Alternative Health Care Center of the Black Hills

GENERAL INFORMATION

(If more space is needed when filling in certain sections, please feel free to provide separate sheet)

Name: First _____ Middle _____ Last _____

Date: ____/____/____ Date of Birth: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female

SSN: _____ Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐ Widow

Spouse/Significant Other's Name: _____

Primary Address: _____ Apt. No.:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Do you work? Where? _____

☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Homemaker ☐ Unemployed

Your job is: ☐ Difficult ☐ Enjoyable ☐ Stressful ☐ Relaxed

Your job requires: ☐ Heavy Lifting ☐ Sitting ☐ Standing ☐ Walking

Best Phone and Times to Reach You: _____

Email: _____ Fax: _____

Emergency Contact: Name: _____ Phone: _____

Relationship to you: _____ Address: _____

City: _____ State: _____ Zip: _____

Your Genetic Background: ☐ African ☐ Asian ☐ European ☐ Ashkenazi ☐ Native American

☐ Middle Eastern ☐ Mediterranean ☐ Other _____

Highest Education Level: ☐ High School or Equivalent ☐ Graduate ☐ Post-Graduate

Job Title: _____

Nature of Business: _____

Primary Pharmacy: Name _____ Phone _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Fax: _____

Whom may we thank for referring you? _____

How did you hear about us? ☐ Website ☐ Facebook ☐ Magazine/Ad ☐ Radio ☐ Other _____

INSURANCE INFORMATION

We file a claim to your insurance company as a courtesy to you. Only one visit per day will be submitted; however, you are responsible for any co–payment and deductible amounts at the time of service, unless previously arranged. You will also be responsible for any services that are not covered by your insurance company, unless previously arranged. Payment options and arrangements may be discussed at any time; however, it is best to let us know in advance so we can get account information accessible.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with: Name of Insurance Company(ies): _____ and assign directly to Alternative Health Care Center all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above–named facility may use my health care information and may disclose such information to the above–named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance for the purpose of benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Representative _____

Please print name of Patient, Parent, Guardian, or Personal Representative _____

Date ____/____/____ Relationship to Patient _____

PAYMENT INFORMATION

We offer a few different methods of payment to make your journey to wellness as convenient as possible. We discuss these payment options with you at your Report of Findings visit. We accept cash, check, credit and debit.

HEALTH CONCERNS & GOALS

Please list current and/or ongoing areas of concern you would like to address in order of priority.

Health Concern or Goal #1 (Please describe as many details as you can) _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: ☐ Better ☐ Worse ☐ About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

_____

What makes it better? _____

What makes it worse? _____

Rate your pain right now on a scale of 0–10, with 0 being no pain at all and 10 being hospital–worthy: _____

What would you rate your pain at its best? _____ What would you rate your pain at its worst? _____

If pain is associated with your condition, please check all that apply: *(Type of pain)*

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain radiate down your leg(s) or arm(s)? _____

Have you experienced this before? _____ How often do you experience this condition? _____

Is it constant or does it come and go? _____

Does it prevent you from doing certain activities or limit your daily living routine such as:

☐ Working ☐ Lifting ☐ Personal Care ☐ Sitting ☐ Standing ☐ Sleeping ☐ Walking

☐ Social Life ☐ Exercising ☐ traveling ☐ Other _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 (Please describe as many details as you can) _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: ☐ Better ☐ Worse ☐ About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

_____

What makes it better? _____

What makes it worse? _____

Rate your pain right now on a scale of 0–10, with 0 being no pain at all and 10 being hospital–worthy: _____

What would you rate your pain at its best? _____ What would you rate your pain at its worst? _____

If pain is associated with your condition, please check all that apply: *(Type of pain)*

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain radiate down your leg(s) or arm(s)? _____

Have you experienced this before? _____ How often do you experience this condition? _____

Is it constant or does it come and go? _____

Does it prevent you from doing certain activities or limit your daily living routine such as:

☐ Working ☐ Lifting ☐ Personal Care ☐ Sitting ☐ Standing ☐ Sleeping ☐ Walking

☐ Social Life ☐ Exercising ☐ traveling ☐ Other _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #3 (Please describe as many details as you can) _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: ☐ Better ☐ Worse ☐ About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

_____

What makes it better? _____

What makes it worse? _____

Rate your pain right now on a scale of 0–10, with 0 being no pain at all and 10 being hospital–worthy: _____

What would you rate your pain at its best? _____ What would you rate your pain at its worst? _____

If pain is associated with your condition, please check all that apply: *(Type of pain)*

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain radiate down your leg(s) or arm(s)? _____

Have you experienced this before? _____ How often do you experience this condition? _____

Is it constant or does it come and go? _____

Does it prevent you from doing certain activities or limit your daily living routine such as:

☐ Working ☐ Lifting ☐ Personal Care ☐ Sitting ☐ Standing ☐ Sleeping ☐ Walking

☐ Social Life ☐ Exercising ☐ traveling ☐ Other _____

Anything else you feel is important about this condition? _____

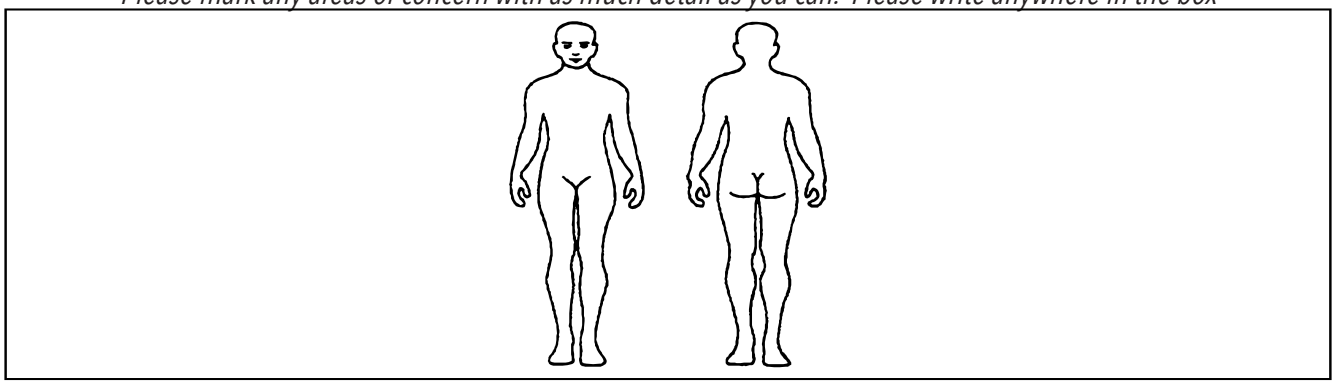
In general, what do you hope to achieve with your visits here? _____

_____

_____

When was the last time you felt exceptionally well? _____

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box



MEDICAL HISTORY

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

☐ Doctor of Chiropractic *Name:* _____ *City:* _____

Treatment Focus: _____

☐ M.D. / D.O. *Name:* _____ *City:* _____

Treatment Focus: _____

☐ Physical Therapist *Name:* _____ *City:* _____

Treatment Focus: _____

☐ Acupuncture *Name:* _____ *City:* _____

Treatment Focus: _____

☐ Other: _____ *Name:* _____ *City:* _____

Treatment Focus: _____

Hospitalizations *(car accidents, horseback riding accidents, illnesses, surgeries, etc.)* ☐ None

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Allergies

Medication/Supplement/Food:	*Reaction:*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide Month/Year of onset.* ☐ *Past Condition* ☐ *Ongoing Condition*

Gastrointestinal

- ☐ ☐ Irritable Bowel Syndrome ____ / ____
- ☐ ☐ Inflammatory Bowel Disease ____ / ____
- ☐ ☐ Crohn's ____ / ____
- ☐ ☐ Ulcerative Colitis ____ / ____
- ☐ ☐ Gastritis or Peptic Ulcer Disease ____ / ____
- ☐ ☐ GERD *(reflux)* ____ / ____
- ☐ ☐ Celiac Disease ____ / ____
- ☐ ☐ Hemorrhoids ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Cardiovascular

- ☐ ☐ Heart Attack ____ / ____
- ☐ ☐ Other Heart Disease ____ / ____
- ☐ ☐ Stroke ____ / ____
- ☐ ☐ Elevated Cholesterol ____ / ____
- ☐ ☐ Arrhythmia *(irregular heart rate)* ____ / ____
- ☐ ☐ Hypertension *(high blood pressure)* ____ / ____
- ☐ ☐ Rheumatic Fever ____ / ____
- ☐ ☐ Mitral Valve Fever ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Cancer

- ☐ ☐ Lung Cancer ____ / ____
- ☐ ☐ Breast Cancer ____ / ____
- ☐ ☐ Colon Cancer ____ / ____
- ☐ ☐ Ovarian Cancer ____ / ____
- ☐ ☐ Prostate Cancer ____ / ____
- ☐ ☐ Skin Cancer ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Genital & Urinary Systems

- ☐ ☐ Kidney Stones ____ / ____
- ☐ ☐ Gout ____ / ____
- ☐ ☐ Interstitial Cystits ____ / ____
- ☐ ☐ Frequent Urinary Tract Infections ____ / ____
- ☐ ☐ Frequent Yeast Infection ____ / ____
- ☐ ☐ Erectile or Sexual Dysfunction ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Metabolic/Endocrine

- ☐ ☐ Type 1 Diabetes ____ / ____
- ☐ ☐ Type 2 Diabetes ____ / ____
- ☐ ☐ Hypoglycemia ____ / ____
- ☐ ☐ Metabolic Syndrome ____ / ____ *(Insulin Resistance/Pre-Diabetes)*
- ☐ ☐ Hypothyroidism *(low thyroid)* ____ / ____
- ☐ ☐ Hyperthyroidism *(overactive thyroid)* ____ / ____
- ☐ ☐ Endocrine Problems ____ / ____
- ☐ ☐ Polycystic Ovarian Syndrome *(PCOS)* ____ / ____
- ☐ ☐ Infertility ____ / ____
- ☐ ☐ Weight Gain ____ / ____
- ☐ ☐ Weight Loss ____ / ____
- ☐ ☐ Frequent Weight Fluctuations ____ / ____
- ☐ ☐ Bulimia ____ / ____
- ☐ ☐ Anorexia ____ / ____
- ☐ ☐ Binge Eating Disorder ____ / ____
- ☐ ☐ Night Eating Disorder ____ / ____
- ☐ ☐ Eating Disorder *(non-specific)* ____ / ____
- ☐ ☐ Other: _____ ____ / ____

DISEASES/DIAGNOSIS/CONDITIONS *(continued...)*

Musculoskeletal/Pain

- ☐ ☐ Osteoarthritis ____ / ____
- ☐ ☐ Fibromyalgia ____ / ____
- ☐ ☐ Chronic Pain ____ / ____
- ☐ ☐ Tendonitis ____ / ____
- ☐ ☐ Tension Headaches ____ / ____
- ☐ ☐ TMJ Problems ____ / ____
- ☐ ☐ Foot Cramps ____ / ____
- ☐ ☐ Joint Deformity ____ / ____
- ☐ ☐ Joint Pain ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Inflammatory/Autoimmune

- ☐ ☐ Chronic Fatigue Syndrome ____ / ____
- ☐ ☐ Autoimmune Disease ____ / ____
- ☐ ☐ Rheumatoid Arthritis ____ / ____
- ☐ ☐ Lupus SLE ____ / ____
- ☐ ☐ Immune Deficiency Disease ____ / ____
- ☐ ☐ Herpes–Genital ____ / ____
- ☐ ☐ Cold Sores ____ / ____
- ☐ ☐ Severe Infectious Disease ____ / ____
- ☐ ☐ Poor Immune Function *(frequent infections)* ____ / ____
- ☐ ☐ Food Allergies ____ / ____
- ☐ ☐ Environmental Allergies ____ / ____
- ☐ ☐ Multiple Chemical Sensitivities ____ / ____
- ☐ ☐ Latex Allergy ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Respiratory Diseases

- ☐ ☐ Asthma ____ / ____
- ☐ ☐ Chronic Sinusitis ____ / ____
- ☐ ☐ Bronchitis ____ / ____
- ☐ ☐ Emphysema ____ / ____
- ☐ ☐ Pneumonia ____ / ____
- ☐ ☐ Tuberculosis ____ / ____
- ☐ ☐ Sleep Apnea ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Head, Eyes & Ears

- ☐ ☐ Conjunctivitis ____ / ____
- ☐ ☐ Distorted Sense of Smell ____ / ____
- ☐ ☐ Distorted Taste ____ / ____
- ☐ ☐ Ear Fullness ____ / ____
- ☐ ☐ Ear Pain ____ / ____
- ☐ ☐ Hearing Loss ____ / ____
- ☐ ☐ Hearing Problems ____ / ____
- ☐ ☐ Headache ____ / ____
- ☐ ☐ Migraine ____ / ____
- ☐ ☐ Sensitivity to Loud Noises ____ / ____
- ☐ ☐ Vision Problems *(other than glasses)* ____ / ____
- ☐ ☐ Macular Degeneration ____ / ____
- ☐ ☐ Vitreous Detachment ____ / ____
- ☐ ☐ Retinal Detachment ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Nails

- ☐ ☐ Bitten ____ / ____
- ☐ ☐ Brittle ____ / ____
- ☐ ☐ Curve Up ____ / ____
- ☐ ☐ Frayed ____ / ____
- ☐ ☐ Fungus–Fingers ____ / ____
- ☐ ☐ Fungus–Toes ____ / ____
- ☐ ☐ Pitting ____ / ____
- ☐ ☐ Ragged Cuticles ____ / ____
- ☐ ☐ Ridges ____ / ____
- ☐ ☐ Soft ____ / ____
- ☐ ☐ Thickening of Finger Nails ____ / ____
- ☐ ☐ Thickening of Toenails ____ / ____
- ☐ ☐ White Spots/Lines ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Skin Diseases

- ☐ ☐ 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 ____ / ____
- ☐ ☐ Hives ____ / ____
- ☐ ☐ Jock Itch ____ / ____
- ☐ ☐ Lackluster Skin ____ / ____
- ☐ ☐ Moles with Color/Size Change ____ / ____
- ☐ ☐ Oily Skin ____ / ____
- ☐ ☐ Pale Skin ____ / ____
- ☐ ☐ Patchy Dullness ____ / ____
- ☐ ☐ Rash ____ / ____
- ☐ ☐ Red Face ____ / ____
- ☐ ☐ Sensitive to Poison Ivy/Oak ____ / ____
- ☐ ☐ Shingles ____ / ____
- ☐ ☐ Skin Darkening ____ / ____
- ☐ ☐ Strong Body Odor ____ / ____
- ☐ ☐ Hair Loss ____ / ____
- ☐ ☐ Vitiligo ____ / ____
- ☐ ☐ Eczema ____ / ____
- ☐ ☐ Psoriasis ____ / ____
- ☐ ☐ Melanoma ____ / ____
- ☐ ☐ Skin Cancer ____ / ____
- ☐ ☐ Other: _____ ____ / ____

DISEASES/DIAGNOSIS/CONDITIONS *(continued...)*

Neurologic/Mood

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

Female Reproductive

☐ ☐ Breast Cysts ____ / ____
☐ ☐ Breast Lumps ____ / ____
☐ ☐ Breast Tenderness ____ / ____
☐ ☐ Breast Implants ____ / ____
☐ ☐ Ovarian Cysts ____ / ____
☐ ☐ Poor Libido *(sex drive)* ____ / ____
☐ ☐ Vaginal Discharge ____ / ____
☐ ☐ Vaginal Odor ____ / ____
☐ ☐ Vaginal Itch ____ / ____
☐ ☐ Vaginal Pain with Sex ____ / ____
☐ ☐ Other: _____ ____ / ____

Male Reproductive

☐ ☐ Discharge from Penis ____ / ____
☐ ☐ Ejaculation Problems ____ / ____
☐ ☐ Genital Pain ____ / ____
☐ ☐ Impotence ____ / ____
☐ ☐ Prostate or Urinary Infection ____ / ____
☐ ☐ Lumps in Testicles ____ / ____
☐ ☐ Poor Libido *(sex drive)* ____ / ____
☐ ☐ Other: _____ ____ / ____

Injuries *(check box if yes and provide date/description)*

☐ ☐ Back Injury ____ / ____ _____
☐ ☐ Head Injury ____ / ____ _____
☐ ☐ Neck Injury ____ / ____ _____
☐ ☐ Broken Bones ____ / ____ _____
____ / ____ _____
____ / ____ _____
☐ ☐ Other: _____ ____ / ____

Surgeries *(check box if yes and provide date of surgery)*

☐ ☐ None
☐ ☐ Appendectomy ____ / ____
☐ ☐ Hysterectomy +/– Ovaries ____ / ____
☐ ☐ Gall Bladder ____ / ____
☐ ☐ Hernia ____ / ____
☐ ☐ Tonsillectomy ____ / ____
☐ ☐ Dental Surgery ____ / ____
☐ ☐ Joint Replacement: Knee / Hip ____ / ____
☐ ☐ Heart Surgery: Bypass Valve ____ / ____
☐ ☐ Angioplasty or Stent ____ / ____
☐ ☐ Pacemaker ____ / ____
☐ ☐ Other: _____ ____ / ____

Preventative Tests *(check box if yes and provide test date)*

☐ ☐ Blood Tests ____ / ____
☐ ☐ Full Physical Exam ____ / ____
☐ ☐ X–Ray ____ / ____ *Body Part?* _____
☐ ☐ Dental X–Ray ____ / ____
☐ ☐ Bone Density ____ / ____
☐ ☐ Colonoscopy ____ / ____
☐ ☐ Cardiac Stress Test ____ / ____
☐ ☐ EKG ____ / ____
☐ ☐ Hemoccult Test *(stool test for blood)* ____ / ____
☐ ☐ MRI ____ / ____
☐ ☐ CT Scan ____ / ____
☐ ☐ Upper Endoscopy ____ / ____
☐ ☐ Upper GI Series ____ / ____
☐ ☐ Ultrasound ____ / ____
☐ ☐ Eye Exam ____ / ____
☐ ☐ Breast Exam ____ / ____
☐ ☐ Prostate Exam ____ / ____
☐ ☐ Other: _____ ____ / ____

Blood Type

☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ unknown

GYNECOLOGIC HISTORY *(for women only)*

Obstetric History *(check box if yes and provide relevant quantity)*

☐ Pregnancy: _____ ☐ Vaginal Delivery: _____ ☐ Cesarean Delivery: _____ ☐ Miscarriage: _____ ☐ Abortion: _____

☐ Living Children: _____ ☐ Post–Partum Depression: _____ ☐ Toxemia: _____ ☐ Gestational Diabetes: _____

☐ Baby over 8lbs: _____ ☐ Premature: _____ ☐ Low Birth Weight (<6lbs): _____ ☐ Physical Therapist

☐ Breast Feeding Your Child *(how long?)*: _____ ☐ Oral Contraceptives *(how long?):* _____

Menstrual History

Age at first period: _____ Mensus Frequency: _____ Length between menses: _____ Pain: ☐ Yes ☐ No

Clotting: ☐ Yes ☐ No Has your period ever skipped? ☐ Yes ☐ No How long? _____

Last Menstrual Period: _____

Do you use contraceptive? ☐ Yes ☐ No *If yes:* ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy ☐ Other

Women's Disorders / Hormonal Imbalances

☐ Fibrocystic Breasts ☐ Breast Cancer ____ /____ ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐ Painful Periods ☐ Heavy Periods ☐ PMS

Last Mammogram _____ /_____ Anything Abnormal? _____ ☐ Breast Biopsy _____ /_____

☐ Thermogram _____ /_____ /_____ Last PAP Test ____ / ____ / ____ ☐ Normal ☐ Abnormal

Date of Last Bone Density: ____ /____ /_____ Results: ☐ High ☐ Low ☐ Within Normal Range

Are you in menopause? ☐ Yes ☐ No Age of onset of menopause: _____

Check box if you are experiencing:

☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness

☐ Decreased Libido ☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain

☐ Loss of Control of Urine ☐ Palpitations ☐ Painful Intercourse

☐ Use of hormone replacement therapy *(how long?)*_____ What hormones and dosage? _____

MEN'S HISTORY *(for men only)*

Have you had a PSA done: ☐Yes ☐No Date of last test: ____/____/____ Highest PSA Level: ☐ 0–2 ☐ 2–4 ☐ 4–10 ☐ >10

Check all boxes that apply:

Do you regularly have morning erections? ☐ Yes ☐ No ☐ Increased Fat Accumulation ☐ Headaches

☐ Emotional Reactions ☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection ☐ Prostate Cancer

☐ Nocturia *(urination at night):* How many times a night? _____ ☐ Urgency/Hesitancy/Change in Urinary Stream

☐ Loss of Control of Urine ☐ Testicular Injury ☐ Testosterone Replacement ☐ More Fatigue and/or muscle soreness

MEDICATIONS If more space is needed, please write on a separate sheet

Current Medications *(Both prescription and over-the-counter)*

Medication	Dose	Frequency	Start Date *(month/year)*	Reason for Use

Previous Medications *(Last 10 years)*

Medication	Dose	Frequency	Start Date *(month/year)*	End Date *(month/year)*	Reason for Use

Natural Supplements *(vitamins, minerals & homeopathy)*

Supplement & Brand	Dose	Frequency	Start Date *(month/year)*	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No

Describe: _____

Have you had prolonged (*3 days or longer)* or regular use of NSAIDS *(i.e. Advil, Aleve, Motrin, Asperine, etc.)*? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

For what reason, and for how long, did you use pain relievers? _____

How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____

Have you had prolonged or regular use of Acid Blocking Drugs *(i.e. Tagamet, Zantac, Prilosec, etc.)*? ☐ Yes ☐ No

Have you taken antibiotics **more than** 1x per year? ☐ Yes ☐ No

Have you had long-term use of antibiotics *(more than 10 days)*? ☐ Yes ☐ No

How many times have you taken antibiotics throughout your lifetime? _____

Have you ever used steroids *(i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.)*? ☐ Yes ☐ No

GI HISTORY

Foreign travel? ☐ Yes ☐ No *Where?* _____

Wilderness Camping? ☐ Yes ☐ No *Where?* _____

Have you had severe: ☐ Gastroenteritis ☐ Diarrhea ☐ Crohn's/Ulcerative Colitis ☐ Parasites

Do you feel like you digest your food well? ☐ Yes ☐ No Do you feel bloated after meals? ☐ Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature *Pregnancy Complications:* _____

Birth Complications: _____

☐ Breast Fed *How long?* _____ ☐ Bottle Fed

Age at introduction of: *Solid Foods:* _____ *Dairy:* _____ *Wheat:* _____

Did you eat candy or sugar as a child? ☐ Yes ☐ No

DENTAL HISTORY

Dental Surgery? _____

☐ Silver Mercury Fillings *How many?* _____ ☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain

☐ Bleeding Gums ☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No Do you brush regularly? ☐ Yes ☐ No

☐ Thermogram _____ /_____ /_____ Last PAP Test ____ / ____ / ____ ☐ Normal ☐ Abnormal

What toothpaste do you use? _____ Have you had Fluoride treatments? ☐ Yes ☐ No

DIET

Do you have known adverse food reactions, allergies, or sensitivities? ☐ Yes ☐ No *If yes, describe symptoms and list all foods:*

_____

_____

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Aches & Pains ☐ Headaches

Do you adversely react to: *(Check all that apply)*

☐ Monosodium Glutamate *(MSG)* ☐ Aspartame *(NutraSweet)* ☐ Preservatives *(ex. sodium benzoate)*

☐ Cheese ☐ Citrus foods ☐ Chocolate ☐ Alcohol ☐ Red Wine ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Sulfite containing foods *(wine, dried fruit, salad bars)* ☐ Other: _____

ENVIRONMENTAL & DETOXIFYING ASSESSMENT

Which of these significantly affect you? (*Check all that apply)*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: _____

In your home or work environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

How often do you use your cell phone? _____ hrs/day How often do you use your computer? _____ hrs/day _____ hrs/wk

Have you ever turned yellow *(jaundiced)*? ☐ Yes ☐ No

Have you ever been told you have Gilbert's syndrome or a liver disorder? ☐ Yes ☐ No

If yes, explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides *(frequent visits of exterminator)* ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other: _____

Chemical *(name/date/length of exposure, if known):* _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

What detergents/soaps do you use *(brand names)*? _____

What deodorant? _____

What beauty products do you use *(lotions, hair products, make-up, etc.)*? _____

_____

FAMILY HISTORY

Check family members that apply	**Mother**	**Father**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Aunts**	**Uncles**	**Other**
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, Spondylitis)*												
Inflammatory Bowel Disease												
Multiples Sclerosis												
Auto Immune Disease *(such as Lupus)*												
Irritable Bowl Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse *(such as alcoholism)*												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar / Mood Disorder												
Other: _____												
Other: _____												
Other: _____												

SOCIAL HISTORY

Weight Stats

Height: _____*ft.* _____*in.* Current Weight: _____ Usual Weight Range *(+/– 5lbs)*: _____

Desired Weight Range *(+/– 5lbs)*: _____ Highest Adult Weight: _____ Lowest Adult Weight: _____

Have you experienced weight fluctuations greater than 10 lbs? ☐ Yes ☐ No Body fat %: _____

Is your weight, in the recent past, increasing, decreasing, or staying the same? *If changing, describe:* _____

_____

Nutrition History

Have you ever had a nutrition consultant? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No *Describe:* _____

_____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No *(Check all that apply)*

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism ☐ Macrobiotic ☐ Paleo

☐ Specific Program for Weight Loss/Maintenance *(type)*: _____ ☐ Other: _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No If Yes, what was it? _____

Do you avoid any particular foods? ☐ Yes ☐ No If yes, types & reason: _____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? _____

Do you eat organic foods? ☐ Yes ☐ No

What percentage of your food is organic (pesticide free, non–GMO, etc.)? _____

How many meals do you eat out per week? ☐ 0 – 1 ☐ 1 – 3 ☐ 3 – 5 ☐ >5 meals per week

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

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

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

_____

What foods would be the hardest to reduce or eliminate? _____

Smoking

Currently smoking? ☐ Yes ☐ No *How many years?*_____ *Packs per day:* _____ *Attempts to quit:* _____

Previous smoking? *How many years?*_____ *Packs per day:* _____ *Date quit:* _____

Secondhand smoke exposure? _____ *From where?* _____

Alcohol Intake

How many drinks currently per week? *(1 Drink = 5 oz. wine, 12 oz. beer, or 1 oz. spirit)*

☐ None ☐ 1 – 3 ☐ 4 – 6 ☐ 7 – 10 ☐ > 10 If 'None' – Skip to 'Other Substances'

Most common beverage? _____

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you ever take an eye–opener? ☐ Yes ☐ No

Do you notice a tolerance to alcohol? *(Can you 'hold' more than others?)* ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Other Substances

Caffeine intake: ☐ Yes ☐ No Cups/day: ☐ Coffee ☐ Tea ☐ 1 ☐ 2 – 4 ☐ > 4/day

Caffeinated sodas or diet sodas intake: ☐ Yes ☐ No

Number of 12 oz. sodas per day: ☐ 1 ☐ 2 – 4 ☐ > 4/day Favorite Soda: _____

Are you currently using any recreational drugs? ☐ Yes ☐ No *Type:* _____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

Exercise

Current exercise program

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio / Aerobics			
Strength			
Other *(Yoga, Pilates, Gyrotonics, etc.)*			
Sports or Leisure Activities *(Golf, Tennis, Roller-blading, etc.)*			

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

List your problems that limit activity: _____

_____

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

_____

Do you usually sweat when exercising? ☐ Yes ☐ No

Psychosocial

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No Have you ever experienced major losses in your life? ☐ Yes ☐ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

Stress / Coping

Have you ever sought counseling? ☐ Yes ☐ No *Describe:* _____

Are you currently in therapy? ☐ Yes ☐ No *Describe:* _____

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

How do you deal with stress? _____

Daily Stressors: *Rate on a scale of 1–10* Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you practice meditation or relaxation technique? ☐ Yes ☐ No *How often?* _____

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

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

If yes, please explain: _____

Do you regularly give gratitude for everything in your life? ☐ Yes ☐ No

How would you describe your overall attitude towards life? _____

Do you have a spiritual practice? ☐ Yes ☐ No *Describe:* _____

Sleep / Rest

Average number of hours you sleep per night: ☐ > 10 ☐ 8 – 10 ☐ 6 – 8 ☐ < 6

What time do you typically go to sleep? ____:_____ AM / PM Do you have trouble going to sleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No Do you use sleeping aids? ☐ Yes ☐ No *Describe:* _____

Roles / Relationship

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐ Widow

Spouses name: _____

Child's Name	Age	Gender

Who is living in your Household? *Number:* _____ *Names:* _____

Their employment / occupation: _____

Resources for emotional support: *(Check all that apply)*

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

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

READINESS ASSESSMENT

In order to improve your health, how willing are you to: *Rate on a scale of: 5 (very willing) to 1 (not willing)*

Significantly improve your diet _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutritional supplements each day _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Start preparing your own meals _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Practice a relaxation technique _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Have periodic lab tests to asses your progress _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Get regular bodywork such as chiropractic or massage _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Setting regular appointments _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Read books or articles to learn about your health and solutions _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Be fully responsible for your own healing _____ ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

_____

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

_____

At the present time, how supportive do you thing the people in your household will be to your implementing the above changes?
Rate on a scale of: 5 (very supportive) to 1 (not supportive at all) ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 *Comments:* _____

_____

_____

How much ongoing support and contact (office visits) from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)* ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Please list how often you would be willing to make appointments if needed: _____
Comments: _____

_____

_____

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

17. Cut down the amount of time you spent on work or other activities: (1) ☐ Yes (2) ☐ No
18. Accomplished less than you would like: (1) ☐ Yes (2) ☐ No
19. Didn't do work or other activities as carefully as usual: (1) ☐ Yes (2) ☐ No

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(1) ☐ Not at all (2) ☐ Slightly (3) ☐ Moderately (4) ☐ Quite a bit (5) ☐ Extremely

21. How much bodily pain have you had during the past 4 weeks?

(1) ☐ None (2) ☐ Very mild (3) ☐ Mild (4) ☐ Moderate (5) ☐ Severe (6) ☐ Very Severe

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(1) ☐ Not at all (2) ☐ Slightly (3) ☐ Moderately (4) ☐ Quite a bit (5) ☐ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks... (choose one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
23. Did you feel full of pep?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
24. Have you been a very nervous person?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
25. Have you felt so down in the dumps that nothing could cheer you up?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
26. Have you felt calm and peaceful?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
27. Did you have a lot of energy?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
28. Have you felt downhearted and blue?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
29. Did you feel worn out?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
30. Have you been a happy person?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
31. Did you feel tired?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐

32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities (visiting with friends, relatives, etc.)?

(1) ☐ All of the time (2) ☐ Most of the time (3) ☐ Some of the time (4) ☐ A little of the time (5) ☐ None of the time

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't Know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
34. I am as healthy as anybody I know.	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
35. I expect my health to get worse.	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
36. My health is excellent.	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐

Patient Signature: Date:

EMERGENCIES OR DECEASED PERSONS: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death. We may disclose your health information to coroners or medical examiners.

PUBLIC HEALTH & SAFETY: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA problems with products and reactions to medications, reporting disease or infection exposure, and preventing or lessening a serious threat to the health or safety of a particular person or to the general public.

JUDICIAL & ADMINISTRATIVE PROCEEDINGS: We may disclose your health information in administrative or judicial proceedings.

LAW ENFORCEMENT & SPECIALIZED GOVERNMENT AGENCIES: We may disclose your health information to law enforcement officials for purposes such as identifying/locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes, or for military, national security, prisoner and government benefits purposes.

CHANGE OF OWNERSHIP: In the event that AHCC is sold, your health information will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS: You have the right to: request restrictions on certain uses and disclosures of your health information (however, AHCC is not required to agree to the restriction(s) that you request); inspect and copy your health information; request that AHCC amend your protected health information (however, AHCC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and how you can disagree with the denial); request a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES: AHCC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, AHCC is required by law to comply with this Notice. AHCC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

I HAVE READ THE PRIVACY NOTICE AND UNDERSTAND MY RIGHTS CONTAINED IN THE NOTICE: By way of my signature, I provide AHCC with my authorization and consent to use and disclose my protected health care information as described in the Privacy Notice.

I authorize AHCC to use/disclose health information about me to (family member/friend):

Patient's Printed Name:

Patient's Signature **Date:**