THE OPTIMAL HEALTH MEDICAL CENTER

INTRODUCTORY PATIENT INFORMATION

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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 _________________

Marital Status __________________________

Highest Education Level ☐ High School ☐ Under-Graduate ☐ Post-Graduate

Job Title ____

Employer ____

Mailing Address Street ____ Apt No. __________

City ____ State ________ Zip ________________

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

Cell Phone ____________________________

Work Phone ____________________________ Can you be contacted at work? ☐ Yes ☐ No

Email address ____

Emergency Contact Name _______________________________________ Phone__________________________

Street ____ Apt No. __________

City ____ State ________ Zip ________________

Relationship to you _______________________________________

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 # ________________

CoPay Amount ______________________

Email ______________________ Employer Name ________________

**Please provide First Name, Middle Initial, and Last Name.*

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 I had a magic wand and could erase three problems, they would be:

1.______________________

2.______________________

3.______________________

The last time I felt well was ______________________

Did something trigger this change in health? ______________________

What makes you feel worse?______________________

What makes you 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: Post Nasal Drip ☑ *Moderate* *Treatment: Elimination Diet* ☑ *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

GASTROINTESTINAL

Past	Current	Onset Date	Condition
☐	☐	___/___	Irritable Bowel Syndrome
☐	☐	___/___	Inflammatory Bowel Disease
☐	☐	___/___	Crohn's
☐	☐	___/___	Ulcerative Colitis
☐	☐	___/___	Gastritis or Peptic Ulcer Disease
☐	☐	___/___	GERD (reflux)
☐	☐	___/___	Celiac Disease
☐	☐	___/___	Other____________________

CARDIOVASCULAR

Past	Current	Onset Date	Condition
☐	☐	___/___	Heart Attack
☐	☐	___/___	Other Heart Disease
☐	☐	___/___	Stroke
☐	☐	___/___	Elevated Cholesterol
☐	☐	___/___	Arrhythmia (irregular heart rate)
☐	☐	___/___	Hypertension (high BP)
☐	☐	___/___	Rheumatic Fever
☐	☐	___/___	Mitral Valve Prolapse
☐	☐	___/___	Other

METABOLIC/ENDOCRINE

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

CANCER

Past	Current	Onset Date	Condition
☐	☐	___/___	Lung Cancer
☐	☐	___/___	Breast Cancer
☐	☐	___/___	Colon Cancer
☐	☐	___/___	Ovarian Cancer
☐	☐	___/___	Prostate Cancer
☐	☐	___/___	Other____________________

MUSCULOSKELETAL/PAIN

Past	Current	Onset Date	Condition
☐	☐	___/___	Osteoarthritis
☐	☐	___/___	Fibromyalgia
☐	☐	___/___	Chronic Pain
☐	☐	___/___	Other____________________

RESPIRATORY

Past	Current	Onset Date	Condition
☐	☐	___/___	Asthma
☐	☐	___/___	Chronic Sinusitis
☐	☐	___/___	Bronchitis
☐	☐	___/___	Emphysema
☐	☐	___/___	Pneumonia
☐	☐	___/___	Tuberculosis
☐	☐	___/___	Sleep Apnea
☐	☐	___/___	Other____________________

SKIN DISEASES

Past	Current	Onset Date	Condition
☐	☐	___/___	Eczema
☐	☐	___/___	Psoriasis
☐	☐	___/___	Acne
☐	☐	___/___	Melanoma
☐	☐	___/___	Skin Cancer
☐	☐	___/___	Other____________________

INFLAMMATORY/AUTOIMMUNE

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

GENITAL AND URINARY SYSTEMS

Past	Current	Onset Date	Condition
☐	☐	___/___	Kidney Stones
☐	☐	___/___	Gout
☐	☐	___/___	Interstitial Cystitis
☐	☐	___/___	Frequent Urinary Tract Infections
☐	☐	___/___	Frequent Yeast Infections
☐	☐	___/___	Erectile Dysfunction
☐	☐	___/___	Other____________________

MEDICAL HISTORY (CONT)

Neurologic/Mood

Past	Current	Onset Date		Past	Current	Onset Date	
☐	☐	___/___	Depression	☐	☐	___/___	Anxiety
☐	☐	___/___	Bipolar Disorder	☐	☐	___/___	Schizophrenia
☐	☐	___/___	Headaches	☐	☐	___/___	Migraines
☐	☐	___/___	ADD/ADHD	☐	☐	___/___	Autism
☐	☐	___/___	Mild Cognitive Impairment	☐	☐	___/___	Memory Problems
☐	☐	___/___	Parkinson's Disorder	☐	☐	___/___	ALS
☐	☐	___/___	Seizures	☐	☐	___/___	Other ___________________________

PREVENTIVE TEST check box if 'yes' and provide the date and location of test

Yes?	Location		Yes?	Location	
☐	______________	Full Physical	☐	______________	Hemoccult Test (stool test for blood)
☐	______________	Bone Density	☐	______________	MRI
☐	______________	Colonoscopy	☐	______________	CT Scan
☐	______________	Cardiac Stress Test	☐	______________	Upper Endoscopy
☐	______________	EBT Heart Scan	☐	______________	Upper GI Series
☐	______________	EKG	☐	______________	Ultrasound

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

Yes?	Location		Yes?	Location	
☐	______________	Appendectomy	☐	______________	Dental Surgery
☐	______________	Hysterectomy+/- Ovaries	☐	______________	Joint Replacement (knee/hip)
☐	______________	Gall Bladder	☐	______________	Heart Surgery (bypass valve)
☐	______________	Hernia	☐	______________	Angioplasty or Stent
☐	______________	Tonsillectomy	☐	______________	Pacemaker
☐	______________	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	__________	____

BLOOD TYPE

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

MEDICAL HISTORY (CONT)

WOMEN'S GYNECOLOGICAL HISTORY provide number, age and date as needed

Obstetrical History

If yes, how many?

_____ Pregnancies
_____ Living Children
_____ Caesareans
_____ Abortions
_____ Vaginal Deliveries
_____ Babies over 8lbs
_____ Miscarriages

Check box if 'yes.'

☐ Breast Feeding? If yes, how long? ___________
☐ Toxemia
☐ Post-Partum Depression
☐ Gestational Diabetes

Menstrual History

_________ Age at First Period
_________ Date of Last Period
_________ Menses Frequency
_________ Avg Length of Period

☐ I clot with menstruation.
☐ I have pain with menstruation.
☐ I have skipped periods. If yes, for how long? _____
☐ I have used hormonal contraception. If yes, for how long? ______
What type? ☐ Pills ☐ Patch ☐ Nuva Ring ☐ Hormonal IUD
☐ I have used other types of contraception.
What type(s)? ☐ Condoms ☐ Copper IUD ☐ Partner Vasectomy ☐ Diaphragm

Women's Disorders/Hormonal Imbalances

☐ Fibrocystic Breasts
☐ Endometriosis
☐ Fibroids
☐ Painful or Heavy Periods
☐ Infertility
☐ PMS
☐ Hot Flashes
☐ Mood Swings
☐ Joint Pains
☐ Vaginal Dryness
☐ Decreased Libido
☐ Heavy Bleeding
☐ Headaches
☐ Weight Gain
☐ Concentration/Memory Problems
☐ Palpitations
☐ Loss of Control of Urine
☐ Breast Biopsy? When? ________
☐ I use hormone replacement therapy. If yes, for how long? ________
☐ I am in menopause. Age at onset of menopause: ________
___________ Date of Last Mammogram
___________ Date of Last Pap Test ☐ Normal ☐ Abnormal
___________ Date of Last Bone Density Test ☐ Normal ☐ High ☐ Low

MEN'S HISTORY (FOR MEN ONLY) check box if 'yes'

☐ PSA Test? ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10
☐ Prostate Enlargement
☐ Prostate infection
☐ Impotence
☐ Difficulty Getting Erection
☐ Difficulty Maintaining Erection
☐ Change in Libido
☐ Loss of Control of Urine
☐ Frequent urination at night? If yes, how often? ______
☐ Urgency/Hesitancy/Change in Urine Stream

MEDICAL HISTORY (CONT)

HOSPITALIZATIONS provide details about past hospitalizations

Date Reason

_______ ____

_______ ____

_______ ____

_______ ____

_______ ____

GI HISTORY check box if 'yes'

☐ Foreign Travel? If yes, where? ____________________

☐ Wilderness Camping? If yes, where? ____________________

☐ Severe Gastroententeritis

☐ Severe Diarrhea

☐ I feel I do NOT digest food well.

☐ I feel bloated after meals.

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'

☐ I have had a nutrition consultation.

☐ I have made changes to my eating habits due to health.

If yes, describe: ____

I am following a special diet or nutritional program. Check all that apply.

☐ Low Fat ☐ Gluten Restricted ☐ High Protein

☐ Low Sodium ☐ Low Carbohydrate ☐ No Dairy

☐ No Wheat ☐ Vegetarian ☐ Diabetic

☐ Vegan ☐ Ultrametabolism ☐ Other: ______________

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

__________ Height (feet/inches)

__________ Current Weight

__________ Usual Weight Range +/- 5 lbs.

__________ Desired Weight Range +/- 5 lbs.

__________ Highest Adult Weight

__________ Lowest Adult Weight

__________ % Body Fat

☐ No Weight Fluctuations (>10 lbs)

I weigh myself: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

☐ I have had my metabolism (resting metabolic rate) checked? If yes what was it? ________

☐ I avoid particular foods. If yes, types and reasons: ______________________________

____

☐ I grocery shop. If not, who does the shopping? ______________________________

☐ I read food labels. If yes, what do you look for? ______________________________

☐ I cook. If not, who does the cooking? ______________________________

If I 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

The most important thing I should change about my diet to improve my health is: ________________

____

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 > 50% meals away from home ☐ Travel frequently ☐ Non-availability of healthy foods

☐ Do not plan meals or menus ☐ Reliance on convenience items ☐ Poor snack choices

☐ Love to eat ☐ Eat because I have to ☐ Struggle with eating issues

☐ 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

☐ Have a negative relationship to food ☐ Emotional eater (eat when sad, lonely, depressed, bored)

☐ Significant other or family members don't like healthy foods

☐ Significant other or family members have special dietary needs or food preferences

SMOKING check box if 'yes'

☐ I currently smoke. If yes, how many years? ________ # packs per day? ________ # of attempts to quit? ________

☐ I previously smoked. If yes, how many years? ________ # packs per day? ________

☐ I am/have been exposed to second hand smoke.

SOCIAL HISTORY (CONT)

ALCOHOL INTAKE check box if 'yes'

☐ I drink. If yes, how many drinks/week? ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 (*one drink = 5 oz wine, 12 oz beer, 1.5 oz spirits*)

☐ I used to drink. If yes, it was: ☐ Mild ☐ Moderate ☐ High

☐ I have been told to cut down my alcohol intake.

☐ I get annoyed when people ask me about my drinking.

☐ I feel guilty about my alcohol consumption.

☐ I take an eye-opener.

☐ I notice a tolerance to alcohol (I can "hold" more than others).

☐ I have been unable to remember what I did during a drinking episode.

☐ I get into arguments or physical fights when I have been drinking.

☐ I have been arrested or hospitalized because of drinking.

☐ I have thought about getting help to control or stop my drinking.

OTHER SUBSTANCES check box if 'yes'

☐ I drink caffeinated coffee and/or tea. If yes, how much?

Coffee cups/day ☐ 1 ☐ 2-4 ☐ >4

Tea cups/day ☐ 1 ☐ 2-4 ☐ >4

☐ I drink 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.) ____________________________

☐ I currently use recreational drugs. Type: ____

☐ I have 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 level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

In the following, check box if 'yes.'

☐ I have problems that limit activity. If yes, what are they: ________________________________

____

☐ I usually sweat when exercising.

☐ I feel unusually fatigued after exercise. Describe ____

____

SOCIAL HISTORY (CONT)

PSYCHOSOCIAL check box if 'yes'

- ☐ I feel significantly less vital than I did a year ago.
- ☐ I am happy.
- ☐ I feel my life has meaning and purpose.
- ☐ I have experienced major losses in my life.
- ☐ I believe stress is presently reducing the quality of my life.
- ☐ I like the work I do.
- ☐ I spend the majority of my time and money to fulfill responsibilities and obligations.
- ☐ I would describe my experience as a child in my family as happy and secure.

STRESS/COPING check box if 'yes'

- ☐ I have sought counseling in the past.
- ☐ I am currently in therapy? If yes, how come? ______________________________
- ☐ I feel I have an excessive amount of stress in my life.
- ☐ I feel I 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).

_____Work _____Family _____Social _____Finances _____Health _____Other: ______________________

- ☐ I have been abused, a victim of a crime, or experienced a significant trauma.
- ☐ I practice meditation or relaxation techniques. How often? ______________________________

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

SLEEP/REST check box if 'yes'

I sleep an average of ☐ >10 ☐ 8-10 ☐ 6-8 ☐ < 6 hours per night.

- ☐ I have trouble falling asleep.
- ☐ I feel rested upon awakening.
- ☐ I have problems with insomnia.
- ☐ I snore.
- ☐ I use sleeping aids? Explain: ______________________________

ROLES/RELATIONSHIPS

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partnership ☐ Widow

List Children:

Name	Age	Gender	Occupation	Living at Home?

Is there anyone else living in your household? Number:_____Names: ______________________________

Their employment/occupations: ______________________________

____

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

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

- ☐ I am satisfied with my sex life.

SOCIAL HISTORY (CONT)

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

ENVIRONMENTAL & DETOXIFICATION ASSESSMENT

Check box if 'yes'

☐ I have known adverse food reactions or sensitivities. If yes, describe: ______________________

☐ I have food allergies or sensitivities. If yes, to what? ______________________

☐ I have an adverse reaction to caffeine.

☐ I have turned yellow (jaundiced).

☐ I have been told I have Gilbert's Syndrome or a liver disorder.

☐ I dry clean my clothes frequently.

☐ I have pets and/or farm animals.

☐ I lived or worked in a damp or moldy environment or had other mold exposures.

When I drink caffeine, I feel ☐ irritable ☐ wired ☐ aches and pains.

I adversely react to

☐ MSG Monosodium Glutamate ☐ Aspartame (Nutrasweet) ☐ Caffeine

☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate

☐ Alcohol ☐ Red Wine ☐ Preservatives (ex. Sodium Benzoate)

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Other: ______________

The following significantly affect me

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes

☐ Other ______________

In my work or home environment, I am exposed to

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

I have a known history of significant exposure to harmful chemicals such as the following:

☐ Herbicides ☐ Pesticides ☐ Organic Solvents Heavy Metals

☐ Insecticides (frequent visits of exterminator) ☐ Other ______________

Chemical Name, Date, Length of Exposure ______________________

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

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Caffeine Dependency
- ☐ Chocolate Cravings
- ☐ Carbohydrate Cravings (breads, pasta, etc.)
- ☐ Sweet Cravings (candy, cookies, cakes, etc.)

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

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 ____

____

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.

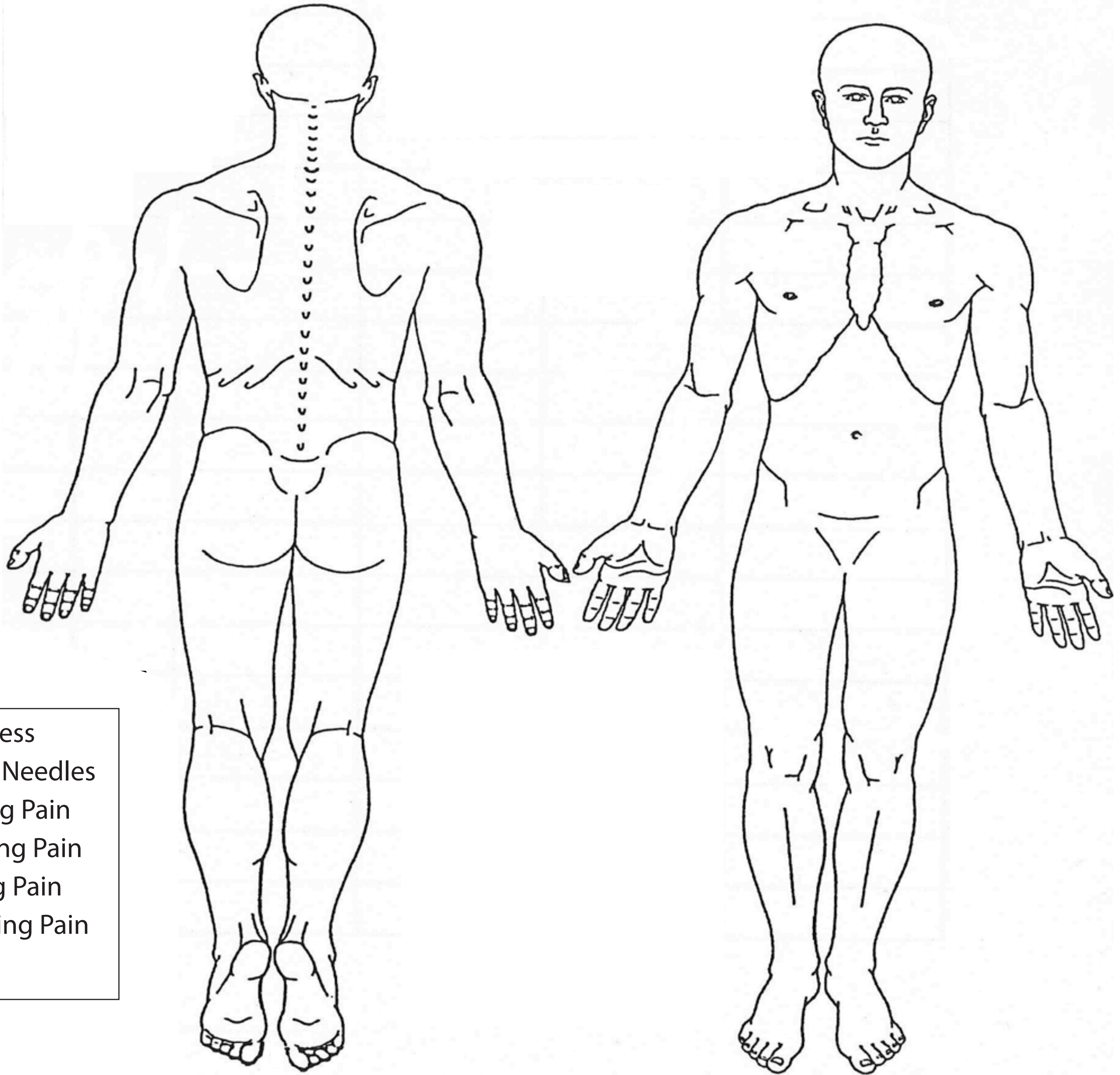
LIFE EVENT	Slight	Moderate	Great	Your Score
Change in social activities	10	15	20	
Change in sleeping habits	10	15	20	
Change in residence	10	20	30	
Change in work hours	15	20	25	
Change in church activities	15	20	25	
Tension at work	20	25	30	
Small children in the home	20	25	30	
Change in living conditions	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

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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

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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