JAMIE CHAN-ORTEGA, Ph.D., L.Ac.
Oasis Healing Arts
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heal@oasishealingforyou.com

FUNCTIONAL MEDICINE ADULT NEW PATIENT INTAKE FORMS

PLEASE BRING THESE FORMS FULLY COMPLETED
TO YOUR FIRST APPOINTMENT

PLEASE KEEP PAGES 1 - 5 FOR YOUR RECORDS

Dear Patient,

Welcome! We are happy that you have chosen the path of Functional Medicine to address your health concerns. We believe Functional Medicine offers the best of both worlds: cutting-edge laboratory diagnostics based on the latest scientific research, coupled with lifestyle medicine and ancient wisdom: rest, stress management, diet, nutrition, movement, breathing, quiet time, and botanical and nutritional supplements. We are looking forward to partnering with you to achieve true wellness.

FUNCTIONAL MEDICINE INITIAL CONSULTATION:
In-depth health history intake and consult with Dr. Jamie (60 min)
Review of body systems
Review of relevant FM diagnostic labs
Pay for consult, labs, and any supplements purchased
Please plan 60 minutes for the initial consult and an additional 15-20 minutes to go over tests and/or supplements

FUNCTIONAL MEDICINE - SECOND CONSULTATION:
Consult with Dr. Jamie (45-60 min)
Review lab results
Review personalized treatment program created for you by Dr. Jamie
Pay for follow-up and any supplements purchased
Schedule follow-up appointments

FUNCTIONAL MEDICINE ONGOING CONSULTATIONS:
Consult with Dr. Jamie (45-50 min)
Evaluate progress
Review and/or modify treatment program as necessary
Pay for follow-up and any supplements purchased
Schedule follow-up appointments

PRACTICE POLICIES FOR PATIENTS

Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve true wellness.
It is important to read all of the enclosed information carefully, complete all the forms, and bring them to your first appointment.

WEBSITE

Information about Oasis Healing Arts and all relevant patient forms are available through the website: www.oasishealingforyou.com OR www.drjamiephd.com.

COPIES OF MEDICAL RECORDS & LABS FROM OUR OFFICE

You will be given a copy of your labs at each visit to keep for your records. Should you require a letter of medical necessity for any tests or supplements there will be a $30 fee and a one week turn-around time.

FUNCTIONAL MEDICINE CONSULTATION FEES

Initial Consultation with Dr. Jamie:	$250 (60 min)
Second Consultation with Dr. Jamie:	$175 (45 min)
Ongoing Consultations with Dr. Jamie:	$175 (45 min)

LAB TESTS

We do not accept insurance to cover lab tests.
All labs involve stool, urine, saliva, or bloodspot (skin prick) samples and can be done on your own in the comfort of your home. You will be given all lab kits and step-by-step instructions for home test kits at the time of your consult. Once all of the final lab results are received, we will review them with you at your follow-up visits.

SUPPLEMENTS

All of the supplements that are recommended by Dr. Jamie are available for purchase in our office or online through our webstore. Supplements purchased online will be mailed directly to you. Dr. Jamie will educate you and recommend foods and nutritional supplements as part of your treatment program, but you are under no obligation to purchase supplements from our office or website.

RETURNS/REFUNDS

Supplements (except for probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 7 days of purchase.

CREDIT CARDS

We require a credit card number at the time of scheduling your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs and supplements unless otherwise specified by you at the time of check out. We do not take American Express.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS

There is a 72-hour (3 business days) cancellation and rescheduling policy for Functional Medicine appointments. **Your appointment must be cancelled or rescheduled at least 72 hours (3 business days) prior to your consultation time or you will be charged a $50 cancellation fee**. You may cancel your appointment by calling the office at 562-789-1588 or emailing heal@oasishealingforyou.com. Your

phone call to cancel or your email to cancel must be time-stamped no less than 72 hours (3 business days) prior to your appointment time or your credit card will be charged the late cancellation fee.

LATE ARRIVAL APPOINTMENTS

We are committed to being on time with patients' appointments in order to prevent increased waiting times. If you arrive late to the office for your consult, your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

FOLLOW-UP APPOINTMENTS

At the time of check out you will be scheduled for a follow-up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 72 hours / 3 business days prior to your scheduled appointment.

PAYMENT OPTIONS

Cash, check, and credit card (MasterCard, Visa, Discover) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized and payment will be due. Over-the-phone or in-person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account.

INSURANCE INFORMATION

Medical insurance is not accepted for Functional Medicine consults and our office cannot assist you with claim resolution. In addition, Dr. Jamie is not a Medicare provider. If requested, we can provide you with an itemized receipt that you can submit to your insurance carrier. Dr. Jamie does not submit her Functional Medicine medical notes to insurance companies.

DISABILITY FORMS

Dr. Jamie does not fill out medical disability forms for patients, nor does she submit her Functional Medicine medical notes to support disability claims.

OFFICE HOURS

Our office hours are Monday 11am to 6pm, Tuesday through Thursday 9am to 530pm, and Friday 9am to 4pm PST.

If you are going to stop by the office to pick up supplements we ask that you kindly email your order to us at heal@oasishealingforyou.com prior to your visit, and notify us of the approximate time you will be stopping in. You may also call it in at 562-789-1588.

PHONE CALLS AND MESSAGES

Phone messages will be responded to within 24 hours (during business hours).

To reach the office, please call 562-789-1588

If you call after hours, please leave a message and the office staff will return your call on the next business day.

If you have a medical emergency, call 911 or go directly to the nearest ER.

When leaving a message, please be brief, speak slowly, and include the following information:

- Full name and date of birth
- Reason for call
- Phone number(s) - please repeat this twice
- E-mail address (if desired)

EMAIL

If you would like to schedule / reschedule / cancel an appointment, want to pick up supplements, or have questions about labs or anything administrative, please email **heal@oasishealingforyou.com.**
If you have a BRIEF medical question for Dr. Jamie please email her at **DrJamieOHA@gmail.com**.
Please note that it can take Dr. Jamie up to 72 hours to respond to emails, particularly if it is the weekend.

Wishing you true wellness,
Dr. Jamie and the Oasis Healing Arts team

IMPORTANT PATIENT INFORMATION

APPOINTMENTS

- Initial consult is $250 and ongoing consultations are $175.
- There is a 72 hour / 3 business day cancellation policy (please see cancellation policy in Practice Policies for Patients).
  We reserve the right to charge your credit card $50 if the appointment is not canceled or rescheduled 72 hours (3 business days) prior to your appointment. By signing below you agree to our cancelation policy and authorize Oasis Healing Arts to charge your credit card on file for any missed visits.

LAB TESTS & SUPPLEMENTS

- All lab results will be reviewed with you during your second consultation (or whichever consultation immediately follows the time Dr. Jamie has received your results from the lab(s), reviewed them, and created your treatment program).
- Supplements (except probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 7 days of purchase.

RETURN CHECK FEE

- A $35 fee will be assessed for all checks returned for insufficient funds.

BILLING/INSURANCE

- You may request an itemized receipt at the completion of your visit that you may submit to your insurance for reimbursement. We do not help with insurance claim resolution.
- Payment for the office visit/consultation, phone consultation, or lab tests is expected at time of service. All credit card payments will be processed the same day of the visit or phone consult.
- Oasis Healing Arts does not accept insurance for Functional Medicine consults.

PRIMARY CARE PHYSICIAN

Please note that Dr. Jamie is not your primary care physician and we recommend that you have a primary care physician.

_____ _____

Patient Signature Date

INFORMED CONSENT REGARDING E-MAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Oasis Healing Arts provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
    a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward email to other recipients with or without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.
    b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.
2. It is the policy of Oasis Healing Arts that all e-mail messages sent or received, which concern the diagnosis, or treatment of the patient will be a part of that patient's protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Oasis Healing Arts will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
    a. All e-mail to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, Dr. Jamie, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
    b. Oasis Healing Arts practitioners may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
    c. We at Oasis Healing Arts will endeavor to read e-mails promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
    d. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.
    e. Oasis Healing Arts cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or

internet communication. However, Dr. Jamie is not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

f. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Oasis Healing Arts staff of any type of information you do not want to be sent by e-mail.
g. It is the responsibility of the patient to protect their password or other means of access to e-mail sent, or received, from Oasis Healing Arts, to protect confidentiality. Oasis Healing Arts is not liable for breaches of confidentiality caused by the patient. Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing. I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Oasis Healing Arts at heal@oasishealingforyou.com

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name Printed: _____

Signature: _____

Date:_____

GENERAL INFORMATION

Full Name:

_____

Date of Birth: _____ Age: _____

Gender: + Male + Female

Highest Education Level: + High School + Under-Graduate + Post-Graduate

Job Title:

_____

Nature of Occupation / Business:

_____

Primary Address:

_____

Number & Street City State Zip

Cell Phone: _____
Home Phone: _____
Work Phone: _____
E-mail: _____

Emergency Contact: _____ Phone Number: _____

_____

Number & Street City State Zip

Physician's Name: _____ Phone Number: _____

Who Referred you to Dr. Jamie / Oasis Healing Arts?

+ Google (What was your words did you Google search include?) _____

+ Social Media _____

+ Family Member _____

+ Friend _____

+ Other _____

OASIS HEALING ARTS FUNCTIONAL MEDICINE MEDICAL QUESTIONNAIRE

ALLERGIES

Medication / Supplement / Food:

_____

Reaction:

_____

COMPLAINTS / CONCERNS

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

_____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well?

_____

Did something trigger your change in health?

_____

What makes you feel worse?

_____

What makes you feel better?

_____

Please list top three current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe
Ex: headaches		X	

Prior Treatment / Therapeutic Approach	Excellent	Good	Fair
Ex: Elimination Diet	X		

MEDICAL HISTORY - DISEASES / DIAGNOSIS / CONDITIONS

Check the box next to the conditions you have and provide date of onset

GASTROINTESTINAL

- Irritable Bowel Syndrome _____
- Inflammatory Bowel Disease _____
- Crohn's Disease _____
- Ulcerative Colitis _____
- Gastritis or Peptic Ulcer Disease _____
- GERD (reflux) _____
- Celiac Disease _____
- Constipation _____
- Loose Stools _____
- Bloating _____
- Flatulence (gas) _____
- Other _____
  _____

CARDIOVASCULAR

- Heart Attack _____
- Other Heart Disease _____
- Stroke _____
- Elevated Cholesterol _____
- Arrythmia (irregular heart rate) _____
- Hypertension (high blood pressure) _____
- Rheumatic Fever _____
- Mitral Valve Prolapse _____
- Other _____
  _____

METABOLIC / ENDOCRINE

- Type 1 Diabetes _____
- Type 2 Diabetes _____
- Weight Gain _____
- Weight Loss _____

- Hypoglycemia _____
- Metabolic Syndrome _____
- Insulin Resistance or Pre-Diabetes _____
- Hypothyroidism (low thyroid) _____
- Hyperthyroidism (overactive thyroid) _____
- Polycystic Ovarian Syndrome (PCOS) _____
- Infertility _____
- Frequent Weight Fluctuations _____
- Bulimia _____
- Anorexia _____
- Binge Eating Disorder _____
- Night Eating Syndrome _____
- Eating Disorder (non-specific) _____
- Other _____
_____

CANCER

- Lung Cancer _____
- Breast Cancer _____
- Colon Cancer _____
- Ovarian Cancer _____
- Prostate Cancer _____
- Skin Cancer _____
- Other _____
_____

GENITOURINARY

- Kidney Stones _____
- Gout _____
- Interstitial Cystitis _____
- Frequent Urinary Tract Infections _____
- Frequent Yeast Infections _____
- Erectile and/or Sexual Dysfunction _____
- Other _____
_____

MUSCULOSKELETAL / PAIN

- Osteoarthritis _____
- Fibromyalgia _____
- Chronic Pain _____
- Other _____
_____

INFLAMMATORY / IMMUNE

- Chronic Fatigue Syndrome _____
- Autoimmune Disease _____
- Rheumatoid Arthritis _____
- Lupus SLE _____
- Immune Deficiency Disease _____
- Herpes-Genital _____
- Severe Infectious Disease _____
- Poor Immune Function _____
- Food Allergies _____
- Environmental Allergies _____
- Multiple Chemical Sensitivities _____
- Latex Allergy _____
- Other _____
_____

RESPIRATORY DISEASES

- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Emphysema _____
- Pneumonia _____
- Tuberculosis _____
- Sleep Apnea _____
- Other _____
_____

SKIN DISEASES

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Skin Cancer _____
- Other _____
_____

NEUROLOGIC / MOOD

- Depression _____
- Anxiety _____
- Bipolar Disorder _____
- Headaches _____
- Migraines _____
- ADD/ADHD _____
- Autism _____
- Mild Cognitive Impairment _____
- Memory Problems _____
- Parkinson's Disease _____
- Multiple Sclerosis _____
- ALS _____
- Seizures _____
- Other _____
_____

INJURIES

Check box if yes: Back Injury Head Injury Neck Injury Broken Bones

SURGERIES

Check box if yes and provide date of surgery

- Appendectomy _____
- Hysterectomy +/- Ovaries _____
- Gall Bladder _____
- Hernia _____
- Tonsillectomy _____
- Dental Surgery _____
- Joint Replacement –Knee/Hip _____
- Spinal Surgery _____
- Heart Surgery–Bypass Valve _____
- Angioplasty or Stent _____
- Pacemaker _____
- Other _____
_____

HOSPITALIZATIONS

+ None

Date:	Reason:

GYNECOLOGIC HISTORY *(for women only)*

OBSTETRIC HISTORY

(Check box if yes and provide number)

+ Pregnancies_____ + Caesarean_____ + Vaginal deliveries_____
+ Miscarriage_____ + Abortion_____ + Living Children_____
+ Postpartum Depression + Toxemia + Gestational Diabetes
+ Baby Over 8 Pounds + Breastfeeding For how long?_____

MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length: _____
Pain: + Yes + No Clotting: + Yes + No
Has your period ever skipped? + Yes + No For how long?_____
Last Menstrual Period: _____
Use of hormonal contraception such as: + Birth Control + Pills + Patch + Nuva Ring
How long?_____
Do you use contraception? + Yes + No
+ Condom + Diaphragm + IUD + Partner Vasectomy

WOMEN'S DISORDERS / HORMONAL IMBALANCES *(for women only)*

+ Fibrocystic + Breasts + Endometriosis + Fibroids Infertility
+ Painful Periods + Heavy periods + PMS
Last PAP Test: _____ + Normal + Abnormal
Are you in menopause? + Yes + No
Age at Menopause: _____
+ Hot Flashes + Mood Swings + Concentration / Memory Problems
+ Vaginal Dryness + Decreased Libido
+ Heavy Bleeding + Joint Pains + Headaches + Weight Gain
+ Loss of Control of Urine + Palpitations
+ Use of hormone replacement therapy How long?_____

MEN'S HISTORY *(for men only)*

+ Prostate Enlargement + Prostate infection + Change in Libido + Impotence
+ Difficulty Obtaining an Erection + Difficulty Maintaining an Erection
+ Nocturia (urination at night) How many times at night? _____
+ Urgency/Hesitancy/Change in Urinary Stream + Loss of Control of Urine

GI HISTORY

Foreign Travel? + Yes + No Where? _____
Wilderness Camping? + Yes + No Where? _____
Have you ever had severe: + Gastroenteritis + Diarrhea
Do you feel like you digest your food well? + Yes + No
Do you feel bloated after meals? + Yes + No

DENTAL HISTORY

Silver Mercury Fillings: + Yes + No How many? _____
+ Gold Fillings
+ Root Canals If yes, how many? _____
+ Implants If yes, how many? _____
+ Tooth Pain
+ Bleeding Gums
+ Gingivitis
+ Problems with Chewing
Do you floss regularly? + Yes + No

MEDICATIONS

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE (mo/yr)	REASON FOR USE

PREVIOUS MEDICATIONS: (Last 5 years)

MEDICATION	DOSE	FREQUENCY	START DATE (mo/yr)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS (VITAMINS / MINERALS / HERBS / HOMEOPATHY)

SUPPLEMENT & BRAND	DOSE	FREQUENCY	START DATE (mo/yr)	REASON FOR USE

Have your medications or supplements ever caused you unusual side effects or problems? ⊣ Yes ⊣ No
Describe: _____
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ⊣ Yes ⊣ No
Have you had prolonged or regular use of Tylenol? ⊣ Yes ⊣ No
Have you had prolonged or regular use of Acid Blockers (Tagamet, Zantac, Prilosec, etc.) ⊣ Yes ⊣ No
Frequent antibiotics (> 2 times/year) ⊣ Yes ⊣ No
Long term antibiotics ⊣ Yes ⊣ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ⊣ Yes ⊣ No
Use of oral contraceptives ⊣ Yes ⊣ No

NUTRITION HISTORY

Have you ever had a nutritional consultation? ⊣ Yes ⊣ No
Have you made any changes in your eating habits because of your health? ⊣ Yes ⊣ No
Describe:

_____

Do you currently follow a special diet or nutritional program? ⊣ Yes ⊣ No
Check all that apply:
⊣ Low Fat ⊣ Low Carbohydrate ⊣ High Protein ⊣ Low Sodium ⊣ Diabetic
⊣ No Dairy ⊣ No Wheat ⊣ No Gluten ⊣ Vegetarian ⊣ Vegan
Specific Program for Weight Loss/Maintenance Type:

_____

Other

_____

Height (feet/inches)_____ Current Weight _____
Usual Weight Range +/- 5 lbs _____ Desired Weight Range +/- 5 lbs _____
Highest adult weight _____ Lowest adult weight _____
Weight Fluctuations (> 10 lbs.) ⊣ Yes ⊣ No Body Fat % _____
How often do you weigh yourself? ⊣ Daily ⊣ Weekly ⊣ Monthly ⊣ Rarely ⊣ Never
Do you avoid any particular foods? ⊣ Yes ⊣ No
If yes, types and reason

_____

_____

Do you grocery shop? ⊣ Yes ⊣ No
If no, who does the shopping?_____
Do you read food labels? ⊣ Yes ⊣ No
Do you cook? ⊣ Yes ⊣ No If no, who does the cooking?_____
How many meals do you eat out per week? ⊣ 0-1 ⊣ 1-3 ⊣ 3-5 ⊣ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

⊣ Fast eater ⊣ Erratic eating pattern ⊣ Eat too much ⊣ Late night eating ⊣ Dislike healthy food ⊣ Time constraints ⊣ Eat more than 50% meals away from home ⊣ Travel frequently ⊣ Non-availability of healthy foods ⊣ Do not plan meals or menus ⊣ Reliance on convenience items ⊣ Significant other or family members don't like healthy foods	⊣ Significant other or family members have special dietary needs or food preferences ⊣ Love to eat ⊣ Have a negative relationship with food ⊣ Struggle with eating issues ⊣ Emotional eater (eat when sad, lonely depressed, bored) ⊣ Eat too much under stress ⊣ Eat too little under stress ⊣ Don't care to cook ⊣ Eating in the middle of the night ⊣ Confused about nutrition advice

SMOKING

Currently Smoking? ⊣ Yes ⊣ No
How many years? _____ Packs per day: _____ Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____
Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, or 1.5 ounces spirits
⊣ None ⊣ 1-3 ⊣ 4-6 ⊣ 7-10 ⊣ >10 If "None," skip to Other Substances
Previous alcohol intake? ⊣ None ⊣ Yes (⊣ Mild ⊣ Moderate ⊣ High)
Have you ever been told you should cut down your alcohol intake? ⊣ Yes ⊣ No
Do you ever feel guilty about your alcohol consumption? ⊣ Yes ⊣ No
Do you notice a tolerance to alcohol (can you "hold" more than others)? ⊣ Yes ⊣ No
Have you ever been unable to remember what you did during a drinking episode? ⊣ Yes ⊣ No
Do you get into arguments or physical fights when you have been drinking? ⊣ Yes ⊣ No
Have you ever been arrested or hospitalized because of drinking? ⊣ Yes ⊣ No
Have you ever thought about getting help to control or stop your drinking? ⊣ Yes ⊣ No

OTHER SUBSTANCES

Caffeine Intake: ⊣ Yes ⊣ No
Coffee cups/day: ⊣ 1 ⊣ 2-4 ⊣ >4 | Tea cups/day: ⊣ 1 ⊣ 2-4 ⊣ > 4
Caffeinated Sodas or Diet Sodas Intake: ⊣ Yes ⊣ No
12-ounce can/bottle ⊣ 1 ⊣ 2-4 ⊣ >4 per day

Are you currently using any recreational drugs (marijuana, ecstasy, etc)? ⊣ Yes ⊣ No
Type_____
Have you ever used IV recreational drugs? ⊣ Yes ⊣ No

EXERCISE

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio / Aerobics			
Strength			
Other			
Sports or Leisure Activities (golf, tennis, rollerblading, etc)			

Rate your level of motivation for including exercise in your life? ⊣ Low ⊣ Medium ⊣ High
List problems that limit activity:

_____

_____

Do you feel unusually fatigued after exercise? ⊣ Yes ⊣ No
If yes, please describe:

_____

_____

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ⊣ Yes ⊣ No
Are you happy? ⊣ Yes ⊣ No
Do you feel your life has meaning and purpose? ⊣ Yes ⊣ No
Do you believe stress is presently reducing the quality of your life? ⊣ Yes ⊣ No
Do you like the work you do? ⊣ Yes ⊣ No
Have you ever experienced major losses in your life? ⊣ Yes ⊣ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? ⊣ Yes ⊣ No
Would you describe your experience as a child in your family as happy and secure? ⊣ Yes ⊣ No

STRESS/COPING

Have you ever sought counseling? ⊣ Yes ⊣ No
Are you currently in therapy? ⊣ Yes ⊣ No
Describe:

_____

Do you feel you have an excessive amount of stress in your life? ⊣ Yes ⊣ No
Do you feel you can easily handle the stress in your life? ⊣ Yes ⊣ No
Daily Stressors: Rate on scale of 1-10
Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____
Do you practice meditation or relaxation techniques? ⊣ Yes ⊣ No How often? _____
Check all that apply: ⊣ Yoga ⊣ Meditation ⊣ Prayer ⊣ Imagery ⊣ Breathing ⊣ Tai Chi
Other:

_____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ⊣ Yes ⊣ No

SLEEP / REST

Average number of hours you sleep per night: ⊣ >10 ⊣ 8-10 ⊣ 6-8 ⊣ < 6
Do you have trouble falling asleep? ⊣ Yes ⊣ No
Do you feel rested upon awakening? ⊣ Yes ⊣ No
Do you have problems with insomnia? ⊣ Yes ⊣ No
Do you snore? ⊣ Yes ⊣ No
Do you use sleeping aids? ⊣ Yes ⊣ No
Explain: _____

ROLES / RELATIONSHIPS

Marital status: ⊣ Single ⊣ Married ⊣ Divorced ⊣ Long Term Partnership ⊣ Widow
# of Children _____ Age of Each Child: _____
Who else is living in household? _____
Under what circumstances? (ex: my mother - dementia) _____
_____

Resources for emotional support?
Check all that apply:
⊣ Spouse ⊣ Family ⊣ Friends ⊣ Religious/Spiritual ⊣ Pets ⊣ Other: _____

Are you satisfied with your sex life? ⊣ Yes ⊣ No

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall in your life				
At school				
In your job				
In your social life				
With your friends				
With sex				
With your spouse / significant other				
With your children				
With your parents				
With having a positive attitude				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ⊣ Yes ⊣ No
If yes, describe
symptoms:_____
Do you have any food allergies or sensitivities? ⊣ Yes ⊣ No
If yes, list
all:_____
Do you have an adverse reaction to caffeine? ⊣ Yes ⊣ No
When you drink caffeine do you feel: ⊣ Irritable or wired ⊣ Aches & Pains

Do you adversely react to any of the following?:
⊣ Monosodium glutamate (MSG) ⊣ Aspartame (Nutrasweet) ⊣ Caffeine
⊣ Garlic ⊣ Onion ⊣ Cheese ⊣ Citrus Foods ⊣ Chocolate ⊣ Alcohol ⊣ Red Wine
⊣ Sulfite Containing Foods (wine, dried fruit, salad bars) ⊣ Preservatives (ex. sodium benzoate)
⊣ Cigarette Smoke ⊣ Perfumes/Colognes ⊣ Auto Exhaust Fumes
⊣ Other: _____
In your work or home environment, are you exposed to:
⊣ Chemicals ⊣ Electromagnetic Radiation ⊣ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following:
⊣ Herbicides ⊣ Insecticides (frequent visits of exterminator) Pesticides Organic Solvents Heavy Metals
Other_____

Do you dry clean your clothes frequently? Y+ Yes + No
Do you or have you lived or worked in a damp or moldy environment? + Yes + No
Do you have any pets or farm animals? + Yes + No

SYMPTOM REVIEW

Please check all symptoms experienced within the past 6 months to the present.

GENERAL
- ⊣ Cold Hands & Feet
- ⊣ Cold Intolerance
- ⊣ Low Body Temperature
- ⊣ Low Blood Pressure
- ⊣ Daytime Sleepiness
- ⊣ Difficulty Falling Asleep
- ⊣ Early Waking
- ⊣ Fatigue
- ⊣ Fever
- ⊣ Heat Intolerance
- ⊣ Night Waking
- ⊣ Nightmares
- ⊣ No Dream Recall

HEAD, EYES & EARS
- ⊣ Conjunctivitis
- ⊣ Distorted Sense of Smell
- ⊣ Distorted Taste
- ⊣ Ear Fullness
- ⊣ Ear Pain
- ⊣ Ear Ringing/Buzzing
- ⊣ Eye Pain
- ⊣ Hearing Problems
- ⊣ Headache
- ⊣ Migraine
- ⊣ Sensitivity to Loud Noises
- ⊣ Vision problems (other than glasses)
- ⊣ Macular Degeneration

MUSCULOSKELETAL
- ⊣ Back Muscle Spasm
- ⊣ Calf Cramps
- ⊣ Chest Tightness
- ⊣ Foot Cramps
- ⊣ Joint Deformity
- ⊣ Joint Pain
- ⊣ Joint Redness
- ⊣ Joint Stiffness
- ⊣ Muscle Pain
- ⊣ Muscle Spasms
- ⊣ Muscle Stiffness
- ⊣ Muscle Twitches - eyes
- ⊣ Muscle Twitches - arms, legs
- ⊣ Muscle Weakness
- ⊣ Neck Muscle Spasm
- ⊣ Tendonitis
- ⊣ Tension Headache
- ⊣ TMJ Problems

MOOD / NERVES
- ⊣ Anxiety
- ⊣ Blackout
- ⊣ Depression

Difficulty:
  - ⊣ Concentrating
  - ⊣ With Balance
  - ⊣ With Thinking
  - ⊣ With Speech
  - ⊣ With Memory
- ⊣ Dizziness / Vertigo
- ⊣ Fainting
- ⊣ Fearfulness
- ⊣ Irritability
- ⊣ Lightheadedness
- ⊣ Numbness
- ⊣ Phobias: _____
- ⊣ Panic Attacks
- ⊣ Paranoia
- ⊣ Seizures
- ⊣ Suicidal Thoughts
- ⊣ Tremor/Trembling

EATING
- ⊣ Binge Eating
- ⊣ Bulimia
- ⊣ Can't Gain Weight
- ⊣ Can't Lose Weight
- ⊣ Can't Maintain Healthy Weight
- ⊣ Frequent Dieting
- ⊣ Poor Appetite
- ⊣ Salt Cravings
- ⊣ Carbohydrate Craving (breads, pastas)
- ⊣ Sweet Cravings (candy, cookies, cakes)
- ⊣ Chocolate Cravings
- ⊣ Caffeine Dependency

DIGESTION
- ⊣ Anal Spasms
- ⊣ Bad Teeth
- ⊣ Bleeding Gums
- ⊣ Bloating
- ⊣ Bloating After Meals
- ⊣ Blood in Stools
- ⊣ Burping
- ⊣ Canker Sores
- ⊣ Cold Sores
- ⊣ Constipation
- ⊣ Cramps
- ⊣ Diarrhea
- ⊣ Alternating Diarrhea and Constipation
- ⊣ Difficulty Swallowing
- ⊣ Dry Mouth
- ⊣ Excess Flatulence/Gas
- ⊣ Fissures
- ⊣ Foods "Repeat" (Reflux)
- ⊣ Gas
- ⊣ Heartburn
- ⊣ Hemorrhoids
- ⊣ Indigestion
- ⊣ Nausea
- ⊣ Vomiting

Intolerance to:
  - ⊣ Lactose
  - ⊣ All Dairy Products
  - ⊣ Wheat
  - ⊣ Gluten (Wheat, Rye, Barley)
  - ⊣ Corn
  - ⊣ Eggs
  - ⊣ Fatty Foods
  - ⊣ Yeast
- ⊣ Liver Disease/Jaundice
- ⊣ Lower Abdominal Pain
- ⊣ Mucus in Stools
- ⊣ Periodontal Disease
- ⊣ Sore Tongue
- ⊣ Strong Stool Odor
- ⊣ Undigested Food in Stools

SKIN & HAIR PROBLEMS

- Acne on Face
- Acne on Body
- Athlete's Foot
- Bumps on Back of Upper Arms
- Easy Bruising
- Eczema
- Hair Loss
- Hives
- Jock Itch
- Oily Skin
- Pale Skin
- Rash
- Red Face / Ears
- Sensitivity to Insect Bites
- Shingles
- Strong Body Odor
- Sweating - Excessive
- Sweating - None
- Vitiligo

ITCHING SKIN

- Skin in General
- Anus
- Arms
- Ear Canals
- Eyes
- Feet
- Hands
- Legs
- Nipples
- Nose
- Penis
- Roof of Mouth
- Scalp
- Throat

SKIN, DRYNESS OF

- Eyes
- Feet
- Hair
- Hands
- Mouth/Throat
- Scalp
- Skin In General

LYMPH NODES

- Enlarged/neck
- Tender/neck
- Other Enlarged/Tender

NAILS

- Bitten
- Brittle
- Fungus-Fingers
- Fungus-Toes
- Ridges
- Soft

Thickening of:

- Fingernails
- Toenails
- White Spots/Lines

RESPIRATORY

- Bad Breath
- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat
- Hay Fever, seasonal
- Hay Fever, perennial (all year)
- Nasal Stuffiness
- Nose Bleeds
- Post Nasal Drip
- Sinus Fullness
- Sinus Infection
- Snoring
- Wheezing

CARDIOVASCULAR

- Angina/chest pain
- Breathlessness
- Heart Murmur
- Irregular Pulse
- Palpitations
- Swollen Ankles/Feet
- Varicose Veins

URINARY

- Bed Wetting
- Hesitancy (trouble getting started)
- Infection
- Kidney Disease
- Leaking/Incontinence
- Pain/Burning
- Prostate Infection
- Urgency

MALE REPRODUCTIVE

- Discharge From Penis
- Ejaculation Problem
- Genital Pain
- Impotence
- Prostate or Urinary Infection
- Lumps In Testicles
- Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex

Premenstrual:

- Bloating
- Breast Tenderness
- Carbohydrate Cravings
- Chocolate Cravings
- Constipation
- Decreased Sleep
- Diarrhea
- Fatigue
- Increased Sleep
- Irritability

Menstrual:

- Cramps
- Heavy Periods
- Irregular Periods
- No Periods
- Scanty Periods
- Spotting Between

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 several 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 a relaxation technique 5 4 3 2 1
Engage in regular exercise 5 4 3 2 1
Have periodic lab tests to assess your progress..... 5 4 3 2 1

Comments

_____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):
How confident are you of your ability to organize and follow through on the above health related Activities? 5 4 3 2 1
If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities

_____

_____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):
At the present time, how supportive do you think the people in your household will be to your implementing the above changes? 5 4 3 2 1

Comments

_____

_____

_____