

Dr. Heather L. Rooks, DC



**COMPREHENSIVE HEALTH HISTORY FORMS &
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

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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: Yes No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: Yes No

Genetic Testing Yes 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 whom 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 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: _____

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COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. 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 as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date: _____

First Name: _____ Middle: _____ Last: _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (____) ____-____ Work (____) ____-____ Cell (____) ____-____

Email _____

Age _____ Date of Birth ____/____/____ Place of birth _____ Gender: Female __ Male __
City or town & country, if not US

Referred by: _____

Name, address, & phone number of primary care physician: _____

Marital Status:

Single _____ Married _____ Divorced _____ Widowed _____ Long Term Partnership _____

Emergency Contact: _____

Relationship

Name

Phone

Address

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

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CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

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? _____

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? _____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		

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ILLNESS	WHEN/ONSET	COMMENTS
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
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

WHERE HOSPITALIZED	WHEN	REASON

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

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	Comment
Where you a full term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:

	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				

CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Don't Know	Comment
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	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___

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FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- | | | |
|---|--|---|
| <input type="checkbox"/> Pregnancies _____ | <input type="checkbox"/> Caesarean _____ | <input type="checkbox"/> Vaginal deliveries _____ |
| <input type="checkbox"/> Miscarriage _____ | <input type="checkbox"/> Abortion _____ | <input type="checkbox"/> Living Children _____ |
| <input type="checkbox"/> Post partum depression _____ | <input type="checkbox"/> Toxemia _____ | <input type="checkbox"/> 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
- Partner vasectomy
- Other (non-hormonal-please describe) _____

Hormonal

- Birth control pills
- Patch
- Nuva Ring
- Other (please describe) _____

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. _____

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? _____

- | | | | | | |
|--------------------------------------|-------------------------------|----------------------------------|-----------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Estrogen | <input type="checkbox"/> Ogen | <input type="checkbox"/> Estrace | <input type="checkbox"/> Premarin | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Provera |
| <input type="checkbox"/> Other _____ | | | | | |

DIAGNOSTIC TESTING

Last PAP test: ____/____/____ Normal: _____ Abnormal _____

Last Mammogram ____/____/____ Breast biopsy? Date: ____/____/____

Date of last bone density ____/____/____ Results: High _____ Low _____ Within normal range _____

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FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

REVIEW OF SYMPTOMS

Check (✓) those items that applied to you in the **past**. **Circle** those that **presently** apply

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
- Bugs love to bite you
- Bumps on back of arms & front of thighs
- Skin cancer
- Strong body odor

Is your skin sensitive to:

- Sun
- Fabrics
- Detergents
- Lotions/Creams

HEAD:

- Poor Concentration
- Confusion
- Headaches:
 - After Meals
 - Severe
 - Migraine
 - Frontal
 - Afternoon
 - Occipital
 - Afternoon
 - Daytime
 - Relieved by:
 - Eating Sweets
- 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
- Pressure
- Hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing hallucinations

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NOSE/SINUSES

- Stuffy
- Bleeding
- Running/Discharge
- Watery nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- 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 ? When ___/___/___
- Phlebitis

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

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
- Syphilis
- Bedwetting
- Have trichomonas

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)

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
 - 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)
 - How many times at night? _____
 - Urgency/Hesitancy/Change in Urinary Stream
 - Loss of bladder control

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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

PAIN ASSESSMENT

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. _____

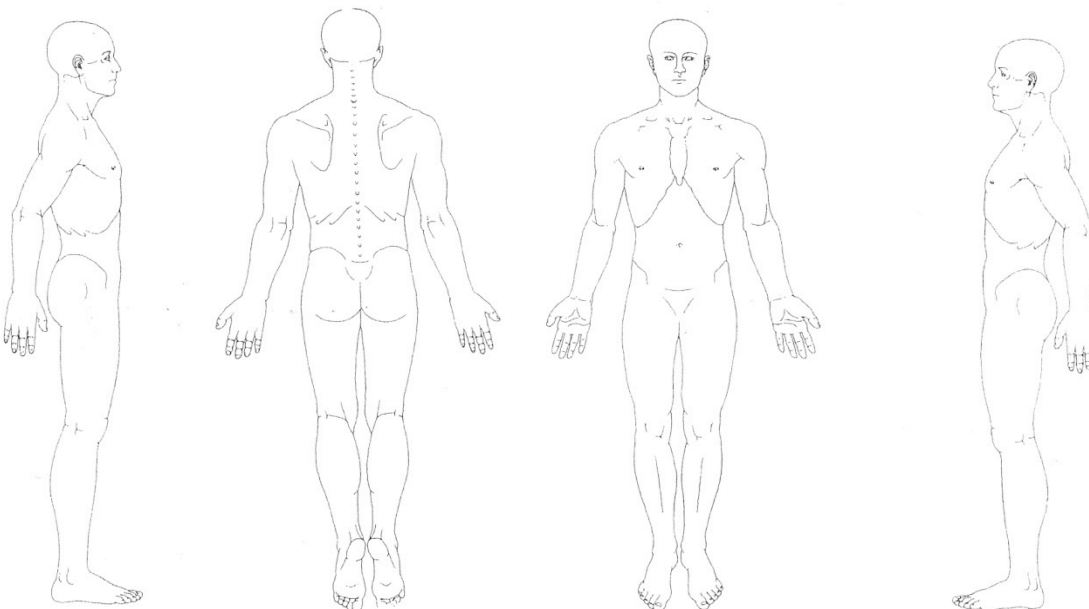
1 2 3 4 5 6 7 8 9 10

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



Right Side

Back

Front

Left side

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DENTAL HISTORY

	<u>Yes</u>	<u>No</u>
Problem with sore gums (gingivitis)?	_____	_____
Ringing in the ears (tinnitus)?	_____	_____
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?	_____	_____

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

NUTRITIONAL HISTORY

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

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Bacon/Sausage	<input type="checkbox"/> Butter	<input type="checkbox"/> Beans (legumes)
<input type="checkbox"/> Bagel	<input type="checkbox"/> Coffee	<input type="checkbox"/> Brown rice
<input type="checkbox"/> Butter	<input type="checkbox"/> Eat in a cafeteria	<input type="checkbox"/> Butter
<input type="checkbox"/> Cereal	<input type="checkbox"/> Eat in restaurant	<input type="checkbox"/> Carrots
<input type="checkbox"/> Coffee	<input type="checkbox"/> Fish sandwich	<input type="checkbox"/> Coffee
<input type="checkbox"/> Donut	<input type="checkbox"/> Fried foods	<input type="checkbox"/> Fish
<input type="checkbox"/> Eggs	<input type="checkbox"/> Hamburger	<input type="checkbox"/> Green vegetables
<input type="checkbox"/> Fruit	<input type="checkbox"/> Hot dogs	<input type="checkbox"/> Juice
<input type="checkbox"/> Juice	<input type="checkbox"/> Juice	<input type="checkbox"/> Margarine
<input type="checkbox"/> Margarine	<input type="checkbox"/> Leftovers	<input type="checkbox"/> Milk
<input type="checkbox"/> Milk	<input type="checkbox"/> Lettuce	<input type="checkbox"/> Pasta
<input type="checkbox"/> Oat bran	<input type="checkbox"/> Margarine	<input type="checkbox"/> Potato
<input type="checkbox"/> Sugar	<input type="checkbox"/> Mayo	<input type="checkbox"/> Poultry
<input type="checkbox"/> Sweet roll	<input type="checkbox"/> Meat sandwich	<input type="checkbox"/> Red meat
<input type="checkbox"/> Sweetener	<input type="checkbox"/> Milk	<input type="checkbox"/> Rice
<input type="checkbox"/> Tea	<input type="checkbox"/> Pizza	<input type="checkbox"/> Salad
<input type="checkbox"/> Toast	<input type="checkbox"/> Potato chips	<input type="checkbox"/> Salad dressing
<input type="checkbox"/> Water	<input type="checkbox"/> Salad	<input type="checkbox"/> Soda
<input type="checkbox"/> Wheat bran	<input type="checkbox"/> Salad dressing	<input type="checkbox"/> Sugar
<input type="checkbox"/> Yogurt	<input type="checkbox"/> Soda	<input type="checkbox"/> Sweetener
<input type="checkbox"/> Oat meal	<input type="checkbox"/> Soup	<input type="checkbox"/> Tea
<input type="checkbox"/> Milk protein shake	<input type="checkbox"/> Sugar	<input type="checkbox"/> Vinegar
<input type="checkbox"/> Slim fast	<input type="checkbox"/> Sweetener	<input type="checkbox"/> Water
<input type="checkbox"/> Carnation shake	<input type="checkbox"/> Tea	<input type="checkbox"/> White rice
<input type="checkbox"/> Soy protein	<input type="checkbox"/> Tomato	<input type="checkbox"/> Yellow vegetables
<input type="checkbox"/> Whey protein	<input type="checkbox"/> Vegetables	<input type="checkbox"/> Other: (List below)
<input type="checkbox"/> Rice protein	<input type="checkbox"/> Water	
<input type="checkbox"/> Other: (List below)	<input type="checkbox"/> Yogurt	
	<input type="checkbox"/> Slim fast	
	<input type="checkbox"/> Carnation shake	
	<input type="checkbox"/> Protein shake	

How much of the following do you consume each week?

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 a special diet or nutritional program? Yes____ No____

- | | |
|--|--|
| <input type="checkbox"/> Ovo-lacto | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Dairy restricted | <input type="checkbox"/> Blood type diet |
| <input type="checkbox"/> Other (describe)_____ | |

Please tell us if there is anything special about your diet that we should know. _____

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:

- | | |
|--|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| | <input type="checkbox"/> Other_____ |

Do you feel **better** when you eat a lot of:

- | | |
|--|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| | <input type="checkbox"/> Other_____ |

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Does skipping meals greatly affect your symptoms? Yes _____ No _____

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) _____

Do you have an aversion to certain foods? 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	
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			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

Intestinal gas:

- Daily
- Occasionally
- Excessive
- Present with pain
- Foul smelling
- Little odor

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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 in your job or at home? Yes ____ No ____

If yes, indicate which

- | | |
|--------------------------|----------|
| <input type="checkbox"/> | Lead |
| <input type="checkbox"/> | Arsenic |
| <input type="checkbox"/> | Aluminum |
| <input type="checkbox"/> | Cadmium |
| <input type="checkbox"/> | Mercury |

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10__ 6-8__ less than 6__

Do you:

- | | |
|---|---|
| <input type="checkbox"/> Have trouble falling asleep? | <input type="checkbox"/> Snore? |
| <input type="checkbox"/> Feel rested upon waking? | <input type="checkbox"/> Use sleeping aids? |
| <input type="checkbox"/> Have problems with insomnia? | |

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EXERCISE HISTORY

Do you exercise regularly? Yes _____ No _____

If yes, please indicate:

Type of exercise	Times/week				Length of session			
	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? _____

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How well have things been 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_____

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. Heather Rooks