Steven J. Bock MD, PLLC

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(Please note we are only there on Wednesdays)

Patient Name: _____ DOB : _____
Address: _____
City: _____ State:_____ Zip : _____
Phone : _____ Occupation: _____
Married: _____ Single: _____ Referred by: _____
Pharmacy Name : _____ Pharmacy Phone :_____
Pharmacy Address (including zip code):_____
_____
Emergency Contact:_____
Phone Number:_____

Chief Complaint and Present Illness:

Complaint:

_____
_____
_____

Describe in detail:

_____
_____
_____

When did it begin and how did it:

_____
_____
_____

What treatment have you had and by whom:

_____
_____
_____

When and where did you have your last complete physical:

_____
_____
_____

What were the results:

_____

_____

List current medical conditions

_____
_____
_____
_____
_____

List past medical problems

_____
_____
_____
_____
_____

Medical History

If needed, comment on any of the above:

_____

_____

_____

Hospitalizations:

When	Where	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug History:

Medications/ Supplements	Dosing
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Test/ Exam:	Year of Last	Test/Exam:	Year of Last
Rectal/ Stool exam	_____	Pap Smear	_____
Colonoscopy	_____	Mammogram	_____
Eye Exam	_____	Bone density scan	_____
Hearing evaluation	_____	Echocardiogram	_____
Gallbladder x-ray	_____	T.B. Testing	_____
PSA	_____	Chest x-ray	_____
Stress test	_____	EKG	_____
Prostate	_____	Gynecological Exam	_____

Diseases/ Immunizations

Have you ever had:	Treatment	Year
( ) Smallpox	_____	_____
( ) Tetanus	_____	_____
( ) Polio	_____	_____
( ) Hepatitis B	_____	_____
( ) Flu	_____	_____
( ) Mumps	_____	_____
( ) Measles	_____	_____
( ) Rubella	_____	_____
( ) Mono	_____	_____
( ) Herpes	_____	_____
( ) Shingles	_____	_____

Social History:

Do you exercise regularly? Yes _____ No _____

If **yes** what type? _____

How often? _____

Do you consider yourself to be under a **Low, Moderate or High** stress level? _____

What do you do to help you deal with stress?

_____

_____

Occupational History:
What do you do or did you do for a living?

_____

_____

Tobacco:
Do you use tobacco products? Yes _____ No _____
If **no**, did you use tobacco in the past and for how long? _____

Alcohol:
Do you drink alcohol? Yes _____ No _____
If **yes**, how much do you drink currently? _____
If **no**, did you drink alcohol in the past and how much? _____

Caffeine:
Do you consume caffeine? Yes _____ No _____
If **yes**, how much do you drink currently? _____

List your:
Maximum weight _____ Minimum weight _____ Desired weight _____

Family History: If any blood relative has suffered and of the following- please fill in the box with an **X** and indicate which relative.

Illness	**Your Illness**	**Father**	**Mother**	**Brother/Sister**	**Children**	**Grandparents**
Alcoholism						
Allergies						
Alzheimers						
Anemia						
Asthma						
Bleeding Problems						

Cancer						
Convulsions						
Diabetes						
Digestive Problems						
Drinking/ Drug Problems						
Eczema						
Emphysema Fibroid/ Fibrosis						
Frequent Infections						
High Blood Pressure						
High Cholesterol						
Heart Disease						
Heart Trouble						
Hepatitis						
Kidney/ Bladder Problems						
Migraine						
Menstrual Problems						
Mental illness						
Neurological Problems						
Osteoporosis						
Rheumatic Fever						
Stroke						

Stomach Problems						
Thyroid Disease						

Other:

_____

Symptom Checklist

(This is not meant to be used as a diagnostic tool, but is provided to streamline the office interview)

Risk Profile: (Please Check)

Tick infested area _____

Frequent outdoor activities _____

Hiking____ Fishing____ Camping____

Camping ____ Gardening ___ Hunting ___ Ticks noted on pets ____

Do you remember being bitten by a tick? No___ Yes___

Do you remember a "bulls eye rash"? No___ Yes___

Any other rashes? No___ Yes___

If yes, when? _____

Have you ever had any of the following? CIRCLE ALL YES ANSWERS

1. Unexplained fevers, sweats, chills, or flushing
2. Unexplained weight change. Loss or Gain
3. Fatigue, tiredness
4. Unexplained hair loss
5. Swollen glands
6. Sore throat
7. Testicular pain/ pelvic pain
8. Unexplained menstrual irregularity
9. Unexplained milk production; breast pain
10. Irritable bladder or bladder dysfunction
11. Sexual dysfunction or loss of libido
12. Upset stomach
13. Change in bowel function.... Constipation or Diarrhea
14. Chest pain or rib soreness

15. Shortness of breath, cough
16. Heart palpitations; pulse skips, heart block
17. Any history of a heart murmur
18. History of valve prolapse
19. Joint pain or swelling

List Joints:

_____

20. Stiffness of the joints, neck or back
21. Migrating joint pain
22. Muscle pain or cramps
23. Twitching of the face or other muscles
24. Headaches
25. Neck cracks; neck stiffness
26. Tingling, numbness, burning, or stabbing sensations
27. Facial paralysis (Bells Palsy)
28. Eyes/ vision: double, blurry
29. Ears/ hearing: buzzing, ringing, ear pain
30. Increased motion sickness, vertigo
31. Lightheadedness, dizziness, poor balance, difficulty walking
32. Tremor
33. Confusion, difficulty thinking
34. Difficulty with concentration or reading
35. Forgetfulness, poor short term memory
36. Disorientation: getting lost, going to wrong places
37. Difficulty with speech or writing
38. Mood swings, irritability, depression
39. Disturbed sleep... Too much or Too little or Early awakening
40. Exaggerated symptoms or worse hangover from alcohol

Bartonella Symptoms: CIRCLE ALL YES ANSWERS

1. Low grade fevers or sweats: morning or late afternoon
2. Frontal Headaches
3. Flu like feelings
4. Eye symptoms: red, dry, blurred
5. Ears, ringing, hearing problems, increased sensitivity (hyperacusis)
6. Recurrent sore throat
7. Swollen glands,
8. Anxiety, worried, rage, mood swings

9. Transient confusion or disorientation
10. Seizure like nature
11. Sleep disturbance
12. Joint pain and stiffness
13. Muscle pain, calves
14. Foot pain, in the morning, twitching, cramping
15. Shin pain
16. Nerve irritation symptoms, burning, vibrating, numb
17. Tremors
18. Heart palpitations
19. Chest pain
20. Skin Rashes, red stretch marks, tender lumps or nodules, spider veins
21. Gastrointestinal symptoms, abdominal pain, acid reflux
22 fatigue
23 episodes of breathlessness

Babesia Symptoms: CIRCLE ALL YES ANSWERS

1. Chills
2. Fatigue
3. Night sweats, drenching
4. Large muscle pain: Hips, Buttocks, Quads
5. Neurological symptoms
6. Dizziness
7. Tipsy
8. Increase in hunger
9. Decrease in appetite / nausea
10. Headaches, Migraine like, top of head, posterior
11. Anxiety
12. episodes of breathlessness, air hunger
13. joint pain

Review of Systems

Constitutional Symptoms:

Check all that apply

___ increased appetite ___ decreased appetite ___ Chills ___ fatigue ___fever

___ fever improving ___ sweats ___ night sweats ____ weight gain ___ weight loss
___ sleep disturbance

Eyes:
Check or list every symptom you have had if your eyes trouble you:

___ burning	___ double vision	___ pain
___ bloodshot	___ floaters	___ puffy under eyes
___ blurred vision	___ glaucoma	___ sensitive to light
___ change in vision	___ granulated lids	___ sensitive to dark
___ cataracts	___ see halos	___ styes
___ wears contacts	___itching	___ swelling both lids
___ crusty lids	___ irritated	___ twitching both lids
___ dark circles	___ loss of vision	___ watering
___ dryness	___ mucus in eyes	___ wears glasses

Are the symptoms in this section present year round? Yes___ No___

Which is your worst season? _____

Symptoms are worse:

___ upon arising	___ after meals	___ after medication
___ at night	___ upon lying down	___ cold
___ hot	___ humid	___ dry

Ears:
Please check or list every symptom that applies to your ears:

___ crusting inside	___ floating sensation	___ pain
___ dizziness	___ frequent infections	___ ringing roaring
___ drainage	___ hearing aid	___ serous otitis
___ ever lanced	___ hearing loss	___ sense of imbalance
___ earaches	___ itching inside	___ tubes in ears
___ ears stuffed up	___ nerve deafness	___ tinnitus
	___ pressure	___vertigo

Are the symptoms in this section present year round? Yes___ No___

Which is your worst season? _____

Symptoms are worse:

___ upon arising
___ at night
___ hot
___ after meals
___ upon lying down
___ humid
___ after medication
___ cold
___ dry

Nose:
Check every symptom that applies to your nose (to a greater than normal degree)

___ bleeds
___ blocks
___ burns
___ crusts
___ itches
___ mucus blood streak
___ mucus yellow
___ polyps
___ post nasal drip
___requires nose drops/sprays
___ runs
___ sinus infections
___sneeze

Are the symptoms in this section present year round? Yes___ No___

Which is your worst season? _____

Symptoms are worse:

___ upon arising
___ at night
___ hot
___ after meals
___ upon lying down
___ humid
___ after medication
___ cold
___ dry

Mouth and Throat:
Please check or list every symptom that applies to your mouth and throat:

___ bad breath
___bad taste
___ canker sores
___ chapped lips
___ difficulty swallowing
___ dryness
___ fever blisters
___ grind teeth in sleep
___ hoarseness
___ lips crack: corners
___ lips swell
___ neck glands swell
___ neck pain
___ post nasal drip
___ sleep mouth open
___ snore
___ sore raw tongue
___ sore throat
___ throat clearing
___ throat closed
___ throat itches
___ tongue swollen
___ wear dentures

Are the symptoms in this section present year round? Yes___ No___

Which is your worst season? _____

Symptoms are worse:

___ upon arising	___ after meals	___ after medication
___ at night	___ upon lying down	___ cold
___ hot	___ humid	___ dry

Cardiac and Respiratory:

Please check or list every symptom that applies to you:

___ ankle swelling	___ chest pains/rib pain	___ pneumonia
___ angina/heart attacks	___ frequent colds	___ short of breath/air hunger
___ asthma	___ frequent coughs	___ skipped beats
___ bronchitis	___ frequent infections	___ tight chest
___ cough dry	___ murmur	___ tingling
___ cough mucus	___ night sweats	___ rapid heart
___ cough up blood	___ palpitations	___ wheeze

Gastrointestinal/ Digestive:

Please check or list every symptom that applies to you:

___ anal itching	___ decrease in bowel movements	___ indigestion
___ anal pain	___ diarrhea	___lower abdominal pain
___ belching frequently	___ difficulty digesting foods	___ mucus in stool
___ black stools	___ difficulty swallowing	___ on special diet
___ bloating	___ epigastric pain	___ picky eater
___ bloody spots	___ flatulence	___ poor appetite
___ frequent nausea	___ queasy stomach	___ frequent vomiting
___ rectal bleeding	___ changes in bowel habit	___ gallbladder
___colitis	___ gas shortly after eating	___ stomachaches
___colon cancer	___ good appetite	___ stool/ foul odor
___ constipation	___ hepatitis	___cramping
___ heart burn/ acid reflux	___ bowel doesn't feel empty	___undigested food in stomach
___ burning stomach, eating relieves	___ sense of fullness after meals	

Biliary Symptoms

Please check or list every symptom that applies to you:

_____ Greasy or high fat foods cause distress
_____ Lower bowel gas and/ or bloating several hours after eating
_____ Bitter metallic taste in mouth especially in the morning
_____ Unexplained itchy skin
_____ Yellowish cast to eyes
_____ Stool color alternates from clay colored to normal brown
_____ Reddened skin, especially palms
_____ Dry or flaky skin and/or hair
_____ History of gallbladder attack or stones
_____ Have you had your gallbladder removed ___YES ___ NO

Urinary and Genitalia:

Please check or list every symptom that applies to you:

_____ burning
_____ bed wetting
_____ bladder disease
_____ cystitis
_____ decreased libido
_____ discharge
_____ difficulty starting urination
_____ erectile dysfunction
_____frequent urination
_____ genital herpes
_____ have or had cancer
_____ hot flashes
_____ itching
_____ kidney disease
_____ kidney stones
_____ lumps, pain, swelling in testicles
_____ night urination
_____ painful urination
_____ pass blood
_____ prostate cancer
_____ prostate trouble
_____ sexually transmitted disease
_____ unsatisfactory sexual relations
_____ weak stream
_____ yeast infection
_____ being treated for yeast

Herpes History:

Are you subject to: Fever blisters (cold sores) _____
Genital Herpes _____
Shingles _____

On what part of the body do they occur:

_____

When did the attacks first begin:

_____

How frequently do they occur:

_____

How long do the attacks usually last:

_____

Do the attacks follow any pattern or recurrence:

_____

Are lesions brought on by exposure to:

Sunlight_____

Fever _____

Local irritation _____

Endocrine:

Please check off any symptoms that apply. **Group 1 (Carb Intolerance)**

_____ agitated
_____ blurred vision
_____crave sweets during the day
_____ depend on coffe to keep yourself going
_____ difficulty losing weight
_____ eating relieves fatigue
_____eating sweets does not relieve cravings
_____ easily upset
_____ fatigue after meals
_____ Feels shaky
_____ forgetful
_____ frequent urination
_____get lightheaded when meals are missed
_____ increased thirst or appetite
_____ irritable if meals are missed
_____ jittery
_____ must have sweets after meals
_____ nervous
_____ poor memory
_____ tremors
_____ waist girth is equal or larger than hip girth

Group 2 (Low Adrenal Symptoms)

_____ afternoon headaches
_____ headaches with exertion or stress
_____ cannot stay asleep
_____ crave salt
_____ slow starter in the morning
_____ weak nails

Group 3 (High Adrenal Symptons)

_____ cannot fall asleep
_____excessive perspiration with little or no activity
_____ perspire easily under high amounts of stress
_____ weight gain under stress
_____ Wake up tired even after 6 or more hours of sleep

Group 4 (Low Thyroid)

_____ depression, lack of motivation
_____difficult or infrequent bowel movements
_____ dryness of skin and scalp
_____ excessive falling hair
_____ feel cold hands/feet/all over
_____ gain weight easily
_____ Increase in weight even with low calorie diet
_____ mental sluggishness
_____ morning headaches that wear off as the day progresses
_____ requires excessive amounts of sleep to function properly
_____ outer third of eyebrow thins
_____ thinning of hair and scalp/face or genitals
_____ tired/sluggish

Group 5 (High Thyroid)

_____ difficulty gaining weight
_____ heart palpitations
_____ increased pulse even at rest
_____ inward trembling
_____ Insomnia
_____ mental sluggishness

_____ nervousness and emotional
_____ night sweats

(Males Only)

_____ Decrease in libido
_____ Decrease in spontaneous morning erections
_____ Decrease in fullness of erections
_____ Difficulty in maintaining morning erections
_____ episodes of depression
_____ Inability to concentrate
_____ increase in fat distribution around chest and hips
_____ more emotional than in past
_____ muscle soreness
_____ spells of mental fatigue
_____ sweating attacks
_____ unexplained weight gain

Skin:
Check or list any past or current skin symptoms:

___ blanching
___ boils
___ brittle nails
___ bruising
___ cracking
___ dryness
___ eczema
___ edema
___ fungus (nails)
___ fungus (skin)
___ hives
___ itching
___ oiliness
___ peeling
___ photosensitivity
___ rash
___ scalp problems
___ shingles
___ skin lesions
___ stretch marks

Neuro Psychological History:
Check all that apply:

___ aggressive
___ amnesia
___are a workaholic
___ are being controlled by other forces
___ frequently keyed up and jittery
___ startled by sudden noises
___ headache vertex
___ headache behind eyes

___balance problems
___ been addicted to a drug
___ bipolar
___ blackouts
___burning or stabbing sensation in the body
___ considered a nervous person
___ considered clumsy
___ depersonalization
___ depression
___ difficulty falling asleep/sleep apnea
___ difficulty with curiosity
___ difficulty with speech
___ disequilibrium POS
___ disequilibrium NEG
___ dizziness
___ early awakening
___ extremely shy or sensitive
___ fainting
___ feel "lost in time"
___ feel withdrawn
___ feeling of hostility
___ frequently keyed up and jittery
___ frustration
___ go to pieces easily
___ have difficulty staying awake
___ have had visions
___ have heard voices
___ have overused alcohol
___ have over used drugs
___ have seriously considered suicide
___ head injury
___ head pressure
___ headache frontal
___ headache post cervical
___ headaches global
___ hallucinations
___ hospitalized for nerves
___ hyperactivity
___ incessant talker
___ irritable
___ loss of memory
___ loss of strength
___ meningitis
___ muscle twitching
___ nervous breakdown
___ neuropathy
___ numbness
___ numbness tingling
___ obsessiveness
___ often happy
___ often unable to perform work
___ poor balance
___ poor school performance
___ restless legs
___ shaky
___ short attention span
___ sleep walking
___ startled by sudden noise
___ tingling
___ treated for psychoses
___ treated for depression
___ treated for anxiety
___ tremors
___ unable to concentrate
___ use tranquilizers
___ vision changes
___ word retrieval problems

For Children Only:

Check all that apply:

___ clumsy/uncoordinated
___ has few friends
___ often shiny and bad tempered
___ reading problems

___ has trouble sleeping
___ having finicky appetite
___ hyperactive
___ is slow to learn
___ markedly shy or timid
___ sluggish in the morning
___ spells of intense temper
___ unable to gain weight
___ writing problems

Food History:

Do you frequently have:

___ avoid certain foods
___ bothered by certain foods
___ cook from "scratch"
___ crave beverages
___crave certain foods
___ crash diets
___ eat daytime snacks
___ eat "junk" food
___ eat regular meals
___ elimination diet
___ excessive hunger
___ excessive thirst
___ have bedtime snacks
___ over indulge foods
___ rotation diet
___ skip meals
___ use convenience food
___ use exotic food
___ weight gain
___ weight loss

Is there a family history of food intolerance?

_____

Are most of your meals: at home? _____, at restaurants_____, gourmet_____.

Do you mostly eat foods that are fresh_____, canned_____, frozen_____, packaged_____.

What is your favorite and most enjoyed food and beverage?

_____.

As infant or child, did you ever have:

___ avoid certain foods
___ behavior problems
___ bothered by beverages
___ bothered by foods
___ bothered by food odors
___ bottle fed
___ gassiness
___ headaches
___ hyperactivity
___ leg aches
___ learning problems
___ night sweats

___ colic
___ constant hunger
___ constipation
___ crave certain foods
___ depressed
___ diarrhea
___ dyslexia
___ eczema
___ failure to thrive
___ fussiness
___ picky eater
___ poor appetite
___ short attention span
___ skin rash
___ stomach aches
___ vomiting
___ wet the bed
___ withdrawn

Woman Only:

_____ Number of pregnancies
_____ Number of births
_____ Miscarriages
_____ Menopause
_____ premature births
_____ cesareans
_____ Abortions
_____ Taking hormones

Breasts:

_____ breast soreness before periods
_____ breast soreness not related
_____ breast cysts or lumps
_____ breast soreness during periods
_____ had breast biopsy
_____ had mastectomy

Menses: **age of onset: _____**

_____ am now pregnant
_____ backaches
_____ depressed before/during
_____ dizzy before menses
_____ dizzy during
_____ fibroids
_____ had D&C
_____ had miscarriage
_____ had partial or regular/irregular periods
_____ have cramps
_____ heavy flow
_____hot flashes
_____ pelvic infections
_____ scant flow
_____ tense before
_____ tense during
_____ total hysterectomy
_____ use douches
_____ use diaphragm
_____ use foam
_____ use IUD foam
_____ use lubricants
_____ uterine cancer, ovarian cancer
_____ weight increase

_____ ovulation pain
_____ pain with intercourse

(Menstruating Females Only)

_____ Are you menopausal
_____ Alternating menstrual cycle lengths
_____ Extended menstrual cycle, greater than 32 days
_____ Shortened menses, less than every 24 days
_____ Pain and cramping during periods
_____ Scanty blood flow
_____ Breast pain and swelling during menses
_____ Pelvic pain during menses
_____ Irritable and depressed during menses
_____ Acne breakouts
_____ Facial hair growth
_____ Hair loss/ thinning
_____ Heavy blood flow

(Menopausal Females Only)

How many years have you been menopausal _____
Do you ever have uterine bleeding since menopause YES OR NO

_____ Hot flashes
_____ Disinterest in sex
_____ Depression
_____ Shrinking breast
_____ Increased vaginal pain, dryness or itching
_____ Mental fogginess
_____ Mood swings
_____ Painful intercourse
_____ Facial hair growth
_____ Acne

<u>Exposures:</u>
Check all that apply:

<u>Pets:</u> Lyme disease _____
____ cat ____ indoors ____ outdoors____ sleeps on bed
____ dog ____ indoors ____ outdoors ____ sleeps on bed

<u>Exposures to heavy metals (Pb, Hg)</u>
Dental amalgam

Removal_____ when_____
Heavy metal testing _____
Travel_____ Where_____
College____ Where_____

Chemical and Inhalant History:
Please check your exposures:

_____ bird inside
_____ cat inside
_____ computer work
_____ construction
_____ dampness
_____ dog inside
_____ factory worker
_____ farm worker
_____ feather pillow
_____ gas stove
_____ hasemat
_____ heat
_____ hospital worker
_____ hot air
_____ house worker
_____ indoor plants
_____ mercury
_____ office worker
_____ old mattress
_____ painter
_____ pesticides
_____ pet inside
_____ professional worker
_____ salesperson
_____ teacher
_____ teeth amalgam
_____ work around chemicals
_____ work around cosmetics
_____ work around dust
_____ work around fumes
_____ work indoors
_____ work outdoors
_____ work in extreme heat
_____ work in extreme cold
_____ work with animals

Check if you have symptoms from:

_____ Alcohol
_____ art supplies
_____ basement
_____ bird inside
_____ cat inside
_____ central heat/cool
_____ chemicals
_____ cosmetics
_____ cotton
_____ deodorants
_____ insecticides
_____ kapok
_____ lacquers
_____ marshy area
_____ mildew
_____ molds
_____ mothballs
_____ nail polish
_____ new carpet
_____ new home

_____ detergents
_____ diesel fumes
_____ disinfectants
_____ dog inside
_____ dust
_____ drapes
_____ dyes
_____ eye makeup
_____ exhaust fumes
_____ feathers
_____ fertilizers
_____ fireplace
_____ floor furnace
_____ floor wax
_____ fresh newspapers
_____ furniture polish
_____ gasoline fumes
_____ gas stove/heat
_____ glue
_____ grain dust
_____ hair sprays
_____ hemp
_____ herbicides
_____ incense
_____ newsprint
_____ old carpet
_____ old home
_____ old magazines
_____ paints
_____ perfumes
_____ pet inside
_____ photocopy center
_____ potted plants
_____ plastics
_____ raised home
_____ rubber
_____ rugs
_____ sisal
_____ slab home
_____ smoke
_____ solvents
_____ soaps
_____ space heaters
_____ tar
_____tobacco smoke
_____ turpentine
_____ varnishes
_____ wooded area

Check if you have symptoms:

_____ around odors
_____ fall
_____ from dyes
_____ housecleaning
_____ in humid/ windy weather
_____ in moldy areas
_____ summer
_____ spring
_____ when too cold
_____ when too hot
_____ worse in daytime
_____ when cutting grass
_____ when physically exerted
_____ when raking leaves
_____ winter
_____ worse at night

List personal and family hobbies (model planes, etc.)

_____

_____

_____

List family work exposures (e.g. parent, spouse):

_____

_____

Specialist seen: When Result Telephone number

Primary Care Physician:

_____

_____

Rheumatologist:_____

_____

urologist:_____

_____

Cardiologist:_____

_____

Gastroenterologist:_____

_____

Dermatologist:_____

_____

Infectious Disease:_____

_____

Optometrist:_____

_____

Endocrinologist:_____

_____

Other: _____

_____

Psychological Stress Index

Check all that apply:

1. □ Frequently keyed up and jittery
   □ Never □Sometimes □Always
2. □Extremely shy or sensitive; uncomfortable with strangers or new situations
3. □ Misunderstood by others
   □Never □Sometimes □Always
4. □Feelings of hostility and anger on many occasions
   □Never □Sometimes □Always

5. □Consistent irritability
□Never □Sometimes □Always
6. □Unable to perform work
□ At home □ On the job
7. □Addiction difficulties
□ Illicit drugs □Prescription drugs □Alcohol □Food □Past □Present
8. □ Family difficulties
□ With spouse □ Parent □Children □other_____
□ Past □Present
9. □Depression
□Sadness □Cry easily □Disappointment □Self blame □Suicidal thoughts
□Get up early, insomnia □ No appetite

Life Stress Index

Check all that apply:

1. □ Death of spouse
□ Last six months □Within lifetime □In near future
2. □Death of child
□ Last six months □Within lifetime □ In near future
3. □Divorce
□Last six months □Within lifetime □In near future
4. □Jail
□Last six months □ Within lifetime □In near future

5. □Death of family member or close friend
□Last six months □Within lifetime □In near future
6.□ Personal injury
□Last six months □Within lifetime □In near future
7. □ Marriage
□Last six months □ Within lifetime □ In near future
8. □ Loss of employment
□ Last six months □Within lifetime □ In near future
9. □Pregnancy
□ Last six months □Within lifetime □ In near future
10. □Sexual difficulties
□ Last six months □ Within lifetime □ In near future
11. □Financial reversal/ gains

□ Last six months □ Within lifetime □ In near future

Sleep:

□ Muscle twitching □ very light □ disturbing dreams
□awake tired □ heavy □ dreamless
□ insomnia □difficult to fall off to sleep □ frequent wakening
□ narcolepsy □difficult to stay asleep □medication _____
□ snoring □ restless

Energy:

□ low | □constant □ intermittent □ Listless mental/ physical
□ High □ Lack of drive| □recent □always
□ Exhaustion, not refreshed by sleep □ Listless| □during □after exercise
□ Fatigue| □ during □ after exercise □ Other _____

Cravings:

□ Water □ Tobacco
□ Sweets and chocolate □ Salt
□ Coffee or tea □ Sugar
□ Bread □ Other _____
□ Alcohol

Favorite Foods:

_____
_____
_____

Comments:

_____

History of Weight Problem (Record in space provided how long):

□ Gain and/ or lose at least 3-4 lbs in one day
□ Weight control needed constantly
□ Difficult to control despite calorie counting
□ Compulsive eat (specially under emotionally stressful situations)
□ Underweight always

□Overweight always (as child, adolescent, adult)
□ Cholesterol problems. On medication
□ Bulimia (secretive; have had treatment)
□ Anorexia (hospitalized)
□ Fluid relation
□ Frequent dieting
□ Other

_____

Allergies:

□Animal	□ Industrial Chemical	□ Aspirin
□ Pollens	□Foods	□ Asthma
□ Molds	□ Sugar	□ Urticaria (hives)
□ Aerosois	□ Wine and alcohol	□ Conjuctivitis
□ Perfumes	□ Food addictive	□ Allergic Rhinitis
□Air conditioning	□Milk products	□ Other_____
□ Auto exhaust	□ Antibiotics	

Allergy Symptoms:

Have you been previously tested and treated?

_____

Shot: _____How long?

_____

Physician: _____

Is your allergy condition: □constant □seasonal □only indoors □only outdoors

□ both indoors and outdoors □ food related □immediately after meals

□ delayed up to 24 hours

Is there one worse season? _____

Travel:

□ Within USA and Canada
□ Outside country
□ Latin America/ Mexico
□ Far East

□ Europe
□ Africa
| Symptoms| □Fevers □Parasites □Diarrhea □Other _____

Headaches: (record the length of time you have had these symptoms in the space provided):

□ Relieved by □Aspirin □Tylenol □Advil □Fiorinal
□Recurring

Other History: Please indicate if you have ever been exposed to:
□ toxic chemicals
□ pesticides
□ have or had mercury fillings in your teeth
□ heavy metals (ie lead)
□ "played" with mercury as a child
□ sexual, physical, or emotional abuse

AXILLARY BASAL TEMPERATURE RECORD

The purpose of this procedure is to get some information about thyroid function. Please keep a three day consecutive record of you axillary (armpit) temperature. The following procedure should be carefully followed:

1. You can use either a rectal mercury thermometer or a digital thermometer. The thermometer should be left near the bed the night before where you can reach it easily without getting up. A clock or watch should also be prepared for timing purposes.
2. For women: If scheduling allows, it is best for a woman to record the axillary temperature during the first three days of her menstrual cycle (first three days of flow). Otherwise, any three consecutive days may be used.
3. When you awaken, the thermometer should be placed in the armpit for 10 minutes. Press your arm against your body to hold the thermometer in place. If you use the digital thermometer and it beeps, keep it under your arm for the full 10 minutes.

DATE	DAY	TEMPERATURE
_____	ONE	_____

_____	TWO	_____
_____	THREE	_____
_____	FOUR	_____
_____	FIVE	_____
_____	SIX	_____
_____	SEVEN	_____

Food Intake Diary

Name: _____

First Day of Diary: _____

Date Range: _____

Date	Breakfast	AM Snack	Lunch	PM Snack	Dinner	Snack	Temp. Record
Day 1							
Day 2							
Day 3							
Day 4							
Day 5							

Day 6							
Day 7							

METABOLIC CLEARING THERAPY

TESTING SCALE

Patient Name:_____ Date:_____

Rate each of the following symptoms based upon your health profile for the past 30 days.

POINT SCALE

0= Never or almost never having the symptom

1= Occasionally have the symptom, effect is not severe

2= Occasionally have the symptom, effect is severe

3= Frequently have the symptom, effect is not severe

4= Frequently have the symptom, effect is severe

DIGESTIVE TRACT	_____Nausea or vomiting _____Diarrhea _____Constipation _____Bloated feeling _____Belching or passing gas _____Heartburn	**TOTAL_____**
EARS	_____Itchy ears _____Earaches, ear infections _____Drainage from ear _____Ringing in ears, hearing loss	**TOTAL_____**
EMOTIONS	_____Mood swings _____Anxiety, fear or nervousness _____Anger, irritability or aggressiveness _____Depression	**TOTAL_____**
ENERGY/ ACTIVITY	_____Fatigue, sluggishness _____Apathy, lethargy _____Hyperactivity _____Restlessness	**TOTAL_____**
EYES	_____Watery or itchy eyes _____Swollen, reddened or sticky eyelids _____Bags or dark circles under eyes _____Blurred or tunnel vision (Does not include near or far sightedness)	**TOTAL_____**
HEAD	_____Headaches _____Faintness _____Dizziness _____Insomnia	**TOTAL_____**
HEART	_____Irregular or skipped heartbeat _____Rapid or pounding heartbeat _____Chest pain	**TOTAL_____**

JOINTS/ MUSCLES	_____Pain or aches in joints _____Arthritis _____Stiffness or limitation of movement _____Pain or aches in muscles _____Feeling of weakness or tiredness **TOTAL_____**
LUNGS	_____Chest congestion _____Asthma, bronchitis _____Shortness of breath _____Difficulty breathing **TOTAL_____**
MIND	_____Poor memory _____Confusion _____Poor concentration _____Poor physical condition _____Difficulty in enacting decisions _____Stuttering or stammering _____Slurred speech _____Learning disabilities **TOTAL_____**
MOUTH/ THROAT	_____Chronic coughing _____Gagging, frequent need to clear throat _____Sore throat, hoarseness, loss of voice _____Swollen or discolored tongue, gums, lips _____Canker sores **TOTAL_____**
NOSE	_____Stuffy nose _____Sinus problems _____Hay fever _____Sneezing attacks _____Excessive mucus formation **TOTAL_____**

SKIN	
_____Acne _____Hives, rashes, or dry skin _____Flushing or hot flashes _____Excessive sweating	**TOTAL_____**
WEIGHT	
_____Binge eating/drinking _____Craving certain foods _____Excessive weigh	**TOTAL_____**
OTHER	
_____Frequent illness _____Frequent or urgent urination _____Genital itch or discharge	**TOTAL_____**

GRAND TOTAL_____