Naturopathic and Allergy Clinic

Toronto Office .....: Telephone (416) 207-0207, Telefax (416) 207-0272

Email: clinic@live.com

Confidential Adult Patient's Case History

Version September 2017

Dear Patient: This form was specifically designed by our **Naturopathic Doctor, the clinic director Fateh Srajeldin ND,** to help our medical team evaluate your current health condition. Please complete this health questionnaire to the best of your knowledge. Your answers will help us determine in what ways we can help you restore your health. We will only accept your case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④diet as given. Rest assured that all information given on this application and subsequent information in your file will remain completely confidential.

✳**Please make sure to answer all questions that have the mark (✳), then SIGN THE FORM PLEASE. Thank you.**

Personal information

✳Last name: _____ ✳First name: _____ Middle name: _____

✳Date of birth: MM. DD. YY. Sex: ❑ Male, ❑ Female, Height: _____ Weight: _____ Last physical date: _____

✳My Occupation is: _____ My employer is: _____

✳I have been unwell for: _____ Yrs., Physician's name who treated me was: _____

I was treated by a ❑ Medical Dr., ❑ Chiropractor, ❑ Naturopath Dr., ❑ Psychiatrist, ❑ Hospital, ❑ Homeopath, ❑ Herbs.

Was treatment terminated? : ❑ Yes, ❑ No, Did treatment achieve its goal % (explain): _____

✳I was treated for: _____

✳I am currently suffering from and need treatment for: _____

Family members who have similar conditions: ❑ Mother, ❑ Father, ❑ Brother(s), ❑ Sister(s), ❑ Daughter(s), ❑ Son(s), ❑ Adopted.

I am: ❑ Single, ❑ Married, ❑ Divorced, ❑ Separated, ❑ Common Law, ❑ Widow. Number of children: __ (Males __ , Females __)

Number of older brothers: _____ Number of older sisters: _____ My rank in the family is: _____

Number of younger brothers: _____ Number of younger sisters: _____ My favorite sport is: _____

✳My home address: _____ Suite: _____ City: _____ Province: _____ PC code: _____

✳My home telephone ( ): _____ ✳My office telephone ( ): _____ Ext. _____

✳My Cellular number ( ): _____ ✳My email: _____ @ _____

My Fax number ( ): _____ .

My Spouse's / Partners Information

Last name: _____ First name: _____ My spouse's occupation: _____ Age: _____

Home address: ♀ Same as above _____ Suite: _____ City: _____ Province: _____ PC code: _____

Home telephone ( ): _____ Office telephone ( ): _____ Ext. _____

Cellular number ( ): _____ email: _____ @ _____

In case of an emergency who may we contact

✳First name: _____ ✳Last name: _____ ✳Relationship: _____

Telephone (H): ( ) _____ (W): ( ) _____ Ext. _____ Fax: ( ) _____

Do you or your spouse have an extended health insurance at work ❑ Yes, ❑ No.? Name of Insurance company: _____

✳Who referred you to this Clinic : _____

❑ Office sign, ❑ Our Website, ❑ Surfing the Net, ❑ Office Pamphlet, ❑ Word of mouth.

Dear Patient:

The following several pages contain ① declaration form, ② consent to examination form, ③ medical health questionnaire, ④ medical history form and ⑤ dietary questionnaire. There is a sections contains some crucial questions concerning both parents which pertain to your total health as well. Please take some time to answer all of the following questions as accurately as possible. The total interview and the actual examination may last approximately ninety minutes more or less. Further, You will spend approximately thirty minutes with your physician to setup your diet thereafter. You are expected to apply the diet as given. Along with the diet, your daily remedies, frequency and therapies will be set too.

Please note that naturopathic examination, treatments, therapies and remedies are not covered by the Ontario Health Insurance Plan (OHIP). Naturopathic examinations, treatments and therapies could be covered by an extended health insurance plans at your place of Employment. You may consult with your insurance company directly about their coverage. We, at the clinic, do not deal directly with insurance companies and we have no Information about their coverage.

Privacy: All your files and information are extremely confidential, however if you have any extra information concerning more steps of privacy concerning mail, email, phone calls or leaving phone massages, then please give us written instructions here: _____

Continue on page (2) please

Adult Declaration & Consent to Examination and Treatment

Name (please print) _____ **Date:** _____

I understand that the clinic's Naturopath, Dr. Fateh Srajeldin, B.Sc., ND, practices with an eclectic approach to health care. The initial patients' visit to see the naturopath at this clinic will include ① **discussing my medical history from birth to date,** ② **standard external physical examination,** ③ **evaluation of my diet and** ④ **prescribing remedies** based on the outcome of my total visit plus my current symptoms and my current laboratory blood work (if available). I understand that blood testing is not included in today's examination fee. I understand that the treatments may include Clinical Nutrition, Vitamins, Minerals, Enzymes, Co-Enzymes, Anti-Oxidants, Botanical remedies, Homeopathic remedies, Orthomolecular Supplementation, Acupuncture and Intravenous Therapy.
I understand that the Dr. Srajeldin's mission statement is to "provide safe and effective treatments to restore health as permanently as possible in the quickest, gentlest, least harmful way." I understand that the success of the treatment hinges on my compliance and application of the treatments.

I understand that Dr. Fateh Srajeldin, B.Sc., ND is a licensed Naturopathic Doctor (ND) not a Medical Doctor and his examinations and treatments are not covered by OHIP. I also understand that Naturopathic examination, treatments, therapies and remedies are not covered by the Ontario Health Insurance Plan (OHIP). I understand that Naturopathic examinations, treatments and therapies could be covered by my extended health insurance plan at my place of employment (if available). It is my responsibility to consult with my insurance company directly. I understand that The Naturopathic and Allergy Clinic does not deal directly with insurance companies and have no information about my coverage.
Any treatment provided to me as a patient of Dr. Fateh Srajeldin B.Sc., ND is not mutually exclusive from any treatment or advice that I may be receiving or may in the future be receiving from another licensed health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario or elsewhere. I understand that medical therapy and naturopathic/drugless therapy, including homeopathy, are different kinds of therapies.
I understand that Dr. Fateh Srajeldin, B.Sc., ND strives to provide the best possible diagnosis and course of treatment. However, I understand that many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action or application of medical advice or information given.
I understand that the total interview and the actual physical examination (without an internal) may last approximately ninety minutes more or less. Further, I understand that the naturopath may spend approximately sixty minutes with me to setup my diet thereafter if I choose to have my diet restructured. I will apply the diet as given. Along with the diet, my daily remedies, frequency and therapies will be set too.

For female patients
I understand that while the option of breast examination on page (6) is recommended during first visit for all females over the age of 40 years or starting at age 30 years for those who use or have used alcohol, use or have used oral contraception and / or smoke or have smoked, the examination will only be performed if my health condition warrants an examination and I consent and initial "**Breast examination**" in the female section on page (6).

For male patients
I understand that the option for prostate examination on page (6) is recommended during first visit for males over the age of 40 years or starting at age 35 years for those men who use or have used steroids for body building, those men who drink or have drank alcohol and those who smoke or have smoked, the examination will be performed if my health condition warrants an examination and I consent and initial "**Prostate examination**" in the male section on page (6).

I understand that, in the event of a medical emergency, I am advised to seek conventional medical care at a hospital if I am unable to Reach my Naturopathic Doctor.

This is to acknowledge that I have read the above information and understand that these are the terms and conditions at the Naturopathic and Allergy Clinic. I also consent to the examination as been described above and as the examining naturopath sees necessary to help me overcome my symptoms.

I will provide a copy of my most recent blood work done in the past six months. Alternatively, I will arrange, bring, mail or fax all medical tests, (blood, urine, x- ray, ultrasound, MRI, and surgery results), pertaining to my health from my physician's office or the hospital if I was treated at a hospital. I will answer the questionnaire concerning my health to the best of my ability and knowledge. I will pay for all examinations, treatments, therapies and intravenous therapy immediately when rendered.

I understand that remedies and laboratory blood works are not included in the examination fee. I understand that appointment(s) cancellation requires **48** hours advanced notice for full refund otherwise there will be a $50 surcharge applied on each and every examination or therapy missed or cancelled.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Note

Before the date of your appointment, if possible, please arrange, bring, mail or fax all your medical tests, (blood, urine, x-ray, ultrasound, MRI, and surgery results), pertaining to your health from your physician's office or the hospital if you were treated at a hospital.

Fees of Examinations and services

City	Choice ✓	Code	Explanations (Listed time of visits and therapies are approximate)	Our fee schedule	Exclusion
Toronto Clinic		EX1-ID	First Examination 1½ Hrs. One major symptom examination including diet setting	$200.00 None Taxable	Remedies and blood work are NOT included in the first examination or any subsequent examination fee.
		EX1-ND	Full First Examination 1½ Hrs. NOT including diet setting	$200.00 None Taxable	
		EX1-B	Full First Examination 2 Hrs. including diet setting according to my medical health history, my symptoms and my physical examination,	$300.00 None Taxable	
		EX5	Subsequent Examination 30 Mins.	$80.00 None Taxable	

Hints to help you fill this medical history application:

The following are some hints on how to fill the application form as accurate as possible. Every question has two forms of answers. The first group of answers determine whether a symptom should be marked as **one** of the following answers

C… ☑ symptoms are present daily or
F… ☑ symptoms come and go frequently every few days, every week or every month or
P…☑ symptoms appear every several months or every season.

The second answer is placed under **Value** which explains the intensity of the symptom when it come using numbers from (1 to 10). Intensity of a symptom has nothing to do with the frequency of the symptom whether daily or once a week or one a month. Number (1 to 3) indicates the symptom's intensity is very small when it comes. On the other hand, a number (4 or 7) indicates that the symptom's intensity is disturbing and bothersome when it come. The number (8 to 10) symptom's intensity is very painful whether the symptom appears every day or once a month. You should assign or estimate number to every question as you see it. This is not a right or wrong questions. For example :

GASTRO-INTESTINAL

P	F	C	Value	
☐	☐	☑	④	Gas
☑	☐	☐	☐	Jaundice
☑	☐	☐	②	Diarrhea
☐	☐	☑	⑥	Heart burn
☐	☐	☑	③	Indigestion
☐	☐	☑	⑦	Constipation
☐	☑	☐	③	Poor appetite
☑	☐	☐	②	Hemorrhoids
☐	☑	☐	③	Liver trouble
☐	☐	☑	☐	Colon trouble
☐	☐	☑	②	Pain over stomach
☐	☑	☐	☐	Gall bladder trouble

Gas here is constant symptom that appears daily and little moderately bothersome given value of 4

Heart burn here is constant daily symptom that appears daily and very disturbing given value of 6

Poor appetite is moderate symptom that appears frequently and bothersome given value of 3

Pain over stomach here is daily symptom that appears daily but little discomfort given value of 2

This way helps your naturopathic doctor see and feel your symptoms through his/her nervous system.

Continue on page (4) please

Read through the following list of symptoms that apply to you now or in the past. Please ignore symptoms that are not related to your condition. Please check mark ☑ the boxes under the appropriate columns if a symptom is **(P)** = **P**ast symptoms but no longer a concern, **(F)** = **F**requent symptom that keeps coming back and **(C)** = **C**onstant and bothersome symptom and place a numerical value under **Value**. Leave the boxes blank if the symptom being asked does not apply to you. **Thank you**

GENERAL Symptoms

P	F	C	Value	
❑	❑	❑	❑	Fainting
❑	❑	❑	❑	Dizziness
❑	❑	❑	❑	Anemia
❑	❑	❑	❑	Tremor
❑	❑	❑	❑	Neuralgia
❑	❑	❑	❑	Exhausted
❑	❑	❑	❑	Convulsions
❑	❑	❑	❑	Mononucleosis
❑	❑	❑	❑	Chronic Fatigue
❑	❑	❑	❑	Fever or Chills
❑	❑	❑	❑	Cold or warm sweats
❑	❑	❑	❑	Sudden weight loss
❑	❑	❑	❑	Can not lose weight
❑	❑	❑	❑	Leg cramps at night

RESPIRATORY Symptoms

P	F	C	Value	
❑	❑	❑	❑	Croup
❑	❑	❑	❑	Pleurisy
❑	❑	❑	❑	Wheezing
❑	❑	❑	❑	Chest pain
❑	❑	❑	❑	Chronic cough
❑	❑	❑	❑	Chest tightness
❑	❑	❑	❑	Difficult breathing
❑	❑	❑	❑	Spitting blood / phlegm
❑	❑	❑	❑	Asthmatic symptoms
❑	❑	❑	❑	Bronchitis, Chronic/Acute
❑	❑	❑	❑	Whooping cough
❑	❑	❑	❑	Tuberculosis
❑	❑	❑	❑	Emphysema
❑	❑	❑	❑	Pneumonia
❑	❑	❑	❑	Diphtheria
❑	❑	❑	❑	Influenza
❑	❑	❑	❑	Smoking Now / Past
❑	❑	❑	❑	Lungs Meds._____.

SKIN Symptoms

P	F	C	Value	
❑	❑	❑	❑	Acne
❑	❑	❑	❑	Boils
❑	❑	❑	❑	Warts
❑	❑	❑	❑	Blisters
❑	❑	❑	❑	Rosacea
❑	❑	❑	❑	Shingles
❑	❑	❑	❑	Vitiligo
❑	❑	❑	❑	Athletes foot
❑	❑	❑	❑	Bruise easily
❑	❑	❑	❑	Varicose veins
❑	❑	❑	❑	Brittle Nails
❑	❑	❑	❑	Skin ring worms
❑	❑	❑	❑	Skin itch or burn
❑	❑	❑	❑	Sweats profusely
❑	❑	❑	❑	Hives Large/Small
❑	❑	❑	❑	Eczema / Psoriasis
❑	❑	❑	❑	Cold / Dry feet
❑	❑	❑	❑	Corns on Feet / Toes
❑	❑	❑	❑	Skin Meds._____.

MUSCLE, BONE & JOINTS Sx.

P	F	C	Value	
❑	❑	❑	❑	TMJ
❑	❑	❑	❑	Gout
❑	❑	❑	❑	Hernia
❑	❑	❑	❑	Arthritis
❑	❑	❑	❑	Bursitis
❑	❑	❑	❑	Scoliosis
❑	❑	❑	❑	High Uric Acid
❑	❑	❑	❑	Neck stiffness
❑	❑	❑	❑	Fibromyalgia
❑	❑	❑	❑	Painful tail bone
❑	❑	❑	❑	Growing pain
❑	❑	❑	❑	Sciatica pain
❑	❑	❑	❑	Poor Posture
❑	❑	❑	❑	Swollen Joints
❑	❑	❑	❑	Osteosclerosis
❑	❑	❑	❑	Osteoporosis
❑	❑	❑	❑	Tennis elbow
❑	❑	❑	❑	Upper back pain
❑	❑	❑	❑	Middle back pain
❑	❑	❑	❑	Lower back pain
❑	❑	❑	❑	Pain between ribs
❑	❑	❑	❑	Muscle twitches
❑	❑	❑	❑	Rheumatoid arthritis
				Is there any pain or numbness in:
❑	❑	❑	❑	*Shoulders
❑	❑	❑	❑	*Between shoulders
❑	❑	❑	❑	*Arms
❑	❑	❑	❑	*Elbows
❑	❑	❑	❑	*Hands
❑	❑	❑	❑	*Fingers
❑	❑	❑	❑	*Hips
❑	❑	❑	❑	*Legs
❑	❑	❑	❑	*Knees
❑	❑	❑	❑	*Ankles
❑	❑	❑	❑	*Feet
❑	❑	❑	❑	*Heels
❑	❑	❑	❑	*Toes
❑	❑	❑	❑	*Bottom of feet
❑	❑	❑	❑	*Arch of feet
❑	❑	❑	❑	Joints Meds._____.

CARDIO-VASCULAR Symptoms

P	F	C	Value	
❑	❑	❑	❑	Heart palpitation
❑	❑	❑	❑	Slow heart beat
❑	❑	❑	❑	Heart Murmur
❑	❑	❑	❑	Light headed
❑	❑	❑	❑	Angina / Chest pain
❑	❑	❑	❑	Poor circulation
❑	❑	❑	❑	High cholesterol
❑	❑	❑	❑	High blood pressure
❑	❑	❑	❑	Low blood pressure
❑	❑	❑	❑	Dyspnea on exertion
❑	❑	❑	❑	Shortness of breath
❑	❑	❑	❑	Hypertension meds.
❑	❑	❑	❑	_____.
❑	❑	❑	❑	Cholesterol meds
❑	❑	❑	❑	_____.

GASTRO-INTESTINAL Symptoms

P	F	C	Value	
❑	❑	❑	❑	Gas
❑	❑	❑	❑	Nausea
❑	❑	❑	❑	Fissures
❑	❑	❑	❑	Diarrhea
❑	❑	❑	❑	Colitis
❑	❑	❑	❑	Burping
❑	❑	❑	❑	Belching
❑	❑	❑	❑	Heart burn
❑	❑	❑	❑	Indigestion
❑	❑	❑	❑	Constipation
❑	❑	❑	❑	Poor appetite
❑	❑	❑	❑	Hemorrhoids
❑	❑	❑	❑	Liver trouble
❑	❑	❑	❑	Colon trouble
❑	❑	❑	❑	Intestinal worms
❑	❑	❑	❑	Excessive hunger
❑	❑	❑	❑	Stomach pain
❑	❑	❑	❑	Gall bladder pain
❑	❑	❑	❑	Hepatitis A / B / C.
❑	❑	❑	❑	Abdominal distension
❑	❑	❑	❑	Halitosis (bad breath)
❑	❑	❑	❑	Bloated after meals
❑	❑	❑	❑	Anorexia nervosa
❑	❑	❑	❑	Ulcerative colitis
❑	❑	❑	❑	Rectal bleeding
❑	❑	❑	❑	Crohn's disease
❑	❑	❑	❑	Rectal itch
❑	❑	❑	❑	Bulimia
❑	❑	❑	❑	Diverticulitis
❑	❑	❑	❑	Colon polyps
❑	❑	❑	❑	Stomach ulcers
❑	❑	❑	❑	Sleepy after meals
❑	❑	❑	❑	Painful to swallow
❑	❑	❑	❑	Food particles in stool
❑	❑	❑	❑	Digestive Meds.____.

SCALP & HAIR Symptoms

P	F	C	Value	
❑	❑	❑	❑	Dandruff
❑	❑	❑	❑	Psoriasis
❑	❑	❑	❑	Hair loss
❑	❑	❑	❑	Hair lice
❑	❑	❑	❑	Hair splits
❑	❑	❑	❑	Scalp itchy
❑	❑	❑	❑	Scalp painful
❑	❑	❑	❑	Hair implant
❑	❑	❑	❑	Dry or Oily hair
❑	❑	❑	❑	Baldness patches

SLEEP Issues

P	F	C	Value	
❑	❑	❑	❑	Sleeping time _____.
❑	❑	❑	❑	Waking up time _____.
❑	❑	❑	❑	Insomnia_____Min.
❑	❑	❑	❑	Interrupted sleep __X.
❑	❑	❑	❑	Do you day-nap?
❑	❑	❑	❑	Sleepy all day
❑	❑	❑	❑	Sleeping Meds. _____.

MOUTH Issues

P	F	C	Value
❑	❑	❑	❑ Mercury filling
❑	❑	❑	❑ Bad breath often
❑	❑	❑	❑ Thrush on tongue
❑	❑	❑	❑ Mumps
❑	❑	❑	❑ Snore
❑	❑	❑	❑ Teeth trouble
❑	❑	❑	❑ Gums bleeding
❑	❑	❑	❑ Drool every night
❑	❑	❑	❑ Enlarged tonsils
❑	❑	❑	❑ Oral herpes
❑	❑	❑	❑ Cold sores

NASAL Symptoms

P	F	C	Value
❑	❑	❑	❑ Nose tip itch
❑	❑	❑	❑ Nose bleeds (epistaxis)
❑	❑	❑	❑ Nasal obstruction
❑	❑	❑	❑ Nasal congestion
❑	❑	❑	❑ Sneezing spells
❑	❑	❑	❑ Sinus infection
❑	❑	❑	❑ Post nasal drip

EARS Symptoms

P	F	C	Value
❑	❑	❑	❑ Tinnitus
❑	❑	❑	❑ Ear noise
❑	❑	❑	❑ Ear aches
❑	❑	❑	❑ Vertigo
❑	❑	❑	❑ Ears redness
❑	❑	❑	❑ Ear canal itch
❑	❑	❑	❑ Ear discharge
❑	❑	❑	❑ Perforated eardrum
❑	❑	❑	❑ Ear wax excessive

EYES Symptoms

P	F	C	Value
❑	❑	❑	❑ Eyes itch
❑	❑	❑	❑ Eyes redness
❑	❑	❑	❑ Eyes discharge
❑	❑	❑	❑ Sties on eye lid
❑	❑	❑	❑ Failing vision
❑	❑	❑	❑ Near / Far sighted
❑	❑	❑	❑ Glaucoma
❑	❑	❑	❑ Eye infections
❑	❑	❑	❑ Bags under eyes
❑	❑	❑	❑ Pain over eyes
❑	❑	❑	❑ Floaters in the eyes

THROAT Symptoms

P	F	C	Value
❑	❑	❑	❑ Colds
❑	❑	❑	❑ Tonsillitis
❑	❑	❑	❑ Cold sores
❑	❑	❑	❑ Sore throat
❑	❑	❑	❑ Throat itch
❑	❑	❑	❑ Enlarged glands
❑	❑	❑	❑ Enlarged tonsils
❑	❑	❑	❑ Enlarged adenoids
❑	❑	❑	❑ Throat irritation
❑	❑	❑	❑ Voice changed lately
❑	❑	❑	❑ Enlarged Tonsils
❑	❑	❑	❑ Complete voice loss

HEAD Symptoms

P	F	C	Value
❑	❑	❑	❑ Migraine
❑	❑	❑	❑ Headache
❑	❑	❑	❑ Tension Headache
❑	❑	❑	❑ Cluster Headache
❑	❑	❑	❑ Headache after MVA
❑	❑	❑	❑ Headache on waking
❑	❑	❑	❑ Headache if hungry
❑	❑	❑	❑ Headache medication
❑	❑	❑	❑ Headaches /Wk.____.
❑	❑	❑	❑ Headaches Meds.___.

IMMUNIZATION & ALLERGY Shots

Yes	No	
❑	❑	Immunization (Infant)
❑	❑	Immunization (Child)
❑	❑	Immunization (Teens)
❑	❑	Immunization (Adult)
❑	❑	Allergy shots Now / Past
❑	❑	Flu shots: _____.
❑	❑	Others: _____.

ALLERGIES Symptoms

P	F	C	Value
❑	❑	❑	❑ Seasonal allergies
❑	❑	❑	❑ Spring
❑	❑	❑	❑ Summer
❑	❑	❑	❑ Fall
❑	❑	❑	❑ Winter
❑	❑	❑	❑ Allergy to house dust
❑	❑	❑	❑ Allergy to dust mites
❑	❑	❑	❑ Allergy to dairy product
❑	❑	❑	❑ Allergy to perfumes
❑	❑	❑	❑ Allergy to Sulfur
❑	❑	❑	❑ Allergy to medication
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to weeds
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to food additive
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to trees
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to grains
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to vegetables
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to food
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to grasses
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to animals
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to chemicals
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to insects
❑	❑	❑	❑ name: _____.
❑	❑	❑	❑ Allergy to hay fever
❑	❑	❑	❑ winter: _____.
❑	❑	❑	❑ spring: _____.
❑	❑	❑	❑ summer: _____.
❑	❑	❑	❑ fall: _____.
❑	❑	❑	❑ Allergy to molds

ENDOCRINE GLANDS Symptoms

P	F	C	Value
❑	❑	❑	❑ Goiter
❑	❑	❑	❑ Diabetes Mellitus
❑	❑	❑	❑ Diabetes Juvenile
❑	❑	❑	❑ Puffy face
❑	❑	❑	❑ Protruded eyes
❑	❑	❑	❑ Hypoglycemia
❑	❑	❑	❑ Hyperthyroidism
❑	❑	❑	❑ Hypothyroidism
❑	❑	❑	❑ Intolerant to heat/cold
❑	❑	❑	❑ Addison's disease

GENITAL URINARY Symptoms

P	F	C	Value
❑	❑	❑	❑ UTI
❑	❑	❑	❑ Pubic itch
❑	❑	❑	❑ Bed wetting
❑	❑	❑	❑ Blood in urine
❑	❑	❑	❑ Kidneys stones
❑	❑	❑	❑ Frequent urination
❑	❑	❑	❑ Can not hold urine
❑	❑	❑	❑ Kidneys infections
❑	❑	❑	❑ Burning urination
❑	❑	❑	❑ Genital Herpes
❑	❑	❑	❑ Urine incontinence
❑	❑	❑	❑ Slow urination
❑	❑	❑	❑ Swollen ankles
❑	❑	❑	❑ Difficult starting urine

NERVOUS SYSTEM Symptoms

P	F	C	Value
❑	❑	❑	❑ OCD
❑	❑	❑	❑ Epilepsy
❑	❑	❑	❑ Unhappy
❑	❑	❑	❑ Depressed
❑	❑	❑	❑ Panic Disorder
❑	❑	❑	❑ ADD Symptoms
❑	❑	❑	❑ ADHD Symptoms
❑	❑	❑	❑ Anxiety
❑	❑	❑	❑ Social Anxiety
❑	❑	❑	❑ Anxiety due to abuse
❑	❑	❑	❑ Post Traumatic Stress
❑	❑	❑	❑ Phobic Disorder
❑	❑	❑	❑ Hyperactivity
❑	❑	❑	❑ Schizophrenia
❑	❑	❑	❑ Difficult to relax
❑	❑	❑	❑ Tendency to worry
❑	❑	❑	❑ Loses temper often
❑	❑	❑	❑ Tendency to cry
❑	❑	❑	❑ Low self esteem
❑	❑	❑	❑ Hopeless outlook
❑	❑	❑	❑ Tendency to be shy
❑	❑	❑	❑ Dislike criticism
❑	❑	❑	❑ Frightening dreams
❑	❑	❑	❑ Frightening thoughts
❑	❑	❑	❑ Weather affects mood
❑	❑	❑	❑ Poor memory
❑	❑	❑	❑ Harder to concentrate
❑	❑	❑	❑ Thoughts of suicide
❑	❑	❑	❑ Multiple sclerosis
❑	❑	❑	❑ Seizure Grand Mal / Petit
❑	❑	❑	❑ Wets pants constantly
❑	❑	❑	❑ Any Meds._____.

MALIGNANCIES

P	F	C	Value
❑	❑	❑	❑ Leukemia
❑	❑	❑	❑ Lymphoma
❑	❑	❑	❑ Type of Cancer _____.
❑	❑	❑	❑ Metastesized Cancer
❑	❑	❑	❑ Malignency Stage ( )
❑	❑	❑	❑ Malignency _____.

Date of past and current surgeries:

_____ Hernia operation
_____ Gallbladder removed
_____ Tonsillectomy
_____ Tubes in ears
_____ Appendectomy
_____ Nasal adenoids
_____ Cancer surgery
_____ Knee operation
_____ Hysterectomy
_____ C Section
_____ Prosthesis (Implants)

Date of Tests:

_____ Chest X-Ray
_____ Kidney X-Ray
_____ Colon X-Ray
_____ Sinus X-Ray
_____ Gallbladder X-Ray
_____ Electrocardiogram
_____ Sigmoidoscopy
_____ Mammogram
_____ Polio series
_____ Flu shots
_____ Hepetitis shot
_____ Tetanus shots
_____ Typhoid shots
_____ Mumps shots
_____ Measles shots
_____ Gastro-intest series

List drugs known to you whether :

Past	Taking	Allergic	Medications
❑	❑	❑	Antibiotics
❑	❑	❑	Inhalers Ventolin, Symbicort
❑	❑	❑	Insulin meds.
❑	❑	❑	Aspirin, Tylenol
❑	❑	❑	Anxiety meds.
❑	❑	❑	Depression meds.
❑	❑	❑	Metformin meds.
❑	❑	❑	Warfarin meds.
❑	❑	❑	Cortisone
❑	❑	❑	Hormones
❑	❑	❑	Gravol / Antacids
❑	❑	❑	Thyroid meds
❑	❑	❑	Sleeping pills
❑	❑	❑	Hypertension
❑	❑	❑	Intravenous Therapy
❑	❑	❑	Chelation Therapy
❑	❑	❑	Myer's cocktail IV
❑	❑	❑	_____.
❑	❑	❑	_____.
❑	❑	❑	_____.
❑	❑	❑	_____.
❑	❑	❑	_____.

SEXUALITY

Yes	No	
❑	❑	Abstainer
❑	❑	Sexually active
❑	❑	Heterosexual
❑	❑	Homosexual
❑	❑	Bisexual

FOR MEN

P	F	C	Value
❑	❑	❑	❑ *Enlarged prostate
❑	❑	❑	❑ *Discharge from penis
❑	❑	❑	❑ Painful testicles
❑	❑	❑	❑ Lumps in testicles
❑	❑	❑	❑ Impotence
❑	❑	❑	❑ Infertility
❑	❑	❑	❑ Vasectomy
❑	❑	❑	❑ Condom (Lubricated)
❑	❑	❑	❑ Condom (Dry)

_____ Date of prostate exam
I need prostate exam **Yes** ❑ **No** ❑
Your initials please: (must) _____.

FOR FEMALES

P	F	C	Value
			My maiden name is _____.
❑	❑	❑	❑ Hysterectomy Yr ____.
❑	❑	❑	❑ Constant PMS
❑	❑	❑	❑ Congested breasts
❑	❑	❑	❑ Heavy menstrual flow
❑	❑	❑	❑ Hot flashes
❑	❑	❑	❑ Irregular cycle
❑	❑	❑	❑ Lumps in breast
❑	❑	❑	❑ Menopausal symptom
❑	❑	❑	❑ Cervical HPV
❑	❑	❑	❑ *Vaginal discharge
❑	❑	❑	❑ Uterine fibroids
❑	❑	❑	❑ Vaginal bleeding
❑	❑	❑	❑ Genital herpes Yrs.__
❑	❑	❑	❑ Infertility Yrs. __
			Birth control
❑	❑	❑	❑ *Oral contraceptive
❑	❑	❑	❑ Intrauterine device
❑	❑	❑	❑ Withdrawal
❑	❑	❑	❑ Rhythm
❑	❑	❑	❑ Tubal ligation
❑	❑	❑	❑ Diaphragm
❑	❑	❑	❑ Spermicidal cream
❑	❑	❑	❑ Condom (Lubricated)
❑	❑	❑	❑ Condom (Dry)
❑	❑	❑	❑ Pads
❑	❑	❑	❑ Tampons

Date of last cycle _____.
*Pap smear date _____.
Total of pregnancies_____.
Total of premature _____.
Total of Miscarriages _____.
Total of abortions _____.
Total of stillbirths _____.
Date last breast exam _____.
I need breasts exam **Yes** ❑ **No** ❑
Your initials please: (must) _____.

HABITS and their frequencies

P	F	C	Value
❑	❑	❑	❑ Water per day: ____.
❑	❑	❑	❑ Tea per day: ____.
❑	❑	❑	❑ Milk per day: ____.
❑	❑	❑	❑ Cheese per day: ____.
❑	❑	❑	❑ Yogurt per day: ____.
❑	❑	❑	❑ Ice Cream per day: ____.
❑	❑	❑	❑ Cola per day: ____.
❑	❑	❑	❑ Coffee per day: ____.
❑	❑	❑	❑ Beer per day: ____.
❑	❑	❑	❑ Wine per day: ____.
❑	❑	❑	❑ Cigarettes per day: ____.
❑	❑	❑	❑ Chocolate per day: ____.
❑	❑	❑	❑ Whey Scoops per day: ____.
❑	❑	❑	❑ Butter or Margarine
❑	❑	❑	❑ Eat three meals a day
❑	❑	❑	❑ Eat one meal a day
❑	❑	❑	❑ Smoking Marijuana
❑	❑	❑	❑ Street drugs now / past

YOUR PARENTS

The following questions pertain to your parent' health before and while your mother was pregnant with you. The answer to the following would help determine the strength of your inner constitution.

Mom	None	Dad	Value
			Allergies
❑	❑	❑	❑ before pregnancy
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding
			Migraine
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding
			Alcoholism
❑	❑	❑	❑ before pregnancy
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding
			Smoking
❑	❑	❑	❑ before pregnancy
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding
			Epilepsy
❑	❑	❑	❑ before pregnancy
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding
			Asthma
❑	❑	❑	❑ before pregnancy
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding
			Prescribed drugs
❑	❑	❑	❑ before pregnancy
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding
			Street drugs/narcotics
❑	❑	❑	❑ before pregnancy
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding
			Communicable diseases
❑	❑	❑	❑ before pregnancy
❑	❑	❑	❑ during pregnancy
❑	❑	❑	❑ during breast feeding

Personal Notes

❑ **No parental history, I was adopted**
❑ **Did not have a healthy childhood**

The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive bill. You should list the starting year of diseases and the year of their cure such tonsillitis, ears, lungs, throat, skin etc. Also list the year of admission to hospital for whatever reason. ***SEE AN EXAMPLE ON PAGE 9.***
Information such be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. ***You may choose to fill this sheet with your doctor before your examination.***
Some important notes to consider are
1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind,

Duration	Year	Age	Description of incidents
		Birth Day	❑ I was not breast fed **Or** ❑ I was breast fed up for __ months & started solid food at __ months.
		1 Yr.	
		2 Yrs.	
		3 Yrs.	
		4 Yrs.	
		5 Yrs.	
		6 Yrs.	
		7 Yrs.	
		8 Yrs.	
		9 Yrs.	
		10 Yrs.	
		11	
		12	
		13	
		14	
		15	
		16	
		17	
		18	
		19	
		20 Yrs.	
		21	
		22	
		23	
		24	
		25	
		26	
		27	
		28	
		29	
		30 Yrs.	
		31	
		32	
		33	
		34	
		35	
		36	
		37	
		38	
		39	
		40 Yrs.	
		41	
		42	
		43	
		44	
		45	
		46	
		47	
		48	
		49	
		50 Yrs.	
		51	
		52	
		53	
		54	
		55	
		56	
		57	
		58	
		59	
		60 Yrs.	
		61	
		62	
		63	

Please add another sheet

DIET

The next table revolves around your dietary habits. This may be very beneficial in understanding the real causes behind your conditions. Please answer the following questions to the best of your abilities.

What do you eat during breakfast?

1-
2-
3-
4-
5-

What do you eat during lunch?

1-
2-
3-
4-
5-

What do you eat during dinner?

1-
2-
3-
4-
5-

What do you eat or during snacks?

Mid-Day:

Afternoon:

Before bed time:

FOODS THAT YOU CRAVE?

I crave:

- ❑ Chocolate
- ❑ Crunchy foods such as chips & crackers
- ❑ Caffeine such as coffee, tea, & energy drinks
- ❑ Cola, Pop, Soda
- ❑ Sugary foods and Desserts
- ❑ Hard Candy or Gum
- ❑ Protein
- ❑ Dairy
- ❑ Salty foods
- ❑ Fast foods
- ❑ Wine with meals
- ❑ Beer with meals

TYPE OF FOOD THAT YOU CONSUME?

- ❑ I have a strict dietary plan that I follow
- ❑ Most of my meals are home cooked whole foods
- ❑ I eat out less often today than I did 5 years ago
- ❑ I avoid refined grains, breads & pastas
- ❑ I avoid deep fried foods
- ❑ I eat sugary foods & dessert less than 3 times wk.
- ❑ I avoid diet foods
- ❑ I avoid Colas, Pops, Sodas
- ❑ I eat gluten free food
- ❑ I avoid foods that I have allergies to _____.
- ❑ I buy frozen or canned fruits and vegetables

WHEN DO YOU CONSUME FRUITS / VEGETABLES?

I consume:

- ❑ **NO** servings of fruit and vegetables at all
- ❑ Fruits &/or vegetables during breakfast
- ❑ Fruits &/or vegetables during lunch
- ❑ Fruits &/or vegetables during dinner
- ❑ Fruits &/or vegetables for snacks
- ❑ I make time to eat fruits &/or vegetables daily
- ❑ I prepare **fresh** fruits & vegetables
- ❑ I prepare **canned** or **frozen** fruits & vegetables

WHAT FRUITS & VEGETABLES DO YOU CONSUME?

I consume:

- ❑ A wide variety of **organic** fruits
- ❑ A wide variety of **regular** fruits
- ❑ A wide variety of **organic** vegetables
- ❑ A wide variety of **regular** vegetables
- ❑ A wide variety of vegetables
- ❑ A wide range of green leafy vegetables
- ❑ A wide color range of fruits & vegetables
- ❑ Broccoli, cauliflower, kale & Brussels sprouts
- ❑ I add Lemon / Lime juice to my salad

THE FOLLOWING BEST DESCRIBE YOUR DIGESTION?

- ❑ I am often bloated
- ❑ I have low energy after eating
- ❑ I am often constipated
- ❑ I have foggy brain after eating
- ❑ I have general digestive upset after eating
- ❑ I have excess mucus after eating
- ❑ I often have gas or flatulence
- ❑ I often have acid reflux &/or heartburn
- ❑ Going to the bathroom is often difficult
- ❑ I run to the bathroom immediately after food
- ❑ My stool varies in size & consistency

DO YOU CONSUME THE FOLLOWING IN MY FOOD ?

I must add the following to my food

- ❑ Vinegar
- ❑ Balsamic Vinegar
- ❑ Apple Cider
- ❑ Cheese
- ❑ Butter
- ❑ Mayonnaise
- ❑ I am hungry & often don't know why
- ❑ White sugar
- ❑ Salt
- ❑ MSG

THE FOLLOWING YOU DO NOT UNDERSTAND WHY ?

I always feel like

- ❑ Eating often eat when I feel guilt or depressed
- ❑ Eating & not knowing why
- ❑ Eat to reward myself
- ❑ I often eat when I am low energy especially in the
- ❑ I am hungry & often don't know why

The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive bill. You should list the starting year of diseases and the year of their cure such tonsillitis, ears, lungs, throat, skin etc. Also list the year of admission to hospital for whaever reason.
Information such be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. ***You may choose to fill this sheet with your doctor before your examination.***
Some important notes to consider are
1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind,

Duration	Year	Age	Description of incidents
	1951	Birth	Was not breast fed, used formula
		1	Repeated ear infections
		2	
		3	1st set of tubes in the ears
		4	
		5	
	1957	6	2nd set of tubes in ears plus anti biotics
		7	
	1959	8	Asthmatic symptoms, inhalers where prescribed and used daily
		9	
		10	
	1962	11	3rd set of tubes in the ears
		12	
		13	
		14	
		15	
		16	
		17	
		18	
	1970	19	Asthma symptoms disappeared
	1971	20	Motor vehicle accident, hospitalized for a broken leg
		21	
		22	
		23	
	1974	24	Smoking 1 pack a day
	1975	25	Marriage
	1976	26	Repeated Candida infection and discharge, prescribed anti fungal
		27	
	1979	28	1st child birth, normal delivery, epidural
		29	
		30	
		31	
		32	
		33	
	1985	34	2nd child birth, C section
		35	
		36	
		37	
	1989	38	Candida cleared
		39	
	1991	40	Stopped smoking, saddened and depressed by father's death due diabetes and hypertension
	1992	41	Migraine, daily used Advil
	1993	42	Constipation, bowel movement every 3 days, used OTC laxatives
		43	
		44	
		45	
		46	
		47	
		48	
		49	
		50	
		51	
		52	
		53	
		54	
		55	
	2007	56	Today, still have constipation, migraine plus was diagnosed with hypercholesterolemia and hypertension,
		57	
		58	
		59	
		60	
		61	
		62	

Please be as specific as possible since the medical history may hold the key to your complete recovery.

These lines are extended to indicate duration of diseases or medication use

This line indicates that constipation is still a problem medicated with laxatives

Thank you for completing the form