THE OPTIMAL HEALTH MEDICAL CENTER

INTRODUCTORY PEDIATRIC PATIENT INFORMATION

750 George Washington Way, Ste 5
Richland, WA 99352

Ph: 509 943-1122
F: 509 943-1125

www.ohmcenter.com
ohmedcenter@gmail.com

THE OPTIMAL HEALTH MEDICAL CENTER

GENERAL INFORMATION

Legal Name First ________________________ Middle ________________ Last ___________________________

Preferred or Nickname ____ Gender ☐ Male ☐ Female

Date of Birth ____________________________ (mm/dd/yyyy) Age __________________

Mother's Name ____ Occupation _____________________________

Father's Name ____ Occupation _____________________________

Mailing Address Street ____ Apt No. ___________

City ____ State _________ Zip _________________

Home Phone ______________________________ Is this a cell phone number? ☐ Yes ☐ No

Cell Phone ______________________________

Parent's Work Phone ______________________________ Can you be contacted at work? ☐ Yes ☐ No

Parent's Email Address ____

Emergency Contact Name ____ Phone_____________________________

Street ____ Apt No. ___________

City ____ State _________ Zip _________________

Relationship to child ____

Primary Care Physician Name ___________________________________ Phone_________________ Fax _______________

Street ____ Suite ______________

City ____ State _________ Zip _________________

Referred by ☐ Phone book ☐ Website ☐ Media ☐ Other

☐ Friend/Family? What is their name so we can thank them? ______________________________

PHARMACY INFORMATION

Primary Pharmacy

Name ____________________ Phone ______________ Fax* _______________

Street ____

City ______________________________ State ______ Zip __________

**It is extremely important you list the pharmacy's fax number.*

Supplemental/ Compounding Pharmacy

Name ____________________ Phone ______________ Fax* _______________

Street ____

City ______________________________ State ______ Zip __________

**It is extremely important you list the pharmacy's fax number.*

INSURANCE INFORMATION

Primary Insurance

Subscriber Name ______________________ Subscriber DOB ______________

Insurance Name ______________________ Insurance Ph ______________

Street ____

City ______________________________ State ______ Zip __________

Policy # ___________________________ Group # ____________________

Email _________________________ Employer Name __________________

CoPay Amount ______________________

MEDICAL HISTORY

ALLERGIES TO MEDICATIONS/FOODS/SUPPLEMENTS

Cause ______________________ Reaction ______________________

Cause ______________________ Reaction ______________________

Cause ______________________ Reaction ______________________

Cause ______________________ Reaction ______________________

COMPLAINTS/CONCERNS

I hope to achieve the following at this visit? ______________________

____

If you had a magic wand and could help your child in three ways, what would they be?

1.______________________

2.______________________

3.______________________

The last time you felt your child was well was: ______________________

Did something trigger this change in health? ______________________

What makes your child feel worse?______________________

What makes your child feel better? ______________________

Please list current and on going problems in order of priority. Describe the problem and circle the severity; then list the treatment/ approach tried and check the level of success.

Example: Problem: <u>Post Nasal Drip</u> ☑ *Moderate* *Treatment: <u>Elimination Diet</u>* ☑ *Excellent*

1. Problem ______________________ ☐ Severe ☐ Moderate ☐ Mild
   Treatment ______________________ ☐ Excellent ☐ Good ☐ Fair

2. Problem ______________________ ☐ Severe ☐ Moderate ☐ Mild
   Treatment ______________________ ☐ Excellent ☐ Good ☐ Fair

3. Problem ______________________ ☐ Severe ☐ Moderate ☐ Mild
   Treatment ______________________ ☐ Excellent ☐ Good ☐ Fair

4. Problem ______________________ ☐ Severe ☐ Moderate ☐ Mild
   Treatment ______________________ ☐ Excellent ☐ Good ☐ Fair

5. Problem ______________________ ☐ Severe ☐ Moderate ☐ Mild
   Treatment ______________________ ☐ Excellent ☐ Good ☐ Fair

6. Problem ______________________ ☐ Severe ☐ Moderate ☐ Mild
   Treatment ______________________ ☐ Excellent ☐ Good ☐ Fair

MEDICAL HISTORY (CONT)

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (mm/yy)	Purpose of Use

PREVIOUS MEDICATIONS last 10 years

Medication	Dose	Frequency	Start Date (mm/yy)	Purpose of Use

NUTRITIONAL SUPPLEMENTS vitamins, minerals, homeopathy, etc.

Supplement and Brand	Dose	Frequency	Start Date (mm/yy)	Purpose of Use

MEDICAL HISTORY (CONT)

PAST/CURRENT CONDITIONS check box for past or current condition and provide onset date

Past Current Onset Date

GASTROINTESTINAL

- ☐ ☐ ___/___ Irritable Bowel Syndrome
- ☐ ☐ ___/___ Inflammatory Bowel Disease
- ☐ ☐ ___/___ Crohn's
- ☐ ☐ ___/___ Ulcerative Colitis
- ☐ ☐ ___/___ Gastritis or Peptic Ulcer Disease
- ☐ ☐ ___/___ GERD (reflux)
- ☐ ☐ ___/___ Celiac Disease
- ☐ ☐ ___/___ Other ____________________

CARDIOVASCULAR

- ☐ ☐ ___/___ Heart Disease
- ☐ ☐ ___/___ Elevated Cholesterol
- ☐ ☐ ___/___ Hypertension (high BP)
- ☐ ☐ ___/___ Rheumatic Fever
- ☐ ☐ ___/___ Mitral Valve Prolapse
- ☐ ☐ ___/___ Other ____________________

METABOLIC/ENDOCRINE

- ☐ ☐ ___/___ Type 1 Diabetes
- ☐ ☐ ___/___ Type 2 Diabetes
- ☐ ☐ ___/___ Hypoglycemia
- ☐ ☐ ___/___ Metabolic Syndrome (Insulin Resistance or Pre-Diabetes)
- ☐ ☐ ___/___ Hypothyroidism (underactive)
- ☐ ☐ ___/___ Hyperthyroidism (overactive)
- ☐ ☐ ___/___ Endocrine Problems
- ☐ ☐ ___/___ Polycystic Ovarian Syndrome
- ☐ ☐ ___/___ Weight Gain
- ☐ ☐ ___/___ Weight Loss
- ☐ ☐ ___/___ Frequent Weight Fluctuations
- ☐ ☐ ___/___ Bulimia
- ☐ ☐ ___/___ Anorexia
- ☐ ☐ ___/___ Binge Eating Disorder
- ☐ ☐ ___/___ Night Eating Disorder
- ☐ ☐ ___/___ Eating Disorder (other)
- ☐ ☐ ___/___ Other ____________________

MUSCULOSKELETAL/PAIN

- ☐ ☐ ___/___ Arthritis
- ☐ ☐ ___/___ Fibromyalgia
- ☐ ☐ ___/___ Chronic Pain
- ☐ ☐ ___/___ Other ____________________

SKIN DISEASES

- ☐ ☐ ___/___ Eczema
- ☐ ☐ ___/___ Psoriasis
- ☐ ☐ ___/___ Acne
- ☐ ☐ ___/___ Other____________________

Past Current Onset Date

RESPIRATORY

- ☐ ☐ ___/___ Asthma
- ☐ ☐ ___/___ Chronic Sinusitis
- ☐ ☐ ___/___ Bronchitis
- ☐ ☐ ___/___ Frequent Ear Infections
- ☐ ☐ ___/___ Frequent Upper Respitory Infections
- ☐ ☐ ___/___ Sleep Apnea
- ☐ ☐ ___/___ Other____________________

INFLAMMATORY/AUTOIMMUNE

- ☐ ☐ ___/___ Chronic Fatigue Syndrome
- ☐ ☐ ___/___ Autoimmune Disease
- ☐ ☐ ___/___ Rheumatoid Arthritis
- ☐ ☐ ___/___ Lupus SLE
- ☐ ☐ ___/___ Immune Deficiency Disease
- ☐ ☐ ___/___ Severe Infectious Disease
- ☐ ☐ ___/___ Poor Immune Function (frequent infections)
- ☐ ☐ ___/___ Food Allergies
- ☐ ☐ ___/___ Environmental Allergies
- ☐ ☐ ___/___ Multiple Chemical Sensitivities
- ☐ ☐ ___/___ Latex Allergy
- ☐ ☐ ___/___ Other____________________

GENITAL AND URINARY SYSTEMS

- ☐ ☐ ___/___ Kidney Stones
- ☐ ☐ ___/___ Frequent Urinary Tract Infections
- ☐ ☐ ___/___ Frequent Yeast Infections
- ☐ ☐ ___/___ Other____________________

NEUROLOGIC/MOOD

- ☐ ☐ ___/___ Depression
- ☐ ☐ ___/___ Anxiety
- ☐ ☐ ___/___ Bipolar Disorder
- ☐ ☐ ___/___ Schizophrenia
- ☐ ☐ ___/___ Headaches
- ☐ ☐ ___/___ Migraines
- ☐ ☐ ___/___ ADD/ADHD
- ☐ ☐ ___/___ Sensory Integrative Disorder
- ☐ ☐ ___/___ Autism
- ☐ ☐ ___/___ Mild Cognitive Impairment
- ☐ ☐ ___/___ Multiple Sclerosis
- ☐ ☐ ___/___ ALS
- ☐ ☐ ___/___ Seizures
- ☐ ☐ ___/___ Other ____________________

CANCER

- ☐ ☐ ___/___ Type ____________________

MEDICAL HISTORY (CONT)

PREVIOUS EVALUATIONS check box if 'yes' and provide the date and location of test

Yes?	Location		Yes?	Location	
☐	______	Full Physical	☐	______	Physical Therapy
☐	______	Psychological Evaluations	☐	______	Occupational Therapy
☐	______	Wechsler Preschool & Primary School of Int.	☐	______	Sensory Integration Therapy
☐	______	Speech & Language Evaluations	☐	______	Language Classes
☐	______	Genetic Evaluations	☐	______	Sign Language
☐	______	Neurological Evaluations	☐	______	Homeopathic
☐	______	Gastroenterology Evaluations	☐	______	Naturopathic
☐	______	Celiac/Gluten Testing	☐	______	Craniosacral
☐	______	Allergy Evaluations	☐	______	Chiropractic
☐	______	Nutritional Evaluations	☐	______	MRI
☐	______	Auditory Evaluations	☐	______	CT Scan
☐	______	Vision Evaluations	☐	______	Upper Endoscopy
☐	______	Osteopathic	☐	______	Upper GI Series
☐	______	Acupuncture	☐	______	Ultrasound

SURGERIES check box if 'yes' and provide the hospital/clinic

Yes?	Location		Yes?	Location	
☐	______	Appendectomy	☐	______	Dental Surgery
☐	______	Circumcision	☐	______	Hernia
☐	______	Tubes in Ears	☐	______	Adenoids
☐	______	Tonsillectomy			
☐	______	Other Procedure ______________________			

INJURIES check box if 'yes' and provide date and cause if known

Yes?		Date	Cause
☐	Back Injury	______	______________________
☐	Neck Injury	______	______________________
☐	Head Injury	______	______________________
☐	Broken Bones	______	______________________
☐	Other Injury	______	______________________

HOSPITALIZATIONS provide details about past hospitalizations

Date	Reason
______	______________________________
______	______________________________
______	______________________________
______	______________________________
______	______________________________

BLOOD TYPE

My blood type is ☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ Unknown

MEDICAL HISTORY (CONT)

IMMUNIZATIONS check box if 'yes'

- ☐ My child is up to date with immunizations.
- ☐ I feel immunizations have had an impact on his/her health.

If relevant, please bring a copy of your child's immunization record to your first visit.

GI HISTORY check box if 'yes'

- ☐ Foreign Travel? If yes, where? ____________________________
- ☐ Wilderness Camping? If yes, where? ______________________
- ☐ Severe Gastroententeritis
- ☐ Severe Diarrhea
- ☐ My child does NOT digest food well.
- ☐ My child feels/looks bloated after meals.

GIRLS: GYNECOLOGICAL HISTORY check box if 'yes'

__________ Age at First Period

__________ Menses Frequency

__________ Date of Last Period

__________ Avg Length of Period

- ☐ My daughter has missed periods. If yes, for how long? ____________
- ☐ My daughter has painful periods.
- ☐ My daughter has clotting.

PATIENT BIRTH HISTORY check box if 'yes' and provide number as needed

- ☐ I was a full-term baby.
- ☐ I was born prematurely.
- ☐ Breast-fed? If yes, how Long? _____________
- ☐ Bottle-fed
- ☐ Pregnancy Complications? Describe: ____
- ☐ Birth Complications? Describe: ____
- ☐ Ate a lot of candy/sugar as a child

Age at introduction of: _________ Solid Food _________Dairy _________Wheat

DENTAL HISTORY check box if 'yes' and provide number if appropriate

- ☐ Gold Fillings _____
- ☐ Root Canals _____
- ☐ Implants _____
- ☐ Tooth Pain _____
- ☐ Silver Mercury Fillings _____
- ☐ Gingivitis
- ☐ Problems Chewing
- ☐ Bleeding Gums
- ☐ Floss Regularly

MEDICATION HISTORY check box if 'yes'

- ☐ Unusual side effects/problems caused by medications/supplements

  If yes, describe: ____
- ☐ Prolonged or regular use of Motrin, Aspirin and/or NSAIDS (Advil, Aleve, etc.)
- ☐ Prolonged or regular use of Tylenol
- ☐ Prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.)
- ☐ Frequent antibiotic use (>3 times/year)
- ☐ Long-term antibiotic use
- ☐ Past use of steroids (prednisone, nasal allergy inhalers)
- ☐ Oral contraceptive use

FAMILY HISTORY

Check all family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Age (if still alive)											
Age at death (if deceased)											
Cancers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast or Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Auto Immune Diseases (such as Lupus)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema/Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies, Sensitivities or Intolerances	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Sensitivities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALS or other Motor Neuron Diseases	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse (such as alcoholism)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

NUTRITION HISTORY check box if 'yes'

☐ My child has had a nutrition consultation.

☐ We have made changes to my child's eating habits due to health.

If yes, describe: ______________________________

My child is following a special diet or nutritional program. Check all that apply.

☐ Yeast Free	☐ Gluten Free	☐ Gluten Restricted
☐ Weight Management	☐ Ketogenic	☐ No Dairy
☐ No Wheat	☐ Vegetarian	☐ Diabetic
☐ Vegan	☐ Low Oxylate	☐ Specific Carbohydrate

☐ Food Allergy (peanuts, eggs, etc): ______________

☐ Other: ______________

☐ Specific Program for Weight Loss/Maintenance. Type: ______________

☐ My child avoids particular foods. If yes, types and reasons: ______________

____

☐ Who grocery shops? ______________

☐ Who cooks? ______________

If my child could only eat a few foods a week, they would be: ______________

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 child's current lifestyle and eating habits.

☐ Fast eater	☐ Erratic eating pattern	☐ Eat too much
☐ Sensory issues with food	☐ Dislike healthy food	☐ Time constraints
☐ Eat > 50% meals away from home	☐ Picky eater	☐ Limited variety of foods <5/day
☐ Prefers hot food	☐ Prefers cold foods	☐ Poor snack choices
☐ Every meal is a struggle	☐ Most family meals are together	☐ Use food as a bribe or reward
☐ Most meals eaten at the table	☐ High juice intake	☐ High sugar/sweet intake
☐ Drinks soda or diet soda	☐ Cow's milk 3+ cups	☐ Caffeine intake
☐ TV or videos with meals	☐ Challenges wiht food served outside the home (ie friend's home, childcare)	

BREASTFEED HISTORY check box if 'yes'

☐ My child was breastfed. If yes, how long? ______________

☐ My child was breastfed exclusively for __________ months.

☐ My child had problems latching on.

My child's sucking quality was ☐ very good ☐ good ☐ poor

BOTTLE FED HISTORY check box if 'yes'

☐ My child was bottle fed. If yes, how long? ______________ Formula type: ☐ Soy ☐ Cow's Milk ☐ Low Allergy

Introduction of cow's milk at __________ months. Introduction of solids at __________ months.

Introduction of wheat or other grain at __________ months.

☐ My child choked/vomitted/gagged on food.

☐ My child refused to eat solids.

List mother's known food allergies or sensitivities: ______________

Describe eating concerns you have regarding your child: ______________

____

SOCIAL HISTORY (CONT)

OTHER SUBSTANCES check box if 'yes'

☐ My child drinks caffeinated coffee and/or tea. If yes, how much?

Coffee cups/day ☐ 1 ☐ 2-4 ☐ >4

Tea cups/day ☐ 1 ☐ 2-4 ☐ >4

☐ My child drinks caffeinated sodas or diet sodas? If yes, how much/day? ☐ 1 ☐ 2-4 ☐ >4 (*1=12 oz can/bottle*)

List favorite type (Ex. Diet Coke, Pepsi, etc.) ____________________________

☐ My child currently uses recreational drugs. Type: ____________________________

☐ My child uses or has used IV or inhaled recreational drugs. Type: ____________________________

EXERCISE

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

Activity	Type	Frequency/ week	Duration (min)
Stretching			
Cardio/Aerobics			
Strength			
Sports or Leisure Activities (golf, tennis, etc.)			
Other (yoga, pilates, etc.)			

Rate your child's level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

Hom musch time does you child spend watching TV/week? ______________________

How much time does your child spend on the computer or playing video games/week? ______________________

PSYCHOSOCIAL check box if 'yes'

☐ I feel my child feels significantly less vital than they did a year ago.

☐ My child feels his/her life has meaning and purpose.

☐ I feel stress is presently reducing the quality of my child's life.

☐ My child would describe his/her experience in the family as happy and secure.

☐ My child is happy.

☐ My child has experienced major losses in his/her life.

☐ My child likes school.

STRESS/COPING check box if 'yes'

☐ I have sought counseling in the past for my child.

☐ My child is currently in therapy? If yes, how come?____________________________

☐ My child has an excessive amount of stress in my life.

☐ My child can easily handle the stress in my life.

Daily Stressors: Rate on a scale of 1-10 (1 being not at all stressful and 10 being extremely stressful).

_____School _____Family _____Social _____Finances _____Health _____Other: ____________________

☐ My child has been abused, a victim of a crime, or experienced a significant trauma.

☐ My child practices meditation or relaxation techniques. How often? ____________________

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: ____________________

SLEEP/REST check box if 'yes'

My child sleeps an average of ☐ >10 ☐ 8-10 ☐ 6-8 ☐ < 6 hours per night.

☐ My child has trouble falling asleep.

☐ My child has problems with insomnia.

☐ My child feels rested upon awakening.

☐ My child snores.

☐ My child uses sleeping aids? Explain:____________________________

ROLES/RELATIONSHIPS

☐ Is there anyone else living in your household? Number: _____ Names: ________________________________

Who are the main people caring for you child? ________________________________

Their employment/occupations: ________________________________

____

Resource(s) for child's emotional support. (*Check all that apply*):

☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other ____________________

ABOUT THE CHILD'S PARENTS

When were child's parents married? (mm/yy) __________ If separated, when? (mm/yy) __________

If divorced, when? (mm/yy) __________ If remarried, when? (mm/yy) __________

Custody arrangements: ________________________________

Child's Mother

Age at child's birth: __________

Education: __________

Ethnicity: __________

Child's Father

Age at child's birth: __________

Education: __________

Ethnicity: __________

How well have things been going for your child?	Very Well	Fine	Poorly	Doesn't Apply
Overall	☐	☐	☐	☐
At school	☐	☐	☐	☐
In job	☐	☐	☐	☐
In social life	☐	☐	☐	☐
With close friends	☐	☐	☐	☐
With sex	☐	☐	☐	☐
With attitude	☐	☐	☐	☐
With boyfriend/girlfriend	☐	☐	☐	☐
With parents	☐	☐	☐	☐

ENVIRONMENTAL ASSESSMENT

My child has been exposed to:

☐ Mold in bathroom
☐ Moldy/musty school/daycare
☐ Tobacco smoke
☐ Carpet in bedroom
☐ Had water in basement
☐ Mold in cellar, crawl space, basement
☐ Pest Extermination (inside)
☐ Well water
☐ Carpet in most areas of the house
☐ Mold visible on exterior of house
☐ Damp cellar
☐ Pest Extermination (outside)
☐ Forced hot air heat
☐ Feather or down bedding
☐ Heavily wooded or damp surroundings

SYMPTOM REVIEW

Check all current symptoms occurring or present in the past 6 months.

General

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

Head, Eyes and Ears

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

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 Weakness
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems
- ☐ Muscle Twitches Around Eyes
- ☐ Muscle Twitches Arms or Legs

Mood/Nerves

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- ☐ Dizziness (spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling Tremor/Trembling
- ☐ Visual Hallucinations
- ☐ Difficulty Concentrating
- ☐ Difficulty With Balance
- ☐ Difficulty With Thinking
- ☐ Difficulty With Judgment
- ☐ Difficulty With Speech
- ☐ Difficulty With Memory

Eating

- ☐ Poor appetite
- ☐ Thirst
- ☐ Extreme water drinking
- ☐ Bingeing
- ☐ Bread craving
- ☐ Craving for carbohydrates
- ☐ Craving for juice
- ☐ Craving for salt
- ☐ Diet soda craving
- ☐ Pica (eating non-edibles)
- ☐ Abnormal foocravings
- ☐ Carbohydrate intolerance
- ☐ Starch/disaccharide into!.
- ☐ Sugar intolerance
- ☐ Salicylate intolerance
- ☐ Oxalate intolerance
- ☐ Phenolics intolerance
- ☐ MSG intolerance
- ☐ Foocoloring intolerance
- ☐ Gluten Intolerance
- ☐ Casein intolerance
- ☐ Specific food(s) intolerance
- ☐ Lactose intolerance
- ☐ Behavior worse with food
- ☐ Behavior better when fasting

SYMPTOM REVIEW (CONT)

Digestion

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking Corner of Lips
- ☐ Cramps
- ☐ Dentures With Poor Chewing
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Bloating of Lower Abdomen
- ☐ Bloating of Whole Abdomen
- ☐ Boating After Meals
- ☐ Alternating Diarrhea & Constipation
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools
- ☐ Lactose Intolerance
- ☐ Intolerance to Dairy Products
- ☐ Intolerance to Wheat
- ☐ Intolerance to Yeast
- ☐ Intolerance to Gluten (Wheat, Rye, Barley)
- ☐ Intolerance to Corn
- ☐ Intolerance to Fatty Foods
- ☐ Intolerance to Eggs
- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)

Skin Dryness

- ☐ Dryness of Eyes
- ☐ Dryness of Feet
- ☐ Cracking of Feet
- ☐ Peeling of Feet
- ☐ Dryness of Hair
- ☐ Hair Unmanageable
- ☐ Dryness of Hands
- ☐ Any Cracking of Hands
- ☐ Any Peeling of Hands
- ☐ Dryness of Mouth/Throat
- ☐ Dryness of Scalp
- ☐ Dandruff
- ☐ Dryness of Skin in General

Skin Problems

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red Easy
- ☐ Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Lackluster Skin
- ☐ Moles With Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo
- ☐ Jock Itch

Skin Itching

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

SYMPTOM REVIEW (CONT)

Lymph Nodes

- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

Nails

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus on Fingers
- ☐ Fungus on Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of Fingernails
- ☐ Thickening of Toenails
- ☐ White Spots/Lines

Respiratory

- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Productive Cough
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Spring Hay Fever
- ☐ Summer Hay Fever
- ☐ Fall Hay Fever
- ☐ Change of Season
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

Cardiovascular

- ☐ Angina/Chest Pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ 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

SYMPTOM REVIEW (CONT)

Behavior

- ☐ Behavior purposeless
- ☐ Aloof, indifferent, remote
- ☐ Hides skill/knowledge
- ☐ No purpose to play
- ☐ Uninterested in live pet
- ☐ Poor sharing
- ☐ Erratic
- ☐ Hyperactive
- ☐ Tantrums
- ☐ Jumps when pleased
- ☐ Insists on what wanted
- ☐ Falls, gets hurt running climbing
- ☐ Silly
- ☐ Spends time w/ pointless task
- ☐ Arched back with bright lights
- ☐ Flaps hands
- ☐ Likes to flick finger in eye
- ☐ Slapping books
- ☐ Wiggle finger front of face
- ☐ Bites wrist or back of hands
- ☐ Unusual play
- ☐ Doesn't do for self
- ☐ Lacks initiative
- ☐ Poor focus, attention
- ☐ Watches television long time
- ☐ Rejects help
- ☐ Unable to predict actions
- ☐ Constant movement
- ☐ Self mutilation
- ☐ Whirls self like a top
- ☐ Tries to control others
- ☐ Does opposite/asked
- ☐ Shrieks
- ☐ Stares at own hands
- ☐ Imitates others
- ☐ Licking
- ☐ Likes to spin things
- ☐ Tooth tapping
- ☐ Wiggle finger side of face
- ☐ Chews on things
- ☐ Uses adults hand for activity
- ☐ Extremely cautious
- ☐ Lost in thought, unreachable
- ☐ Sits long time staring
- ☐ Won't attempt/can't do
- ☐ Curious/gets into things
- ☐ Destructive
- ☐ Melt downs
- ☐ Runs away
- ☐ Climbs to high places
- ☐ Head banging
- ☐ Teases others
- ☐ Holds hands in strange pose
- ☐ Toe walking
- ☐ Finger flicking
- ☐ Likes spinning objects
- ☐ Rhythmic rocking
- ☐ Visual stims
- ☐ Bites or chews fingers

MOOD

- ☐ Apathy
- ☐ Detached
- ☐ Isolates
- ☐ Always frightened
- ☐ Does not want to be touched
- ☐ Looks like in pain
- ☐ Restless
- ☐ Agitated
- ☐ Blank look
- ☐ Disinterested
- ☐ Negative
- ☐ Anguish
- ☐ Inconsolable crying
- ☐ Moaning, groaning
- ☐ Severe mood swings
- ☐ Anxious
- ☐ Depression
- ☐ Eye contact poor
- ☐ Fright without cause
- ☐ Discontented
- ☐ Irritable
- ☐ Phobias
- ☐ Unhappy

READINESS ASSESSMENT

On a scale of 1 to 5 (5 = Strongly Agree / 1 = Strongly Disagree) rate the following:

	5	4	3	2	1
I am willing to significantly modify my diet.	☐	☐	☐	☐	☐
I will take several nutritional supplements each day.	☐	☐	☐	☐	☐
Will keep a record of everything you eat each day.	☐	☐	☐	☐	☐
I will modify my lifestyle (e.g. work demands, sleep habits).	☐	☐	☐	☐	☐
I am willing to practice a relaxation technique.	☐	☐	☐	☐	☐
I would engage in regular exercise.	☐	☐	☐	☐	☐
I am willing to have periodic lab tests to assess my progress.	☐	☐	☐	☐	☐
I am confident in my ability to follow through on the above activities.	☐	☐	☐	☐	☐
People in your household will be help me follow through with health activities.	☐	☐	☐	☐	☐

☐ I welcome ongoing support and contact (phone consults, emails) from the professional staff at Optimal Health Medical to implement my personal health program.

Comment on your willingness to make changes to improve your health: ____

____

____

____

If you are not confident of your ability to make changes, what aspects of yourself or your life lead you to question your capacity to fully engage in activities to improve your health?____

____

____

Comment on how people in your household will support changes that will improve your health:__________________________

____

____

Other comments about any of the statements in the table above: ____

____

____

THREE-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for three consecutive days including one weekend day.

- Do not change your eating behavior at this time; the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk: what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and half and half).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 tsp, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweets, skipped meal and why, when the meal was at a restaurant, etc.).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.).

THEREE-DAY DIET DIARY

Name: ____ Start Date: __________________

Day 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) ____

Stress/Mood/Emotions ____

Other comments ____

____

DIET DIARY (CONT)

Day 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) ______________________________

Stress/Mood/Emotions ______________________________

Other comments ______________________________

____

Day 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) ______________________________

Stress/Mood/Emotions ______________________________

Other comments ______________________________

____

LIFE STRESS QUESTIONNAIRE

NAME: ______________________________ **DATE:** ____________________

During the past two years, have you had any of the following things happen to you? If so, place the cooresponding number in the last column; choose only those items that apply to you. Chose only one number for each event.

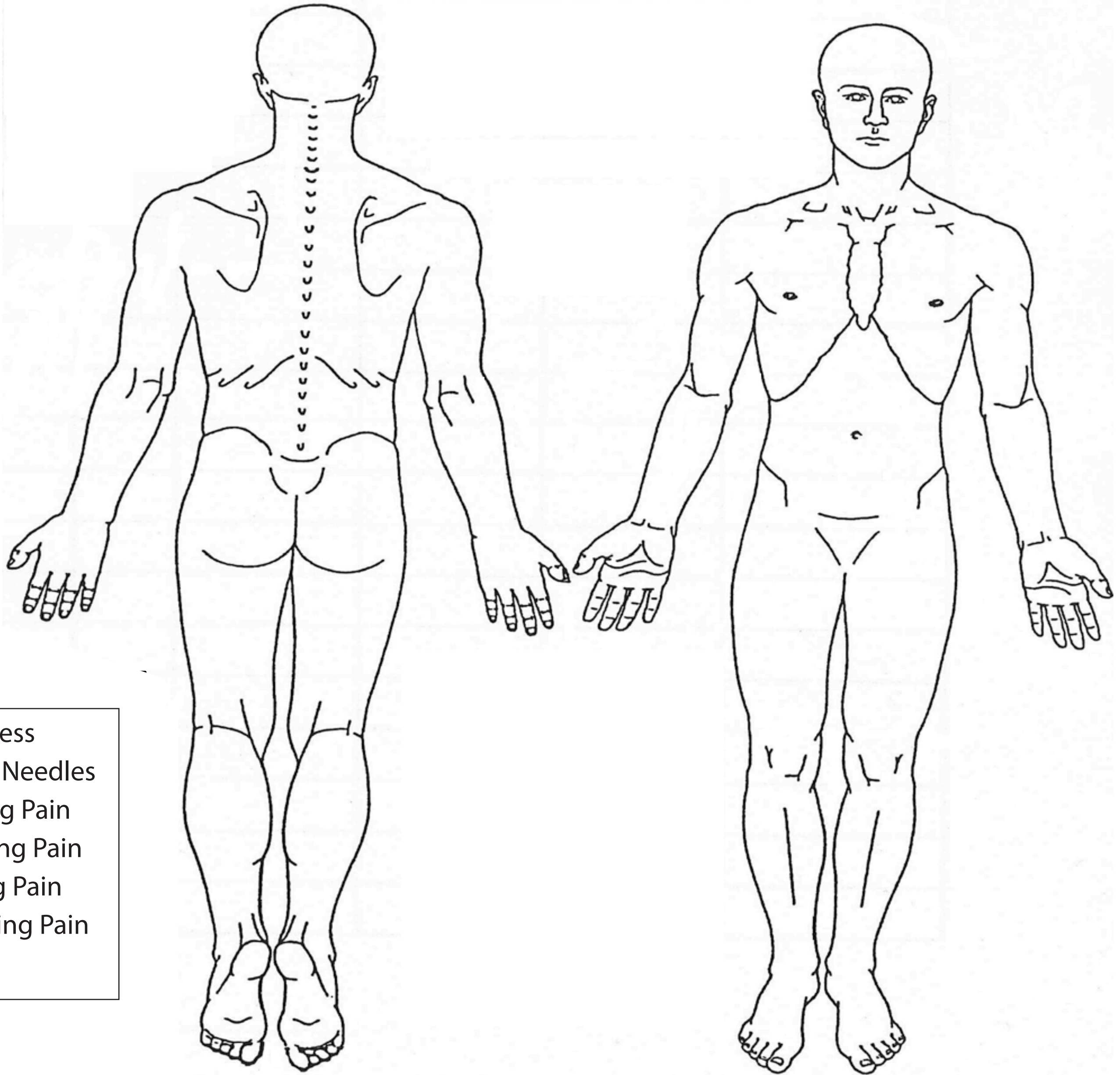
LIFE EVENT	Slight	Moderate	Great	Your Score
Change in social activities	10	15	20	
Change in sleeping habits	10	15	20	
Change in residence	10	20	30	
Change in work hours	15	20	25	
Change in church activities	15	20	25	
Tension at work	20	25	30	
Small children in the home	20	25	30	
Change in living conditions	20	25	30	
Outstanding personal achievement	25	30	35	
Problem teenager(s) in the home	25	30	35	
Trouble with in-laws	25	30	35	
Difficulties with peer group	25	30	35	
Son or daughter leaving home	25	30	35	
Change in responsibilities in work	25	30	35	
Taking over a major financial responsibility	25	30	35	
Foreclosure of mortgage of loan	25	30	35	
Change in relationship with spouse	30	35	40	
Change to different line of work	30	35	40	
Loss of a close friend	30	35	40	
Gain of a new family member	35	40	45	
Sex difficulties	35	40	45	
Pregnancy	35	40	45	
Change in health of family member	40	45	50	
Retirement	40	45	50	
Loss of job	45	50	55	
Change in quality of religious faith	45	50	55	
Marriage	45	50	55	
Personal injury or illness	45	50	55	
Loss of self confidence	55	60	65	
Death of a close family member	50	60	70	
Injury to reputation	50	60	70	
Trouble with the law	55	65	75	
Marital separation	55	65	75	
Divorce	65	75	85	
Death of spouse	80	100	120	
Other (Invalid in family, drug/alcohol abuse)	35	40	45	
Other:	35	40	45	
			Total	

Scoring: >300: high significant life stress | 200-300: significant life stress | 150-200: moderate life stress | <150: low life stress

(Based on studies of Dr. Thomas Holmes, Univ. of Washington, Applying Functional Medicine in Clinical Practice)

CURRENT PROBLEM AREAS

Using the abbreviations below, mark the areas on your body where you feel the listed sensations.



N = Numbness
PN = Pins & Needles
BP = Burning Pain
SP = Stabbing Pain
AP = Aching Pain
RP = Radiating Pain
O = Other

Pain Assessment

What do you believe is the cause of pain? ______________________________

Where is the pain most intense? ______________________________

What makes the pain better/worse? ______________________________

Rate your pain on a scale of 1 to 10 with 1= minimal and 10= severe. __________

If more than one area of pain, please write numbers on the diagram.

OPTIMAL HEALTH MEDICAL CENTER
750 George Washington Way, Suite 5
Richland, WA 99354

CONSENT TO INFORM—YOUR RIGHT TO PRIVACY

Patient's Name ____

We respect your right to privacy regarding medical information. Without additional written consent, may we share information with your spouse?

☐ No

☐ Yes. If yes, their name: ________________________________

We understand you may have concerned relatives. Please list the names of adults, children, other family members and/or contact persons with whom we may share information, without additional written consent, and their relationship to the patient:

☐ Check if N/A (not applicable)

Name: ________________________________ Relationship: __________________________

Name: ________________________________ Relationship: __________________________

What information may we share?

☐ All

☐ Scheduling Info Only

☐ Other. Please specify ____

*Note: If there are any changes on this form, it is the patient's responsibility to let us know at each occurrence.

____

Signature of patient or authorized representative Date

Relationship or status if signed by anyone other than patient: __________________________________

THIS AUTHORIZATION WILL EXPIRE YEARLY, UNLESS OTHERWISE REVOKED

OPTIMAL HEALTH MEDICAL CENTER

750 George Washington Way, Suite 5

Richland, WA 99354

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be scanned into your medical record.

OPTIMAL HEALTH MEDICAL CENTER

750 George Washington Way, Suite 5
Richland, WA 99354

OFFICE POLICIES AND PROCEDURES

January 1, 2014

1. Our office hours are Tuesday-Friday 9am-5pm. We are closed on Mondays.
2. Our phone hours are Tuesday-Friday 9am-5pm. We are closed for lunch between 1-2pm. Feel free to leave a message and we will get back to you as soon as possible.
3. Please be aware that we have a 48 hour cancellation policy. We have reserved your appointment especially for you. We do not overbook or double book like many offices do. If you are unable to make your appointment, please call at least 48 hours before your appointment so that we can reschedule you and so we may can fill your reserved spot with another patient. Please note if you have an appointment on a Tuesday, because we are closed during the weekend and Monday, we would need to hear from you the preceding Friday to avoid a no-show fee of $55.
4. It is your responsibility to contact your insurance company prior to your appointment to ensure Dr. Stringer is a preferred provider. If she is not, it is possible you can still see Dr. Stringer, but you may be charged "out of network" fees.
5. Given the nature of this practice, and that many of the patients and employees are chemically sensitive, we ask that you refrain from wearing perfumes, and perfumed hair products, creams, etc. on the day you come to our office. Thank you.
6. We have a billing company called MTBC that handles all our insurance billing. If you have billing questions, we ask that you first contact your insurance company. If needed, secondly, contact MTBC, who should be able to answer most questions. Lastly, if you have not received satisfactory resolution, you may contact our office to resolve the issue. As you may be aware, the complexities of medical insurance billing are ever increasing. Please take time to understand the nuances of your insurance policy (deductibles, coinsurances, copays) to avoid surprises prior to making your appointment. We are committed to keeping this kind of medicine accessible to as many people as possible. Our office is dedicated to providing the best medical care within the insurance system for as long as we are able to so without compromising the service we provide. To this end, it is vital we allow MTBC to handle the billing and we will handle the healing. Their phone number is available on our website.
7. Please pay all copays, coinsurances, and outstanding balances in full at the time of your appointment. We accept cash, checks and Visa/MasterCard.
8. There is a charge of $30 for Dr. Stringer to fill out any forms (insurance, employee related, etc.). Please allow 10 business days to complete forms.

9. Dr. Stringer is not contracted with Medicare. If you have Medicare and would like to see Dr. Stringer as your doctor, we will require you to sign an Opt Out of Medicare form which states that neither you nor Dr. Stringer can bill Medicare. If you have a non Medicare secondary insurance, you may be able to bill the secondary insurance. However, we are no longer offering this service of billing the secondary insurance. We will be happy to give you the paperwork that will allow you to do your own billing in this situation.
10. We are unable to give out medical information to family members unless specifically agreed upon by the patient per HIPAA regulations. Please speak with the family member who is the patient to obtain confidential patient information.
11. Due to Dr. Stringer's part time hours and desire to concentrate on a Functional Medicine approach, we require clients to have a primary care physician. We will ask you for this at your next visit, if we have not done so already.
12. Dr. Stringer sends out periodic newsletters with information regarding preventive medicine and health related topics of interest, if you do not want to be on this email list, please let our office staff know and we will remove your email from the list. Your email is completely private with us and we will never share it or sell it.

____

Name (printed) Date

____

Signature