

POLICIES

The purpose of this agreement is to allow us to better serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

APPOINTMENTS:

We ask that you show up 15 minutes prior to your initial appointment so you may complete your paperwork. We set up 60-90 minutes for the initial appointment because we find that this is the optimal amount of time to cover everything both the doctor and the client desire to cover. Follow up appointment time will be determined at the first appointment.

We require a 48 hour notice for cancellation of appointments. There will be a \$100 charge for missed appointments. If you need to change the time of your appointment, and call us 48 hours or more before your scheduled appointment, we will be happy to accommodate your needs.

PAYMENT:

All services and products are payable on the day of the service. We take VISA, MC, and Discover; as well as personal checks. Financing is available through Care Credit, contact our office at 402-827-9450 for more information.

ALL PRODUCTS ARE NON-REFUNDABLE DUE TO FEDERAL HEALTH AND SAFETY STANDARDS.

INSURANCE:

Dr. Ryan is not a participating provider with any insurance carrier. Your insurance is an agreement between you and your insurance company, not between your insurance company and our clinic. As a courtesy to our patients, our office will mail you a form that you can then submit to your insurance company to be reimbursed. It is understood and agreed that services rendered are charged to you directly and payment is expected at the time of service. It is imperative that you understand the following conditions and agree to them:

1. You are required to sign the informed consent agreement, financial agreement, and medical records release forms as well as any other assignment documents required by your insurance company and our office.
2. If you are reimbursed by your insurance carrier it will likely be within 30 days from the day you file the claim.
3. You are required to pay for all services provided to you at each visit.
4. Our office will not enter into any disputes with your insurance company over any claim. This is ultimately your responsibility and obligation.
5. Our office cannot guarantee that your insurance company will pay.

MEDICARE AND MEDICAID: Dr. Ryan is not a participating provider for Medicare and Medicaid.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. A photocopy of this authorization shall be as valid as the original.

I have read over the financial policy for this office and accept these terms. I understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure payment of benefits to me. I authorize the use of the signature on all my insurance submissions.

Patient or Guarantor Signature _____ Date _____

NEW PATIENT HISTORY FORM

NAME: _____ AGE: _____ DATE: _____ TIME: _____ am/pm

A. MAJOR SYMPTOMS: Please note that this is a comprehensive history. Details are important in understanding your problems and their causes. The time you take to fill this out is time well spent!

1. Tell us your major symptoms or problems for which you have come to us today and their duration.

B. TREATMENT RECEIVED

1. Number of physicians seen for the problems you have mentioned above, and their specialties:

2. Tell us about the treatment you have received for the problems you have mentioned above, such as investigations, and the tests that you had (including x-rays, CT scans, blood tests), and medicines used – prescription or over-the-counter medicines, etc.

3. Tell us about any side effects you may have had from the medicines or the treatment received for your problems (995.2)

4. If you had any allergy testing done in the past, when was it done, who did it, and what was found?

5. Did you receive any allergy injections, and if so, what symptoms got better, to what degree, and to what degree did it reduce the need for medicines?

C. SYMPTOMS

1. For women only:

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

- 0 = *Never or almost never have the symptoms*
- 1 = *Occasionally have it, effect is not severe*
- 2 = *Occasionally have it, effect is severe*
- 3 = *Frequently have it, effect is not severe*
- 4 = *Frequently have it, effect is severe*

FEMALE REPRODUCTIVE SYSTEM

_____ Ever had vaginal yeast infection (112.1)
 Total number of yeast infections in your lifetime: _____

_____ Ever get any vaginal discharge at all (616.10)

_____ Get premenstrual symptoms a few to several days before menses (625.4)

What premenstrual symptoms (625.4) do you have:

- _____ premenstrual headaches
- _____ premenstrual depression
- _____ premenstrual irritability
- _____ premenstrual anxiety
- _____ premenstrual breast engorgement
- _____ premenstrual bloating
- _____ premenstrual fluid retention
- _____ other premenstrual symptoms: _____

_____ menstrual cramping (625.3)

_____ pelvic pain (625.9)

_____ vaginal pain (625.00)

_____ breast pain (611.71) *

Heavy menstrual bleeding (626.2) Y N

Periods are irregular (626.4) Y N

Number of days you bleed _____ days

How long is your cycle (28, 30 days, etc.) _____

Bleeding in-between menses (626.4) * Y N

Headaches during menstruation Y N

Menopausal Y N

Hot flashes, Night sweats, Vaginal dryness, loss of libido (encircle)

Ever had miscarriage Y N # _____

_____ infertility

_____ rectal itch

Number of years you have taken birth control pills: _____

Age when first started on birth control pill: _____

Are you currently on birth control pills: Y N

Are you currently on female hormones: Y N

Number of years you have taken female hormones: _____

Age when female hormones started: _____

Age when menses started: _____ (years)

When did you have last pap smear: _____

By Dr. _____ Specialty: _____ OB-GYN

Other _____

When did you have last mammogram? _____

D. SOCIAL AND ENVIRONMENTAL HISTORY

1. Do you smoke? How many years?	Y	N	12. Type of range (cooktop) you have: gas electric		
How may packs/day?			13. Type of dryer you have: gas electric		
2. Years in college? Degree:			14. How do you heat your house? gas electric		
3. Do you have a smokers cough?	Y	N	Other form of heating used:		
4. Do you chew tobacco?	Y	N	15. Type of water heater gas electric		
5. Tell us your habits regarding drinking and drugs:			16. Age of your residence: _____ years		
6. Do you smoke at home?	Y	N	17. Type of House: apartment, townhouse, trailer		
Who does?			18. Type of bed: mattress waterbed		
7. Are you exposed to smoke at work?	Y	N	19. Is there dampness/mustiness in basement	Y	N
8. Tell us about your recreation/hobbies			20. Humidifier: on furnace in bedroom	Y	N
9. Do you have a dog? Indoor Outdoor	Y	N	21. Water leakage or damage in current house?	Y	N
10. Do you have a cat? Indoor Outdoor	Y	N	22. Termite treatment in house?	Y	N
11. Any other pets?	Y	N	23. Use of weed killer/bug spray on lawn	Y	N

24. Do any of the following smells bother you (please circle what applies)?

Tobacco smoke (987.8), exhaust fumes (981.3), bleaches, detergents, soaps (989.6), ammonia, odor of new carpeting, asphalt, tar, pine, moth balls, insect spray, paint, varnish, shellac, perfume, hair sprays, cosmetics, gasoline products (980.3), natural gas, floor wax, rubbing alcohol (982.2), rubber, plastics, chlorinated water (987.6), newsprint, new fabric stores, spray cans, food odors, alcohol, formaldehyde, smoke from wood burning or fireplaces, latex, mold/mildew odor, odors in beauty salons, or just odors of any kind.

Please explain why these odors bother you (987.8):

Do any of these smells/chemicals cause eye, ear, nose or throat symptoms (506.2)? Yes No

Do any of these smells/chemicals cause bronchial or chest symptoms (506.0)? Yes No

Do any of these smells/chemicals cause skin rashes (692.4)? Yes No

25. Are you exposed to any of these chemicals especially fragrances, cigarette smoke or pesticides at work? Yes No *If so, which chemical(s)?

26. Are there any air polluting industries in your town or neighboring towns (refineries, mills, factories, etc.) Yes No *If yes, specify:

27. Are you exposed to any other chemicals including toxic chemicals, dusts, fumes, excessive humidity, mists, vapors, solvents, asbestos, or gases: Yes No If so, please explain:

28. How is your sense of smell: average above average (781.1) below average (781.1) *Circle One*

How is your ability to detect leaking utility gas? Acute (781.1) Normal

29. Do any foods bother or disagree with you, or do you avoid any foods/substances including alcohol (980.0) Yes No Explain:

30. Do you over-consume sugar, bread, chocolate, colas, caffeine, alcohol? Yes No *Circle what applies*

31. Do you get sleepy, tired, have runny nose, stuffy nose, indigestion, heartburn, diarrhea, loose stool, abdominal pain, headaches, or any other symptom after eating certain foods? Yes No Explain:

32. Do you get alcohol hangovers (305.00) Yes No Explain:

E. MEDICINES: List the medicines you are taking on the medicine sheet provided with this packet.

1. Are you allergic to any medicines (V14.9): Penicillin (V14.0), Sulfa (V14.2), Other antibiotics (V14.1) Pain Medications (V14.6), Anesthetics (V14.4), OTHER (14.8): _____

Do any medicines cause skin rashes (691.0)? Yes No

F. PAST SURGICAL HISTORY

1. Did you ever have any surgery such as tonsillectomy, adenoidectomy, tubes in the ears, sinus surgery, gall bladder , appendectomy, hysterectomy, ovaries removed, breast operations, hernia (encircle)?
2. Did you ever have any implants put in such as breast, dental, metal implants in joints (i.e. knees, hips, etc.), metal clips following abdominal surgery, dental fillings, root canals, etc. (encircle)?
3. Other surgery: _____

G. MEDICAL

1. Have you ever been diagnosed with any of the following (circle what applies): hypothyroidism* (low thyroid), goiter (enlarged thyroid), Grave’s disease, high cholesterol, *high triglycerides, enlarged prostate (men), prostatitis (men), diabetes*, hypoglycemia*, bursitis (727.3)*, tendonitis, arthritis, TMJ, osteoporosis (733.02)*, fibromyalgia (729.1)*, poison ivy/poison sumac rash, mitral valve prolapse, heart murmur, coronary artery disease, heart disease, heart attack, Raynaud’s disease*, hiatal hernia, irritable bowel syndrome (564.1)*, peptic ulcer, rectal or colon polyps, diverticulitis, gall stones, kidney or bladder stones, cancer, severe or life-threatening reactions to any food such as peanuts, other nuts, fish, shellfish, any drug or any other substance, allergy to stinging insects, especially wasp, honey bee, etc., alcoholism, whiplash injury to neck, gum diseases, bleeding gums, blood transfusion, abnormal pap smear (women), uterine fibroids (women), endometriosis (women), fibrocystic breast (women), abortions, miscarriages.
2. In your previous employments, have you been exposed to: toxic chemicals, pesticides, weed killers, solvents, asbestos (circle what applies)?

H. INFECTIONS: Did you ever have any diseases such as chicken pox, measles, German measles, hepatitis, shingles, genital herpes, Lyme’s Disease, tick bite, HIV, risk factors for HIV, fungal infections of skin or nails, pneumonia, tuberculosis (circle what applies)?

I. EFFECT OF ILLNESS

1. How many days out of the month are your good days, i.e. when you feel perfectly fine and nothing seems to bother you: _____ days out of 30 days
2. How many days out of the month are your bad days, i.e. when your symptoms bother you: _____ days out of 30 days
3. List your most bothersome symptoms here: *If you need more space, add an additional page.*

4. How are these symptoms bothersome for you, i.e. how are they interfering with your daily activities, family life, or career? *If you need more space, add an additional page.*

J. PREVENTIVE CARE: The following are preventive services. These are age oriented, which means not everyone needs everything listed below. The doctor will discuss with you on an individual basis what will be needed in your case. Please encircle what applies to you:

- | | | | |
|---|----|-----|-------------|
| 1. Received flu vaccine for this year (V04.8): | No | Yes | Date: _____ |
| 2. Received tetanus and diphtheria (Td) injection (V06.5): | No | Yes | Date: _____ |
| 3. Received hepatitis vaccine-a series of 3 injections (V05.3): | No | Yes | Date: _____ |
| 4. Received pneumovax (pneumonia) injection (V03.82): | No | Yes | Date: _____ |
| 5. PSA done (for men only-screen for prostate) (V76.44) | No | Yes | Date: _____ |
| 6. Stool for occult blood done (screen for colon cancer) (V76.41) | No | Yes | Date: _____ |
| 7. Sigmoidoscopy done (screen for colon cancer): | No | Yes | Date: _____ |
| 8. HIV Blood Test | No | Yes | Date: _____ |
| 9. Bone Density Studies | No | Yes | Date: _____ |

1. Who lives at home besides you: _____
 Number of children: _____ Age when 1st child born: _____ Age when last child born: _____

2. Tell us about the health of your household (persons living at home besides the patient), i.e. are all of them in perfectly good health or have allergies (V19.6) or are prone to coughs, colds, bronchitis, wheezing, asthma (V17.5), hay fever (V17.6), ear infections, headaches, stomach aches, fatigue, or low level of energy, etc. Please provide the information below. *Use an additional page if needed.*

PERSONS LIVING AT HOME BESIDES THE PATIENT

Name	Age	Relationship to the Patient	Any Health Problems? How bothersome are these problems on a scale of 0, 1, 2, 3, 4
1.			
2.			
3.			
4.			
5.			
6.			

Are there any family members who have been treated, or are being treated at the Environmental Health & Allergy Center? Yes No If yes, who is being, or has been treated there? _____
 Your occupation: _____ No. of years at current job: _____
 Spouse's (husband or wife) occupation: _____
 In the case of a child:
Mother's occupation: _____
Father's occupation: _____
Parents' marital status: _____

Tell us if anyone else in your family has: allergies (V19.6), asthma (V17.5), arthritis (V17.7), high blood pressure (V17.4), heart disease (heart attack, stroke, high cholesterol) (V17.4), diabetes (V18.0), breast cancer (V16.3), other cancer (V16.9), hypothyroid (low thyroid) (V18.1), depression, mental illness, or any other significant ailments in the family (circle all that apply)

L. Thank You

We thank you for giving us the opportunity to help you.
 Were you referred to us by one of our patients? Yes No
 If yes, whom may we thank for your referral: _____
 If not, please explain how you heard about Alternatives: _____

The first step towards your recovery is...

EDUCATION, NOT MEDICATION!

We emphasize education throughout our practice. Education means learning about the causes of illness and how they affect you. To help our patients achieve optimal wellness and reduce dependence on drugs, we have a lot of educational books. Please feel free to ask our staff for specific recommended readings, depending on your problems.

**Please continue on to our Past and Present Chronological Medical History portion of the packet. The information you offer will further help us understand your present state of health.*

PAST AND PRESENT CHRONOLOGICAL MEDICAL HISTORY

Why do we want to know about your past history? On a journey from wellness to sickness, various phenomena are observed. These give us various clues to the causes of your illness. Chronological history exhibits two such phenomena. The first one is called “switching phenomena” where you may notice that some problems that you had in earlier years have vanished completely (commonly known as “outgrown”) and new problems have cropped up. Newer problems are usually more bothersome than the previous ones. The second phenomenon is called the “spreading phenomenon”. Here, you may have started out with one or two symptoms and over the years may have gradually developed more and more problems spreading to more than one organ system.

Now, in this section, please give us a rundown of your health problems from birth until your present age. We will start your history at birth and gradually progress to your current age. For earlier years, you may have to rely upon what your parents or relatives may have told you about your health.

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

- 0 = *Never or almost never have the symptoms*
- 1 = *Occasionally have it, effect is not severe*
- 2 = *Occasionally have it, effect is severe*
- 3 = *Frequently have it, effect is not severe*
- 4 = *Frequently have it, effect is severe*

Age 0 - 1

- colicky
- feeding problems
- frequent coughs and colds
- ear infections
- asthma
- croup
- diaper rashes
- diarrhea
- constipation
- eczema/rashes
- overweight
- underweight
- adverse reactions to immunizations
- do not know/ I was told nothing
- Exposed to indoor tobacco smoke, dog, cat, gas cooktop (Circle what applies)
- other significant problems & hospitalizations *Please give details:*

Age 1 – 5 (preschool years)

- frequent coughs and colds
- sore throats
- tonsillitis
- ear infections
- bronchitis
- asthma/difficulty breathing (encircle)
- sinus problems/stuffy/runny nose (encircle)
- sinus infections
- adenoids
- diaper rashes
- diarrhea
- constipation
- stomachaches
- eczema/rashes
- overweight
- underweight
- hyperactivity/learning problems
- behavioral/developmental/school problems
- adverse reactions to immunizations
- do not know/ I was told nothing
- any surgery:
- Exposed to indoor tobacco smoke, dog, cat, gas cooktop (Circle what applies)
- other significant problems & hospitalizations *Please give details:*

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

0 = *Never or almost never have the symptoms*

1 = *Occasionally have it, effect is not severe*

2 = *Occasionally have it, effect is severe*

3 = *Frequently have it, effect is not severe*

4 = *Frequently have it, effect is severe*

Age 5 - 10 (early school years)

- _____ frequent coughs and colds
 - _____ sore throats
 - _____ tonsillitis
 - _____ ear infections
 - _____ bronchitis
 - _____ asthma/difficulty breathing (encircle)
 - _____ sinus problems/stuffy/runny nose (encircle)
 - _____ sinus infections
 - _____ hay fever
 - _____ headaches
 - _____ pain: muscles/joints/back (encircle)
 - _____ fatigue
 - _____ overweight
 - _____ underweight
 - _____ adenoids
 - _____ bedwetting - until age: _____
 - _____ bladder/kidney infections
 - _____ diarrhea
 - _____ constipation
 - _____ stomachaches
 - _____ eczema/rashes
 - _____ hyperactivity/learning problems/behavioral problems/developmental problems
 - _____ adverse reactions to immunizations
 - _____ chemical odors bothersome
 - _____ do not know/I was told nothing
 - _____ Exposed to indoor tobacco smoke, dog, cat, gas cooktop (Circle what applies)
 - _____ any surgery:
 - _____ other significant problems & hospitalizations
- Please give details:*

Age 10 - 20 (teen years)

- _____ frequent coughs and colds
 - _____ sore throats
 - _____ tonsillitis
 - _____ bronchitis
 - _____ asthma/difficulty breathing (encircle)
 - _____ sinus problems/stuffy/runny nose (encircle)
 - _____ sinus infections
 - _____ hay fever
 - _____ headaches
 - _____ pain: muscles/joints/back (encircle)
 - _____ fatigue
 - _____ overweight
 - _____ underweight
 - _____ acne
 - _____ bladder/kidney infections
 - _____ menstrual problems (for women)
 - _____ vaginal infections (for women)
 - _____ digestive problems
 - _____ hyperactivity/learning problems/trouble concentrating or remembering (encircle)
 - _____ depression/anxiety/insomnia (encircle)
 - _____ chemical odors bothersome
 - _____ high blood pressure
 - _____ low blood pressure
 - _____ heart disease
 - _____ do not remember
 - _____ Exposed to indoor tobacco smoke, dog, cat, gas cooktop (Circle what applies)
 - _____ any surgery:
 - _____ other significant problems & hospitalizations
- Please give details:*

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

0 = *Never or almost never have the symptoms*

1 = *Occasionally have it, effect is not severe*

2 = *Occasionally have it, effect is severe*

3 = *Frequently have it, effect is not severe*

4 = *Frequently have it, effect is severe*

Age 20 - 30 (early adult years)

- frequent coughs and colds
 - sore throats
 - tonsillitis
 - bronchitis
 - asthma/difficulty breathing (encircle)
 - sinus problems/stuffy/runny nose (encircle)
 - sinus infections
 - hay fever
 - headaches
 - pain: muscles/joints/back (encircle)
 - fatigue
 - overweight/underweight (encircle)
 - acne
 - bladder/kidney infections
 - menstrual problems (for women)
 - vaginal infections (for women)
 - digestive problems
 - depression/anxiety/insomnia (encircle)
 - chemical odors bothersome
 - high blood pressure
 - low blood pressure
 - heart disease
 - Exposed to indoor tobacco smoke, dog, cat, gas cooktop (Circle what applies)
 - any surgery:
 - other significant problems & hospitalizations
- Please give details:*

Age 30 - 40

- frequent coughs and colds
 - sore throats
 - tonsillitis
 - bronchitis
 - asthma/difficulty breathing (encircle)
 - sinus problems/stuffy/runny nose (encircle)
 - sinus infections
 - hay fever
 - headaches
 - pain: muscles/joints/back (encircle)
 - fatigue
 - overweight/underweight (encircle)
 - acne
 - bladder/kidney infections
 - menstrual problems (for women)
 - vaginal infections (for women)
 - digestive problems
 - depression/anxiety/insomnia (encircle)
 - chemical odors bothersome
 - high blood pressure
 - low blood pressure
 - heart disease
 - Exposed to indoor tobacco smoke, dog, cat, gas cooktop (Circle what applies)
 - any surgery:
 - other significant problems & hospitalizations
- Please give details:*

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

0 = *Never or almost never have the symptoms*

1 = *Occasionally have it, effect is not severe*

2 = *Occasionally have it, effect is severe*

3 = *Frequently have it, effect is not severe*

4 = *Frequently have it, effect is severe*

Age 40 - 50 (early adult years)

- _____ frequent coughs and colds
 - _____ sore throats
 - _____ tonsillitis
 - _____ bronchitis
 - _____ asthma/difficulty breathing (encircle)
 - _____ sinus problems/stuffy/runny nose (encircle)
 - _____ sinus infections
 - _____ hay fever
 - _____ headaches
 - _____ pain: muscles/joints/back (encircle)
 - _____ fatigue
 - _____ overweight/underweight (encircle)
 - _____ bladder/kidney infections
 - _____ menstrual problems (for women)
 - _____ vaginal infections (for women)
 - _____ menopause (for women); age of onset _____
 - _____ digestive problems
 - _____ depression/anxiety/insomnia (encircle)
 - _____ chemical odors bothersome
 - _____ high blood pressure
 - _____ low blood pressure
 - _____ heart disease
 - _____ Exposed to indoor tobacco smoke, dog, cat, gas cooktop (Circle what applies)
 - _____ any surgery:
 - _____ other significant problems & hospitalizations
- Please give details:*

Age 50 – 60

- _____ frequent coughs and colds
 - _____ sore throats
 - _____ tonsillitis
 - _____ bronchitis
 - _____ asthma/difficulty breathing (encircle)
 - _____ sinus problems/stuffy/runny nose (encircle)
 - _____ sinus infections
 - _____ hay fever
 - _____ headaches
 - _____ pain: muscles/joints/back (encircle)
 - _____ fatigue
 - _____ overweight/underweight (encircle)
 - _____ bladder/kidney infections
 - _____ menstrual problems (for women)
 - _____ vaginal infections (for women)
 - _____ menopause (for women); age of onset _____
 - _____ digestive problems
 - _____ depression/anxiety/insomnia (encircle)
 - _____ chemical odors bothersome
 - _____ high blood pressure
 - _____ low blood pressure
 - _____ heart disease
 - _____ Exposed to indoor tobacco smoke, dog, cat, gas cooktop (Circle what applies)
 - _____ any surgery:
 - _____ other significant problems & hospitalizations
- Please give details:*

2. For Both Men and Women:

(i) _____ Have you ever taken a lot of antibiotics in your lifetime, including childhood: Yes No
Please note: Taking a lot of antibiotics is defined as: if you have ever taken antibiotics more than 2-3 times in a given year, or taken them continuously for a month for any condition, such as acne, urinary tract infection, sinus or bronchial infection, etc.

(ii) _____ Have you ever taken cortisone or cortisone-type medications such as prednisone in your lifetime, either as oral or by injection? Yes No **Please give detail:*

In this section, rate each of the following symptoms based upon your typical health profile.

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ENERGY ACTIVITY

_____ Tired easily/fatigue/low level of energy (780.79) *
 _____ Tired by the end of the day
 _____ Wake up tired
 _____ Sleep excessively (780.54)
 _____ Sleepiness during daytime
 _____ Feel excessively cold at temperatures other people are comfortable in (780.9)

_____ Hypoglycemic symptoms if skip or delay meals (i.e. weak, shaky, nervous, extremely uncomfortable) (251.2) (*encircle*)
 _____ Weight Gain (783.1) *
 _____ Weight Loss (783.21) *
 _____ Underweight (783.22)
 _____ Muscular weakness or muscles tire easily

SKIN

_____ Cold Hands
 _____ Cold Feet
 _____ Dry Skin (706.8)
 _____ Facial puffiness in the morning
 _____ Genital itch (698.1)
 _____ Genital rash
 _____ Hives (708.0) *

_____ Skin rashes (782.1)/Eczema (691.8) *
 _____ Psoriasis (696.1) *
 _____ Acne (706.1)
 _____ Excessive or unwanted hair on body or face (704.1) * (for women)
 _____ Loss of scalp hair (704.00) *
 _____ Warts (078.10)
 _____ Excessive sweating (780.8)

MUSCLES & JOINTS

_____ Ever get muscle aches/muscle pains/muscle spasms (728.85) *
 Where: arms (729.5); forearms, fingers (729.5); thighs (729.5); legs/feet (729.5); chest wall (786.52); flank (789.0); neck (723.1); generalized (780.9) (*circle what applies to you*)
 _____ Muscle cramps/Charley horses (729.82)
 Where: upper extremity (729.82); lower extremity (729.82); other _____
 _____ Leg cramping or leg pain with walking (443.9)
 _____ Low back pain/spasm (724.2) *
 _____ Pain or spasm/tightness, upper back (724.1)
 _____ Temporomandibular (Jaw) pain

_____ Pain or spasm, neck (723.1), shoulders, shoulder blades *Specify the muscles that bother you:*
 _____ Muscle twitching (781.0)
 _____ Arthritis joint pain (716.20) *
 Specify the joints that bother you: shoulders (719.41); elbows (719.42); wrists (719.43); hands (719.44); hips (719.45), knees (719.46); ankle & foot *(719.47); multiple joints (719.49); other joints: _____
 _____ Carpal Tunnel Syndrome (354.0) *
 _____ Prolapsed Disc – Neck, Back (*encircle*)
 _____ Any other painful condition: Explain
 _____ Ever had X-rays of joints? Yes No
 Results:

CARDIOVASCULAR

_____ High blood pressure (401.1) *
 _____ Rapid heartbeat (785.0)
 _____ Irregular or skipped heartbeat (427.9)
 _____ Palpitations (785.1)
 _____ Angina or chest pain (786.50)
 _____ Snoring, sleep apnea
 _____ Low blood pressure (458.9) *
 _____ Hands & feet get cold, blue, painful, swollen on exposure to cold (443.0) * (*circle all that apply*)
 _____ Fluid Retention (276.6)
 _____ Bruise easily

_____ Faintness/dizziness (780.4) *
 _____ Postural dizziness (getting dizzy on standing abruptly) (458.0)*
 _____ Salt cravings
 _____ Swelling ankles, feet, or hands (782.3)
 _____ Varicose veins (454.1)
 _____ High cholesterol/triglycerides *
 _____ Ever had echocardiogram, Stress test, EKG, Angiogram (*encircle*) Results:

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

0 = Never or almost never have the symptoms

1 = Occasionally have it, effect is not severe

2 = Occasionally have it, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

URINARY TRACT

<input type="checkbox"/> Ever had bladder, kidney, or urinary tract infection (595.2) Number of times you had an infection (595.2): <input type="checkbox"/> Frequent urination (788.41)	<input type="checkbox"/> Burning on urination (788.1) <input type="checkbox"/> Awaken at night to urinate (788.43) <input type="checkbox"/> Urinate a lot (788.42) <input type="checkbox"/> Blood in urine (599.7) <input type="checkbox"/> History of Kidney Problems
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NOSE

<input type="checkbox"/> Stuffy nose (478.1): constant daytime nighttime after meals any time of year blows nose constantly (<i>encircle what applies</i>) <input type="checkbox"/> Runny nose (478.1): with dust with smoke at meals or after meals on arising any time of year (<i>encircle</i>) <input type="checkbox"/> Itching of nose <input type="checkbox"/> Sinus problem/sinus discomfort <input type="checkbox"/> Hay fever (477.0) <input type="checkbox"/> Circle when you have symptoms: spring, early summer, later summer, fall, spring through fall	<input type="checkbox"/> Use nasal sprays: Yes No Name: _____ <input type="checkbox"/> Odor of freshly cut grass bothers you <input type="checkbox"/> Nosebleeds (784.7) <input type="checkbox"/> Sneezing (478.1) <input type="checkbox"/> Post-nasal drip (473.9) <input type="checkbox"/> Sinus pain (478.1) <input type="checkbox"/> Sinus infections (473.9) *No. of times/year ____ <input type="checkbox"/> Ever had x-ray of sinuses YES NO Results:
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LUNGS

<input type="checkbox"/> Wheezing (786.07) <input type="checkbox"/> Asthma (493.0) * <input type="checkbox"/> Bronchitis (491.20) <input type="checkbox"/> Difficulty in breathing (786.09) <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Tightness in chest (786.59) <input type="checkbox"/> Chest congestion (514) <input type="checkbox"/> Shortness of breath (786.09) <input type="checkbox"/> Chronic cough (786.2) <input type="checkbox"/> Ever had chest x-ray YES NO Results:
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MOUTH, THROAT, & EARS

<input type="checkbox"/> Cold/flu-like symptoms <input type="checkbox"/> Sore throat (784.1) <input type="checkbox"/> Hoarseness (784.49) <input type="checkbox"/> Loss of voice (784.41) <input type="checkbox"/> Canker sores (528.2) <input type="checkbox"/> Swollen or discolored tongue (529), gums, lips <input type="checkbox"/> Bad breath (784.9) <input type="checkbox"/> Motion sickness (994.6)	<input type="checkbox"/> Feeling of fluid in ears <input type="checkbox"/> Itching of ears/ear aches <input type="checkbox"/> Ear infection (382.4) <input type="checkbox"/> Drainage from ears (388.6) <input type="checkbox"/> Ringing in ears (388.32) <input type="checkbox"/> Hearing loss (389.9)
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EYES

<input type="checkbox"/> Watery (372.14)/itching of eyes (379.99) <input type="checkbox"/> Swollen, reddened, or sticky eyelids (373.00) <input type="checkbox"/> Bags or dark circles under the eyes	<input type="checkbox"/> Dry eyes (372.53) <input type="checkbox"/> Blurred vision (368.8) or tunnel vision (does not include near-sightedness or far-sightedness)
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When did you have your last physical exam? _____

By Doctor: _____ Specialty: _____

What was done?

What was found?

Clothing: How often do you wear 100% natural clothing (*cotton, ramie, wool, silk or linen*)? _____
Synthetic clothing (*polyester, acrylic, nylon, rayon, etc*)? _____ Blends (*natural fabric combined with synthetic*)? _____

Personal Care Products: List the brand names that you use (*Please take time to complete this list*):

Shampoo? _____	Shave Cream? _____
Deodorant? _____	Dish Washing Liquid/Powder? _____
Toothpaste? _____	Laundry Soap? _____
Soap? _____	Tub/Tile Cleaner? _____
Hand/Body Lotion? _____	Glass Cleaner? _____
Facial Cleanser/Moisturizer? _____	All Purpose Cleaner? _____
Hair Spray/Gel? _____	Perfume/Cologne? _____
Personal (sexual) Lubricant? _____	Roach/Ant Spray? _____
Contraceptive jelly/spermicide? _____	Toilet Freshener? _____
Hair Dye? _____	Hair Permanent? _____
Fingernail/Toenail Polish? _____	Face make-up/Eye make-up? _____
Other chemical exposure (<i>from yard, workplace, art chemicals, etc.</i>)? _____	

Appliances: Circle which of the following you use

Gas stove Electric stove Electric heater Electric blanket Water bed Vita Mix Microwave Oven
Air Purifier (*Brand: _____*) Water Purifier (*Brand: _____*)

Cookware: What type of cookware do you use? (Circle) *stainless steel aluminum iron*
teflon-coated glass non-stick Illumina non-stick T-Fal

Other types: _____

Shower Filter: What brand of shower filter do you use (*for chlorine protection*)? _____
When was your filter last changed? _____

Pets: Do you have any pets? _____ If so, what kind/how many? _____
Is it allowed in the house? _____ On your bed? _____ What do you feed your pet(s)? _____

FOOD CHOICES Circle each type of food you eat often:

1. Pre-made foods: a) canned food b) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food
2. Red meat (*beef, pork, lamb*): a) commercially grown b) naturally raised (*Brand: _____*)
3. Chicken: a) commercially grown b) naturally raised (*Brand: _____*)
4. Turkey: a) commercially grown b) naturally raised (*Brand: _____*)
5. Fish: a) canned tuna b) fresh fish c) frozen fish d) at restaurants
6. Fresh vegetables: a) commercially grown (*store bought*) b) organically grown (*store bought*)
c) organically grown (*direct from farmer*) d) from natural growers at a farmer's market
7. Fresh fruit: a) commercially grown (*store bought*) b) organically grown (*store bought*) c) organically grown (*direct from farmer*) d) from natural growers at a farmer's market
8. Whole grains: a) commercially grown (*store bought*) b) organic (*store bought*) c) biogenic (from PR Labs)
9. Whole beans: a) commercially grown (*store bought*) b) organic (*store bought*) c) biogenic (from PR Labs)
10. Eggs/Butter: a) commercial eggs (*store bought*) b) naturally grown eggs c) commercial butter d) natural butter
11. Milk: a) commercial milk b) Alta Dena milk c) goat's milk d) Claravale raw milk
12. Cheese: a) commercial cheese b) organic cheese (*store-bought*) c) biogenic cheese (*Elby Feta cheese, Bulgarian cheese, Danish blue*)
13. Condiments: a) commercial salt and/or pepper b) pink sea salt (*PRL*) c) artificial sweeteners (*Equal, Sweet 'N Low, Coffeemate, etc.*) d) commercial ketchup or mustard e) vinegar f) commercial olive oil g) PRL Moroccan Olive Oil

FOOD STRESSERS Circle which of the following you have every week. In the column, indicate how many times per week you have each item.

Stimulants	Toxic Oils	Commercial Dairy	Highly Heated Foods
Coffee (including decaf)	Fried foods	Cow's milk	Bread (store bought)
Black Tea, caffeine drinks	Fast food	Yogurt	Crackers (store bought)
Soft drinks (colas, etc.)	Potato or corn chips	Ice cream	Bagels (store bought)
Drinks with NutraSweet	Roasted nuts	Cottage cheese	Buns (store bought)
Alcohol (wine, beer, etc.)	Mayonnaise	Sour Cream	Pasta (store bought)
Chocolate	Margarine	Cheese (commercial)	Muffins (store bought)
Candy, pastries, sweets	Peanut butter (commercial)		Cookies (store bought)

FOOD HABITS

- Eating Out: Do you eat out at restaurants? _____ If yes, how often? _____ Where? _____
What type of food do you eat at restaurants? _____
- Home Meals: Do you prepare meals at home? _____ If so, how often? _____ If yes, what type of food do you prepare? _____
- Meal Habits: Do you... (circle) a) skip meals often b) have irregular eating times c) eat food past 7 PM
- MSG: Do you avoid food/drinks that list "natural flavors" (which means hidden MSG) on the label? _____
- Water: Do you drink tap water? _____ What brand of drinking water do you use? _____
If you have a home water purifier, when was the cartridge last changed? _____

TYPICAL DIET Please fill out your typical diet for the last few weeks. Please be as detailed as possible. (For example, instead of writing "chicken", identify what brand and how it was made such as "baked Foster Farms chicken." Instead of writing "salad", identify what it's made of, such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Moroccan Olive Oil")
PLEASE BE HONEST!

BREAKFAST: (Time eaten: _____) _____

LUNCH: (Time eaten: _____) _____

DINNER: (Time eaten: _____) _____

SNACK: (Time eaten: _____) _____

EXERCISE:

What kind of exercise do you do? _____

How often? _____ For how long a time? _____

SUNLIGHT:

Amount of natural sunlight you receive daily outside? _____

Amount of sunlight you receive daily through windows? _____

Hours spent daily under fluorescent lights? _____

Do you use chromalux light bulbs at home? _____ At work? _____

ELECTROMAGNETIC EXPOSURE:

How many hours do you spend daily:

Watching TV? _____ Working on a computer? _____

Talking on a phone? _____ Talking on a cellular phone? _____

Wearing a pager? _____ Wearing a headset? _____

Wearing a wrist watch with battery? _____

Riding in a car/truck/vehicle? _____

Near electrical equipment for long periods of time (such as copy machines, high power lines, computers, etc.)? _____

When you sleep, is your head within 10 feet of a plug in clock? _____

Please bring all of your supplements with you to every visit.
Please list all of your medications and supplements and their doses:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____