

Toxin Exposure

Trichloroethylene/TCE

- ❑ Work close to a copy machine
- ❑ Worked in a printing shop
- ❑ Drink decaffeinated coffee
- ❑ Use typewriter correction fluid
- ❑ Use rug cleaners
- ❑ Use disinfectants
- ❑ Use carbonless paper
- ❑ Use spot removers
- ❑ Use cleaning supplies
- ❑ Use metal degreasers
- ❑ Do recreational painting

Formaldehyde

- ❑ Wear many dry-cleaned clothes
- ❑ Noticed changes of your health since you moved into your home
- ❑ Wear many polyester clothes and permanent press
- ❑ You use Spray Starch
- ❑ Have foam wall insulation
- ❑ Have particleboard, chip board or interior plywood
- ❑ Put up wallpaper in last 2 years
- ❑ Have foam cushions or foam mattresses
- ❑ Live or lived in a trailer
- ❑ Worked in a laboratory
- ❑ Your home has been insulated since your illness
- ❑ Had new carpets. When? _____
- ❑ Use waxes and polishes on your floor
- ❑ Been around resin glues and plastics
- ❑ Have exterior grade plywood on your home
- ❑ Homemade of stucco, plaster or concrete
- ❑ Have a wood burning stove
- ❑ Have draperies
- ❑ Have used acid-cured resin floor finishes
- ❑ Have fire-proof material in your home
- ❑ Smoke in your home
- ❑ Have a photography darkroom
- ❑ Use nail polish remover
- ❑ Use fingernail hardeners

Pesticides and Herbicides Chemicals

- ❑ Use pesticides
- ❑ Use weed killer
- ❑ You use cleaning fluids, waxes
- ❑ Lived or worked at adry cleaning plant
- ❑ Have been around wood preservatives
- ❑ Drink tap water
- ❑ Work with electrical equipment
- ❑ Have mothballs in your closets
- ❑ Gasoline fumes bother you
- ❑ Eat store bought meat
- ❑ Use insecticides
- ❑ Crop-surface sprays
- ❑ Aerosols
- ❑ Fumigants

Volatile Organic Compounds

- ❑ Had home painted in the last 2 years
- ❑ Use cleaning solvents
- ❑ Have soft vinyl floors
- ❑ Handle propane and butane
- ❑ Get your clothes dry-cleaned
- ❑ Store dry-cleaned clothes in closets
- ❑ Barbecue more than 2 times per month
- ❑ Work in a "tightly sealed building"
- ❑ Work close to a laser printer
- ❑ Use moth balls
- ❑ Have nylon carpet
- ❑ Use air fresheners
- ❑ Have a workshop in the home

Phenols (Do you use the following?)

- ❑ Household cleaners
- ❑ Nasal Sprays
- ❑ Styrofoam cups
- ❑ Cough syrup
- ❑ Decongestants
- ❑ Hair sprays
- ❑ Scented deodorants
- ❑ Scotch tape
- ❑ Newsprint
- ❑ Lysol
- ❑ Epoxy
- ❑ Listerine
- ❑ Chloraseptic throat sprays
- ❑ Noxema
- ❑ Mildew cleaners
- ❑ Perfumes
- ❑ Air fresheners
- ❑ Disinfectants
- ❑ Polishes
- ❑ Glues
- ❑ Waxes
- ❑ Mouthwash
- ❑ Hard saucepan handles
- ❑ Smoke in the house
- ❑ Explain any known chemical exposures _____
- ❑ Have you had your home treated for termites when? _____
- ❑ Wash your vehicle by hand

Carbon Monoxide/Nitrogen Oxide/Sulfur Dioxide

- ❑ Have oil or gas stove
- ❑ Have water heaters
- ❑ Chimney is damaged
- ❑ Live near a busy street
- ❑ Garage attached to your home
- ❑ Smoke at home
- ❑ Have an open fireplace
- ❑ Burn candles

Ozone

- ❑ Use an electrical sewing machine
- ❑ Use power tools
- ❑ Use ion generators
- ❑ Work close to a photocopier

Carbon Dioxide

- ❑ Work in a crowded work place
- ❑ Have poor ventilation at work

Asbestos

- ❑ Live in an old home
- ❑ Have old ceiling tiles, plaster, insulation board and heating duct tape
- ❑ Lived in large city with many trucks, buses, etc.
- ❑ Lived near a building which was torn down
- ❑ Mother exposed to any unusual chemicals or drugs during pregnancy
- ❑ Do you have your nails treated? Acrylic Adhesives

Please note the brand of product you use
i.e. Toothpaste: Crest

Shampoo: _____

Toothpaste: _____

Hair Conditioner: _____

Makeup: _____

Lipstick: _____

Make-up Foundation: _____

Deodorant:_____

Perfume: _____

Hairspray: _____

Shaving Cream: _____

Cologne: _____

Facial Creams: _____

Body Creams: _____

Do you have hair permanents? **Yes/No**

Do you have hair colorings? **Yes/No**

Do you use Latex products?

- ❑ Baby bottle nipples
- ❑ Balloons
- ❑ Bandages
- ❑ Diaphragms
- ❑ Hot water bottles
- ❑ Latex gloves
- ❑ Dishwashing gloves
- ❑ Rubber dams for dental work
- ❑ Tires

Heavy Metals, Mold, and General/Miscellaneous Toxins

- ❑ Have basement Molds
- ❑ Home is damp
- ❑ Any water Damage
- ❑ Home flooding
- ❑ Sewage backup
- ❑ Mold on walls and/or bathroom
- ❑ Use a humidifier? Last time cleaned _____
- ❑ Use black hair dye
- ❑ Worked in beauty shop
- ❑ Take illicit drugs as a youth
- ❑ Open your windows at home
- ❑ Work in a machine shop
- ❑ Work in a garden
- ❑ Work or have worked on a farm
- ❑ Have mercury fillings
- ❑ Had mercury fillings removed?. When_____
- ❑ Exposed to radiation? When_____
- ❑ Have a hot tub
- ❑ Use chlorine or bromine
- ❑ Have a well
- ❑ Work around PVC pipe
- ❑ Moved to a new office in the last two years
- ❑ Live in an apartment? How old? _____
- ❑ Eat at salad bars
- ❑ Eat raw fish (sushi)
- ❑ Buy food from street vendors
- ❑ **For Women:** Have breast implants? If yes:
    - Saline
    - Silicone
- ❑ Has any type of metal been used in implants or joints replacements in your body?
  When & Where_____
- ❑ Notice symptoms at work more than at home or vice versa?
- ❑ Symptoms worse going into a mall
- ❑ Have you ever worked in a mall? When _____
- ❑ Have live plants in your home
- ❑ Have pets in your home that use flea/tick control
- ❑ Owned a new vehicle since your symptoms began
- ❑ Furniture been put in storage or possibly fumigated
- ❑ Stained furniture in last 2 years
- ❑ Have a tool shop in your garage
- ❑ Live on or near a golf course
- ❑ Live in or near an industrial area
- ❑ Lived or traveled outside US.
  Where?_____
- ❑ Bought new furniture? Type of Material_____
- ❑ Installed drop ceilings
- ❑ Painted indoors
- ❑ Sided your home
- ❑ Changed your heating system, stove, clothes dryer or water heater
- ❑ Lived in a brand new home
- ❑ Lived in a new office
- ❑ Noticed changes of your health since you moved into your home
- ❑ Do not have a water purification system?
- ❑ Live near a landfill?
- ❑ Unfiltered shower head

Bedroom contents

Mattress Type: _____

- ❑ Have hardwood floors
- ❑ Have carpeting
- ❑ Have blinds
- ❑ Have draperies
- ❑ Have foam pillow
- ❑ Use a feather pillow
- ❑ Use a Dacron pillow
- ❑ Use wool blankets
- ❑ Use cotton blankets
- ❑ Use quilts
- ❑ Use synthetic blankets
- ❑ Have oil or gas stove
- ❑ Have water heaters
- ❑ Chimney is damaged
- ❑ Live near a busy street
- ❑ Garage attached to your home
- ❑ Smoke at home
- ❑ Have an open fireplace
- ❑ Burn candles
- ❑ Have real plants
- ❑ Have artificial plants
- ❑ Use aromatherapy
- ❑ Burn scented candles
- ❑ Have central heat
- ❑ Have a fireplace
- ❑ Have an electric baseboard
- ❑ Use gas heat
- ❑ Use an air filter in your bedroom
- ❑ Central air conditioning
- ❑ Sleep with your windows open
- ❑ Live close to a high traffic road
- ❑ Smoke in bed
- ❑ Allow any pets in your room
- ❑ Have plugged in air fresheners

Hobbies and other activates

- ❑ Silk-screening
- ❑ Make stained glass
- ❑ Make pottery & ceramic products
- ❑ Make jewelry
- ❑ Buy art and craft supplies
- ❑ Use airbrush and spray paints
- ❑ Do quilting and weaving
- ❑ Gardening
- ❑ Make soapstone carvings
- ❑ Use acrylic paint
- ❑ Golf
- ❑ Paintball

Others: _____

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. Hartz, DC

Dr. Zaideman, DC

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:_____