

Intake form

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GDPR Data Protection Regulations. September 2018

* The personal information you have provided in the “Intake Form” and “Diet Diary” is stored in paper form in a locked cabinet, and is duplicated electronically and stored on a password encrypted external hard drive.

* Your information will not be shared with any third party unless we agree that laboratory testing is required. In the event that testing is required, your details (full name, date of birth, and home address) will shared with the appropriate laboratory to facilitate the delivery of test kit materials.
* I am legally required to securely store your data for seven years following your most recent appointment with me. In the case of minors (under 18 years of age) the seven year period commences on their 18th birthday. Following this period, the consultation notes will be destroyed.
* You provide me with permission to contact you via telephone and email regarding therapy-related information (eg consultation reminders, therapeutic plans, and testing information).
* You provide me with permission to share your data (name, date of birth, home address) with relevant third parties (laboratories) to provide you with testing materials.
* Any request to access your personal data of have your data erased must be in writing and signed by you. Email and text message requests are not acceptable.

Please sign below to confirm that you give consent to the above handling of your Personal Data:

**Name** Click or tap here to enter text.

**Signature**

**Date** Click or tap here to enter text.

Elliot Overton DipCNM, CFMP

EONutrition, Unit 24a Hollins Business Centre, Rowley Street, Stafford ST16 2RH

Informed Consent to Nutritional Therapy and Functional Medicine with EONUTRITION

Nutritional therapy and functional medicine is practiced by non-medical professionals and is complimentary to other regulated forms of healthcare in England. Consultations with a nutritional therapist include taking a detailed case history, performing a physical exam if relevant, creating a dietary/lifestyle plan and following up on results and progression of your health. Nutritional therapists employ a range of therapeutic techniques including dietary advice, supplements, testing and lifestyle advice.

While the best course of action is continually sought for the patient there always exists the possibility of side effects, adverse reactions or inefficacy of treatment. Elliot Overton holds your safety and well-being as his top priority in the management of your case and welcomes all questions or concerns you may have.

As a client working with EONutrition I acknowledge that:

1. Elliot Overton has in no way suggested that my being under his care should prevent me from seeking treatment from any other healthcare practitioner.
2. Elliot Overton will strive to deliver the safest and most effective interventions for my case, however there is still the possibility that side effects or adverse reactions might occur, or that therapeutic benefit may not be achieved.
3. I will inform Elliot Overton of all medical conditions I have been diagnosed with, symptoms I am experiencing, and medications I am taking/have taken in the past. I will also inform him of any new medical conditions or symptoms, or medications should they arise.
4. I will inform Elliot Overton if I am pregnant or breastfeeding. I will immediately inform him should I become, or plan to become pregnant or if I begin, or plan to begin to breastfeed.
5. I will inform Elliot Overton if I do not understand any given part of the recommendations given to me or if I am uncomfortable with any aspect of my care.
6. All the information I provide to Elliot Overton and protected by General Data Protection Regulations and is confidential unless disclosure is required by law.
7. My case information may be used for the publication of case reports or case studies. Any information concerning my identity will be excluded from publication, thus maintaining my anonymity.
8. I am free to purchase any products recommended by Elliot Overton for my treatment from a vendor of my choosing, being under no obligation to purchase products from Elliot Overton directly.
9. Recording of online sessions is prohibited unless the explicit consent is gained from Elliot Overton
10. I understand that I am responsible for booking in follow-up appointments and should contact Elliot Overton via email or use the online booking system.
11. I have read and understood the fee and prices schedule.

I declare that I have read and understood the information presented above and that I authorize and consent to my present and future use of the nutritional therapy and functional medicine services by Elliot Overton I understand that I may withdraw this consent at any time.

EONutrition Consultation Fee Schedule\*

Initial Visit - £200

Follow-up Visit – 60 minutes - £100

Block-Buy Package - £500

Cancellation policy

EONutrition requests 48 hours’ notice of a cancellation. **Less than 48 hours or a missed appointment will incur a 100% cancellation fee**. **There will be a 50% rescheduling fee if you cancel within less than 48 hours of your appointment.**

Please note, cancellation fees also apply if you do cannot attend your appointment due to a misunderstanding relating to time zones and you do not give 48 hours. It is your responsibility to ensure that the time zone you are booking is correct. Please check the booking confirmation email as this tells you which time zone your appointment is in.

Refunds

**For block-buy:** Please be aware that you will only receive a refund for the services you have not used. You may not receive a refund for sessions that have already been completed since considerable time and effort is taken to review your case.

Block-buy packages must be used with 12 months. No refund will be given for unused sessions after 12 months.

**Initial or follow up consultations:** You may not receive a refund for sessions that have already been completed since considerable time and effort is taken to review your case.

**Name** Click or tap here to enter text.

**Signature** *Click or tap here to enter text.*

**Date** Click or tap here to enter text.

**HEALTH HISTORY**

Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form. This will assist our goal to provide you with an optimal support plan, enhance our efficiency, and will provide effective use of your scheduled time.

|  |
| --- |
| **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name**: First name. Last Name. |
| **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City/town**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **County:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Post Code:** \_\_\_\_\_\_\_ |
| **Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_ **Mobile phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** F/M. |

**Referred by**:\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Name, address & phone number of GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Marital Status:**

**Single**[ ]  **Married**[ ]  **Divorced**[ ]  **Widowed**[ ]  **Long Term Partnership**[ ]

**Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hours per week** \_\_\_\_\_\_\_\_  **Retired** [ ]

**Nature of Business:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Genetic Background**: Please check appropriate box(es):

|  |  |  |  |
| --- | --- | --- | --- |
| [ ] African American | [ ] Hispanic | [ ] Mediterranean | [ ] Asian |
| [ ] Native American | [ ] Caucasian | [ ] Northern European | [ ] Other |
| **CURRENT HEALTH STATUS/CONCERNS** |
| **Problem** | **Date of Onset** | **Severity/Frequency** | **Treatment Approach** | **Success** |
| ***Example:*** *Headaches* | *May 2006* | *2 times per week* | *Acupuncture/Aspirin* | *Mild improvement* |
|   | . |   |   |   |
|   |   |  . |  . |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |  . |

|  |
| --- |
| **What diagnosis or explanation(s), if any, have been given to you for these concerns?** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **When was the last time that you felt well?**  |   |
| **What seems to trigger your symptoms?** |   |
| **What seems to worsen your symptoms?** |   |
| **What seems to make you feel better?** |   |

|  |
| --- |
| **If there were three problems you could eliminate, what would they be?** |
| 1.  |
| 2.  |
| 3.  |

**PAST MEDICAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| AUTO & INFLAMMATORY | **past** | **current** | GASTROINTESTINAL | **past** | **current** |
| Chronic Fatigue Syndrome |[ ] [ ]  Irritable Bowel Syndrome |[ ] [ ]
| Autoimmune System |[ ] [ ]  Inflammatory Bowel Disease |[ ] [ ]
| Rheumatoid Arthritis |[ ] [ ]  Crohn’s |[ ] [ ]
| Lupus SLE |[ ] [ ]  Ulcerative Colitis |[ ] [ ]
| Immune Deficiency Disease |[ ] [ ]  Gastritis or Peptic Ulcer Disease |[ ] [ ]
| Herpes-Genital |[ ] [ ]  GERD(reflux) |[ ] [ ]
| Severe Infectious Disease |[ ] [ ]  Celiac Disease |[ ] [ ]
| Poor Immune Function (frequent infections) |[ ] [ ]  Gallstones |[ ] [ ]
| Food Allergies |[ ] [ ]  Other |[ ] [ ]
| Environmental Allergies |[ ] [ ]  CARDIOVASCULAR | **past** | **current** |
| Multiple Chemical Sensitivities |[ ] [ ]   |  |  |
| Latex Allergy |[ ] [ ]  Heart Attack |[ ] [ ]
| Hepatitis |[ ] [ ]  Other Heart Disease |[ ] [ ]
| METABOLIC/ENDOCRINE | **past** | **current** | Stroke |[ ] [ ]
|  |  |  | Elevated Cholesterol |[ ] [ ]
|  |  |  | Arrhythmia (irregular heartbeat) |[ ] [ ]
| Type 1 Diabetes |[ ] [ ]  Hypertension (high blood pressure) |[ ] [ ]
| Type 2 Diabetes |[ ] [ ]  Celiac Disease (Rheumatic Fever) |[ ] [ ]
| Hypoglycemia |[ ] [ ]  Mitral Valve Prolapse |[ ] [ ]
| Metabolic Syndrome |[ ] [ ]  Other |[ ] [ ]
| Insulin Resistance or Pre-Diabetes |[ ] [ ]  NEUROLOGICAL | **past** | **current** |
| Hypothyroidism (low thyroid) |[ ] [ ]   |  |  |
| Hypothyroidism (overactive thyroid) |[ ] [ ]   |  |  |
| Endocrine Problems |[ ] [ ]  Depression |[ ] [ ]
| Polycystic Ovarian Syndrome (PCOS) |[ ] [ ]  Anxiety |[ ] [ ]
| Infertility |[ ] [ ]  Bipolar Disorder |[ ] [ ]
| Weight Gain |[ ] [ ]  Schizophrenia |[ ] [ ]
| Weight Loss |[ ] [ ]  Headaches |[ ] [ ]
| Frequent Weight Fluctuations |[ ] [ ]  Migraines |[ ] [ ]
| Bulimia |[ ] [ ]  ADD/ADHD |[ ] [ ]
| Anorexia |[ ] [ ]  Autism |[ ] [ ]
| Binge Eating Disorder |[ ] [ ]  Mild Cognitive Impairment |[ ] [ ]
| Night Eating Disorder |[ ] [ ]  Memory Problems |[ ] [ ]
| Eating Disorder (non-specific) |[ ] [ ]  Parkinson’s Disease |[ ] [ ]
| MUSCULOSKELETAL | **past** | **current** | Multiple Sclerosis |[ ] [ ]
|  |  |  | ALS |[ ] [ ]
|  |  |  | Seizures |[ ] [ ]
| Osteoarthritis |[ ] [ ]  Alzheimer’s |[ ] [ ]
| Fibromyalgia |[ ] [ ]  Other |[ ] [ ]
| Chronic Pain |[ ] [ ]   |  |  |
| GENITO-URINARY | **past** | **current** | CANCER | **past** | **current** |
| Kidney Stones |[ ] [ ]  Lung Cancer |[ ] [ ]
| Gout |[ ] [ ]  Breast Cancer |[ ] [ ]
| Interstitial Cystitis |[ ] [ ]  Colon Cancer |[ ] [ ]
| Frequent Urinary Tract Infections |[ ] [ ]  Ovarian Cancer |[ ] [ ]
| Frequent Yeast Infections |[ ] [ ]  Prostate Cancer |[ ] [ ]
| Erectile Dysfunction or Sexual Dysfunction |[ ] [ ]  Skin Cancer |[ ] [ ]
|  |  |  | Other |[ ] [ ]
| RESPIRATORY | **past** | **current** | SKIN | **past** | **current** |
| Asthma |[ ] [ ]  Eczema |[ ] [ ]
| Chronic Sinusitis |[ ] [ ]  Psoriasis |[ ] [ ]
| Bronchitis |[ ] [ ]  Acne |[ ] [ ]
| Emphysema |[ ] [ ]  Melanoma |[ ] [ ]
| Pneumonia |[ ] [ ]  Skin Cancer |[ ] [ ]
| Tuberculosis |[ ] [ ]  Other |[ ] [ ]
| Sleep Apnea |[ ] [ ]  Eczema |[ ] [ ]

**MEDICATIONS**

|  |  |  |
| --- | --- | --- |
| **How often have you taken antibiotics?** | **Less than 5 times** | **More than 5 times** |
| Infancy/Childhood |[ ] [ ]
| Teen |[ ] [ ]
| Adulthood |[ ] [ ]

|  |  |  |
| --- | --- | --- |
| **How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)** | **Less than 5 times** | **More than 5 times** |
| Infancy/Childhood |[ ] [ ]
| Teen |[ ] [ ]
| Adulthood |[ ] [ ]

|  |
| --- |
| **List all medications. Include all over the counter non-prescription drugs.** |
| **Medication Name** | **Date started** | **Date stopped** | **Dosage** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**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** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?** Yes [ ]  No [ ]

**If yes, please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDHOOD HISTORY**

Please answer to the best of your knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Don’t Know** |
| Where you a full term baby? |[ ] [ ] [ ]
|  A premature birth? (‘preemie’) |[ ] [ ] [ ]
|  Breast fed? |[ ] [ ] [ ]
|  Bottle fed? |[ ] [ ] [ ]
| When pregnant with you, did your mother: |  |
|  Use recreational drugs? |[ ] [ ] [ ]
|  Drink alcohol? |[ ] [ ] [ ]
|  Use estrogen? |[ ] [ ] [ ]
|  Other prescription or non-prescription medications? |[ ] [ ] [ ]

**IMMUNIZATION HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Don’t Know** |
| Did you receive routine vaccinations? |[ ] [ ] [ ]

**CHILDHOOD DIET**

|  |  |  |  |
| --- | --- | --- | --- |
| Was your childhood diet high in: | **Yes** | **No** | **Don’t Know** |
| Sugar? (Sweets, Candy, Cookies, etc) |[ ] [ ] [ ]
| Soda? |[ ] [ ] [ ]
| Fast food, pre-packaged foods, artificial sweeteners? |[ ] [ ] [ ]
| Milk, cheeses, other dairy products? |[ ] [ ] [ ]
| Meat, vegetables, & potato diet? |[ ] [ ] [ ]
| Vegetarian diet?  |[ ] [ ] [ ]
| Diet high in white breads? |[ ] [ ] [ ]

**As a child, were there foods that you had to avoid because they gave you symptoms**? Yes [ ]  No [ ]

**If yes, please explain:** (Example: milk – diarrhea)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDHOOD ILLNESSES**

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **YES** |  |  | **YES** |
| ADD (Attention Deficient Disorder) |[ ]   | Mumps |[ ]
| Asthma |[ ]   | Pneumonia |[ ]
| Bronchitis |[ ]   | Seasonal allergies |[ ]
| Chicken Pox |[ ]   | Skin disorders (e.g. dermatitis) |[ ]
| Colic |[ ]   | Strep infections |[ ]
| Congenital problems |[ ]   | Tonsillitis |[ ]
| Ear infections |[ ]   | Upset stomach, digestive problems |[ ]
| Fever blisters |[ ]   | Whooping cough |[ ]
| Frequent colds or flu |[ ]   | Hyperactivity |[ ]
| Frequent headaches |[ ]   | Jaundice |[ ]

**FEMALE MEDICAL HISTORY**

*(For women only)*

**GYNECOLOGICAL HISTORY**

**Age at first menses**?\_\_\_ **Frequency:** Click here to enter text. **Length**: Click here to enter text.

**Painful**: Yes[ ]  No[ ]  **Clotting**: Yes[ ]  No[ ]

|  |
| --- |
| **Do you currently use contraception?** Yes[ ]  No[ ]  If yes, what please indicate which form: |
| **Non-hormonal:** |  **Hormonal:** |
| [ ] Condom  | [ ] Patch |
| [ ]  Diaphragm | [ ] Nuva Ring  |
| [ ]  IUD | [ ] Oral contraceptive pill |
| [ ]  Partner vasectomy | ☐Other |
| [ ] Other  |  |

**Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long:** Click here to enter text.

**Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle?** Yes [ ]  No [ ]

**Are you menopausal?** Yes[ ]  No[ ]  **If yes, age of menopause**: Click here to enter text.

**REVIEW OF SYMPTOMS**

**Check** **(x)** those items currently apply, or have applied in the last year.

**General**

|  |
| --- |
| [ ] Fever |
| [ ] Chills/Cold all over |
| [ ] Aches/Pains  |
| [ ] General Weakness |
| [ ] Difficulty sweating  |
| [ ] Excessive Sweating |
| [ ] Swollen Glands  |
| [ ] Cold hands & Feet |
| [ ] Fatigue |
| [ ] Difficulty falling asleep |
| [ ] Sleepwalker |
| [ ] Nightmares |
| [ ] No dream recall |
| [ ] Early waking |
| [ ] Daytime sleepiness |
| [ ] Distorted vision |

**SKIN:**

|  |
| --- |
| [ ] Cuts heal slowly |
| [ ] Bruise easily |
| [ ] Rashes  |
| [ ] Pigmentation  |
| [ ] Changing Moles  |
| [ ] Calluses  |
| [ ] Eczema |
| [ ] Psoriasis |
| [ ] Dryness/cracking skin |
| [ ] Oiliness |
| [ ] Itching |
| [ ] Acne |
| [ ] Boils |
| [ ] Hives |
| [ ] Fungus on Nails |
| [ ] Peeling Skin |
| [ ] Shingles |
| [ ] Nails Split  |
| [ ] White Spots/Lines on Nails |
| [ ] Crawling Sensation  |
| [ ] Burning on Bottom of Feet  |
| [ ] Athletes Foot |
| [ ] Cellulite |
| [ ] Bumps on back of arms & front of thighs |
| [ ] Skin cancer |
| [ ] Strong body odor |

**HEAD:**

|  |
| --- |
| [ ] Poor Concentration |
| [ ] Confusion |
| Headaches: |
| [ ] After Meals |
| [ ] Severe |
| [ ] Migraine |
| [ ] Frontal |
| [ ] Afternoon |
| [ ] Occipital |
| [ ] Afternoon |
| [ ] Daytime |
| [ ] Concussion/Whiplash |
| [ ] Mental sluggishness |
| [ ] Forgetfulness |
| [ ] Indecisive |
| [ ] Face twitch |
| [ ] Poor memory |
| [ ] Hair loss |

**EYES:**

|  |
| --- |
| [ ] Feeling of sand in eyes |
| [ ] Double vision |
| [ ] Blurred vision |
| [ ] Poor night vision |
| [ ] See bright flashes |
| [ ] Halo around lights |
| [ ] Eye pains |
| [ ] Dark circles under eyes |
| [ ] Strong light irritates |
| [ ] Cataracts |
| [ ] Floaters in eyes |
| [ ] Visual hallucinations |

**EARS:**

|  |
| --- |
| [ ] Aches |
| [ ] Discharge/Conjunctivitis |
| [ ] Pains |
| [ ] Ringing |
| [ ] Deafness/Hearing loss |
| [ ] Itching |
| [ ] Frequent infections |
| [ ] Tubes in ears |
| [ ] Sensitive to loud noises |

**NOSE/SINUSES**

|  |
| --- |
| [ ] Post nasal drip |
| [ ] No sense of smell |
| Do the change of seasons tend to make your symptoms worse? [ ]  Yes/[ ] No |
| **If yes, is it worse in the:** |
| [ ] Spring |
| [ ] Summer |
| [ ] Fall |
| [ ] Winter |

**MOUTH:**

|  |
| --- |
| [ ] Coated tongue |
| [ ] Sore tongue |
| [ ] Teeth problems |
| [ ] Bleeding gums |
| [ ] Canker sores |
| [ ] TMJ |
| [ ] Cracked lips/ corners |
| [ ] Chapped lips |
| [ ] Fever blisters |
| [ ] Wear dentures |
| [ ] Grind teeth when sleeping |
| [ ] Bad breath |
| [ ] Dry mouth |

**THROAT:**

|  |
| --- |
| [ ] Mucus |
| [ ] Difficulty swallowing |
| [ ] Frequent hoarseness |
| [ ] Tonsillitis |
| [ ] Enlarged glands |
| [ ] Constant clearing of throat |
| [ ] Throat closes up |

**NECK:**

|  |
| --- |
| [ ] Stiffness |
| [ ] Swelling |
| [ ] Lumps |
| [ ] Neck glands swell |

**CIRCULATION/RESPIRATION**:

|  |
| --- |
| [ ] Swollen ankles |
| [ ] Sensitive to hot |
| [ ] Sensitive to cold |
| [ ] Extremities cold or clammy |
| [ ] Hands/Feet go to sleep/numbness/tingling |
| [ ] High blood pressure |
| [ ] Chest pain |
| [ ] Pain between shoulders |
| [ ] Dizziness upon standing |
| [ ] Fainting spells |
| [ ] High cholesterol |
| [ ] High triglycerides |
| [ ] Wheezing |
| [ ] Irregular heartbeat |
| [ ] Palpitations |
| [ ] Low exercise tolerance |
| [ ] Frequent coughs |
| [ ] Breathing heavily |
| [ ] Frequently sighing |
| [ ] Shortness of breath |
| [ ] Night sweats |
| [ ] Varicose veins/spider veins |
| [ ] Mitral valve prolapse |
| [ ] Murmurs |
| [ ] Skipped heartbeat |
| [ ] Heart enlargement |
| [ ] Angina pain |
| [ ] Bronchitis/Pneumonia |
| [ ] Emphysema |
| [ ] Croup |
| [ ] Frequent colds |
| [ ] Heavy/tight chest |
| [ ] Prior heart attack  |
| [ ] Phlebitis |

**KIDNEY/URINARY TRACT:**

|  |
| --- |
| [ ] Burning |
| [ ] Frequent urination |
| [ ] Blood in urine |
| [ ] Night time urination |
| [ ] Problem passing urine |
| [ ] Kidney pain |
| [ ] Kidney stones |
| [ ] Painful urination |
| [ ] Bladder infections |
| [ ] Kidney infections |

**GASTROINTESTINAL**

|  |
| --- |
| [ ] Peptic/Duodenal Ulcer |
| [ ] Poor appetite |
| [ ] Excessive appetite |
| [ ] Gallstones |
| [ ] Gallbladder pain |
| [ ] Nervous stomach |
| [ ] Full feeling after small meal |
| [ ] Indigestion |
| [ ] Heartburn |
| [ ] Acid Reflux |
| [ ] Hiatal Hernia |
| [ ] Nausea |
| [ ] Vomiting |
| [ ] Vomiting blood |
| [ ] Abdominal Pains/Cramps |
| [ ] Gas |
| [ ] Diarrhea |
| [ ] Constipation |
| [ ] Changes in bowels |
| [ ] Rectal bleeding |
| [ ] Tarry stools |
| [ ] Rectal itching |
| [ ] Use laxatives |
| [ ] Bloating |
| [ ] Belch frequently |
| [ ] Anal itching |
| [ ] Anal fissures |
| [ ] Bloody stools |
| [ ] Undigested food in stools |

**WOMEN’S HISTORY (for women only)**

|  |
| --- |
| [ ] Fibrocystic breasts |
| [ ] Lumps in breast |
| [ ] Fibroid Tumors/Breast |
| [ ] Spotting |
| [ ] Heavy periods |
| [ ] Fibroid Tumors/Uterus |

**WOMEN’S HISTORY (for women only)**

|  |
| --- |
| [ ] Painful periods |
| [ ] Change in period |
| [ ] Breast soreness before period |
| [ ] Endometriosis |
| [ ] Non-period bleeding |
| [ ] Breast soreness during period |
| [ ] Vaginal dryness |
| [ ] Vaginal discharge |
| [ ] Partial/total hysterectomy |
| [ ] Hot flashes |
| [ ] Mood swings |
| [ ] Concentration/Memory Problems |
| [ ] Breast cancer |
| [ ] Ovarian cysts |
| [ ] Pregnant |
| [ ] Infertility |
| [ ] Decreased libido |
| [ ] Heavy bleeding |
| [ ] Joint pains |
| [ ] Headaches |
| [ ] Weight gain |
| [ ] Loss of bladder control  |
| [ ] Palpitations |

**MEN’S HISTORY (for men only)**

|  |
| --- |
| [ ] Prostate enlargement |
| [ ] Prostate infection |
| [ ] Change in libido |
| [ ] Impotence |
| [ ] Diminished/poor libido |
| [ ] Infertility |
| [ ] Lumps in testicles |
| [ ] Sore on penis |
| [ ] Genital pain |
| [ ] Hernia |
| [ ] Prostate cancer |
| [ ] Low sperm count |
| [ ] Difficulty obtaining erection |
| [ ] Difficulty maintaining an erection |
| [ ] Nocturia (urination at night)  |
| [ ] Urgency/Hesitancy/Change in Urinary Stream |
| [ ] Loss of bladder control  |

## JOINT/MUSCLES/TENDONS

|  |
| --- |
| [ ] Pain wakes you  |
| [ ] Weakness in legs and arms |
| [ ] Balance problems |
| [ ] Muscle cramping |
| [ ] Head injury |
| [ ] Muscle stiffness in morning |
| [ ] Damp weather bothers you |

**Emotional:**

|  |
| --- |
| [ ] Convulsions |
| [ ] Dizziness |
| [ ] Fainting Spells |
| [ ] Blackouts/Amnesia |
| [ ] Had prior shock therapy |
| [ ] Frequently keyed up and jittery |
| [ ] Startled by sudden noises |
| [ ] Anxiety/Feeling of panic |
| [ ] Go to pieces easily |
| [ ] Forgetful |
| [ ] Listless/groggy |
| [ ] Withdrawn feeling/Feeling ‘lost’ |
| [ ] Had nervous breakdown |
| [ ] Unable to concentrate/short attention span |
| [ ] Vision changes |
| [ ] Unable to reason |
| [ ] Considered a nervous person by others |
| [ ] Tends to worry needlessly |
| [ ] Unusual tension |

**EMOTIONAL (CONTINUED)**

|  |
| --- |
| [ ] Frustration |
| [ ] Emotional numbness |
| [ ] Often break out in cold sweats |
| [ ] Profuse sweating |
| [ ] Depressed |
| [ ] Previously admitted for psychiatric care |
| [ ] Often awakened by frightening dreams |
| [ ] Family member had nervous breakdown |
| [ ] Use tranquilizers |
| [ ] Misunderstood by others |
| [ ] Irritable/ |
| [ ] Feeling of hostility/volatile or aggressive  |
| [ ] Fatigue |
| [ ] Hyperactive |
| [ ] Restless leg syndrome |
| [ ] Considered clumsy |
| [ ] Unable to coordinate muscles |
| [ ] Have difficulty falling asleep |
| [ ] Have difficulty staying asleep |
| [ ] Daytime sleepiness |
| [ ] Am a workaholic |
| [ ] Have had hallucinations |
| [ ] Have considered suicide |
| [ ] Have overused alcohol |
| [ ] Family history of overused alcohol |
| [ ] Cry often |
| [ ] Feel insecure |
| [ ] Have overused drugs |
| [ ] Been addicted to drugs |
| [ ] Extremely shy |

**NUTRITIONAL HISTORY**

Have you made any changes in your eating habits because of your health? Yes[ ]  No[ ]

Do you currently follow a special diet or nutritional program? Yes[ ]  No[ ]

[ ] Ovo-lacto

[ ] Diabetic

[ ] Dairy restricted

[ ] Vegetarian

[ ] Vegan

[ ] Blood type diet

[ ] Other (describe): Click here to enter text.

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): Click here to enter text.

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 |

Do you see food as:

|  |  |
| --- | --- |
| [ ] Necessary fuel[ ] Disinteresting | [ ] A significant source of sensory pleasure [ ] One of the main sources of pleasure and happiness in my life |

Which applies to you?

|  |  |
| --- | --- |
| [ ] Willing to eat various foods despite unpleasant taste[ ] I will occasionally eat foods which I know to be healthy, despite not enjoying them | [ ] Food MUST be pleasurable to eat, or I won’t eat it  |

How willing are you to discontinue eating foods which you enjoy?

|  |  |
| --- | --- |
| [ ] Willing to give up any food to improve my health[ ] Willing to give up foods, as long as I can replace them with something similar | [ ] Willing to give up a couple of foods, but not go on a diet that I think is “restrictive”[ ] Not currently willing to give up any foods that I enjoy |

Please complete the following chart as it relates to your bowel movements:

|  |  |  |  |
| --- | --- | --- | --- |
| **Frequency** | **√** | **Color** | **√** |
| More than 3x/day |[ ]  Medium brown consistently |[ ]
| 1-3x/ day |[ ]  Very dark or black |[ ]
| 4-6x/week |[ ]  Greenish color |[ ]
| 2-3x/week |[ ]  Blood is visible |[ ]
| 1 or fewer x/week |[ ]  Varies a lot |[ ]
|  |  | Dark brown consistently |[ ]
| **Consistency** | **√** | Yellow, light brown |[ ]
| Soft and well formed |[ ]  Greasy, shiny appearance |[ ]
| Often floats |[ ]  **Intestinal gas:** |  |
| Difficult to pass |[ ]  Daily  |[ ]
| Diarrhea |[ ]  Occasionally |[ ]
| Thin, long or narrow |[ ]  Excessive |[ ]
| Small and hard |[ ]  Painful |[ ]
| Loose but not watery |[ ]  Foul smelling |[ ]
| Alternating between hard and loose/watery |[ ]   |  |

**LIFESTYLE HISTORY**

**ALCOHOL INTAKE**

|  |
| --- |
| Have you ever used alcohol? Yes[ ]  No[ ]  |
| If yes, how often do you now drink alcohol?  |
| [ ] No longer drink alcohol | [ ] Average 4-6 drinks per week | [ ] Average >10 drinks per week |
| [ ] Average 1-3 drinks per week | [ ] Average 7-10 drinks per week | Have you ever had a problem with alcohol? Yes[ ]  No[ ]  |

**OTHER SUBSTANCES**

|  |
| --- |
| Do you currently or have you previously used recreational drugs? Yes [ ]  No [ ]   |
| To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes [ ]  No [ ]  |
| If yes, indicate which: |
| [ ] Lead | [ ] Aluminum |
| [ ] Cadmium | [ ] Arsenic |
| [ ] Mercury |  |

|  |
| --- |
| Do you currently have mercury amalgam (silver) fillings in your mouth? Yes [ ]  No [ ]   |
| If yes, how many?: Click or tap here to enter text.  |

|  |
| --- |
| Do you currently or have you previously lived in a moldy house? Yes [ ]  No [ ]   |

**SLEEP & REST HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Average number of hours that you sleep at night?  | More than 10 [ ]   | 8-10 [ ]  | 6-8 [ ]  | Less than 6 [ ]  |
| Do you:  |
| [ ]  Have trouble falling asleep? | [ ]  Have problems with insomnia? |
| [ ]  Feel rested upon wakening? | [ ]  Use sleeping aids? |
| [ ]  Snore? |  |

**EXERCISE HISTORY**

Do you exercise regularly? Yes[ ]  No[ ]

|  |  |  |
| --- | --- | --- |
| If yes, please indicate: |  **Times/week** |  |
| **Type of exercise** | 1x | 2x | 3x | 4x/+ |  |
| 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)

Click here to enter text.

**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.

**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[ ]

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Have you ever been involved in abusive relationships in your life?  |[ ] [ ]
| Have you ever been abused, a victim of a crime, or experienced a significant trauma?  |[ ] [ ]
| Did you feel safe growing up?  |[ ] [ ]
| Was alcoholism or substance abuse present in your childhood home? |[ ] [ ]
| Is alcoholism or substance abuse present in your relationships now?  |[ ] [ ]

|  |
| --- |
|  |

 |
|  |

**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:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **5** | **4** | **3** | **2** | **1** |
| Radically modify your diet  |[ ] [ ] [ ] [ ] [ ]
| Take nutritional supplements each day  |[ ] [ ] [ ] [ ] [ ]
| Modify your lifestyle (e.g. work demands, sleep habits)  |[ ] [ ] [ ] [ ] [ ]
| Practice relaxation techniques  |[ ] [ ] [ ] [ ] [ ]
| Engage in regular exercise  |[ ] [ ] [ ] [ ] [ ]
| Have periodic lab tests to assess progress  |[ ] [ ] [ ] [ ] [ ]