FUNCTIONAL MEDICINE CHARLOTTE

PUTTING THE PIECES TOGETHER

Dr. John Bartemus

DC, BCIM, CFMP, AFNI, DACBN(c)

Doctor of Chiropractic

Board Certified Integrative Medicine

Certified Functional Medicine Practitioner

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & COMPREHENSIVE HEALTH HISTORY FORMS

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records of Dr._____

Address:_____

Telephone number ( ) ___ - _____ Fax number ( ) ___ - _____

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to _____

_____

all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse*:* O Yes O No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: O Yes O No

Genetic Testing O Yes O No

Please note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release_____

(Name of physician, clinic name, or health organization)

employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand the there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name:_____ D.O.B. _____ Last 4 SS# _____

Please Print

Signature: _____ Date_____

Records Requested by:

Doctor's Name: _____

Signature:_____

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COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date:_____

First Name:_____ Middle:_____Last:_____

Address _____ City _____ State _____ Zip Code_____

Home Phone (____) _____-_____ Work (____) _____-_____ Cell (____) ____-_____

Email _____

Age _____ Date of Birth ____/____/_____ Place of birth_____ Gender: Female__Male___

City or town & country, if not US

Referred by:_____

Name, address, & phone number of primary care physician:_____

_____

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: _____

Relationship Name Phone

_____

Address

Occupation _____ Hours per week _____ Retired _____

Nature of Business_____

Genetic Background: Please check appropriate box(es):

- ❑ African American
- ❑ Hispanic
- ❑ Mediterranean
- ❑ Asian
- ❑ Native American
- ❑ Caucasian
- ❑ Northern European
- ❑ Other

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CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

When was the last time that you felt well?_____

What seems to trigger your symptoms?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

_____

_____

How much time have you lost from work or school in the past year due to these conditions?_____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		

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Diabetes		
ILLNESS	**WHEN/ONSET**	**COMMENTS**
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

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DIAGNOSTIC STUDIES	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
SURGERIES	**WHEN**	**COMMENTS**
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

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MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:_____

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CHILDHOOD HISTORY

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Where you a full term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				

Have you had the HPV vaccine? YES_____ NO_____
Did you have the full HPV schedule (3 shots)? YES_____ NO_____

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CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: milk – diarrhea)_____

_____

_____

CHILDHOOD ILLNESSES

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	YES	AGE
ADD (Attention Deficient Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Hyperactivity		
Jaundice		

	YES	AGE
Mumps		
Pneumonia		
Seasonal allergies		
Skin disorders (e.g. dermatitis, eczema)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Other (describe)		
Other (describe)		
Measles		

As a child did you: Have a high absence from school? Yes___ No___

If yes, why?_____

Experience chronic exposure to second hand smoke in your home? Yes___ No___

Experience abuse? Yes___ No___

Have alcoholic parents? Yes___ No___

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FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____ ❑ Caesarean _____ ❑ Vaginal deliveries_____
- ❑ Miscarriage _____ ❑ Abortion _____ ❑ Living Children_____
- ❑ Post partum depression___ ❑ Toxemia _____ ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses?_____ Frequency:_____ Length:_____

Painful: Yes_____ No_____ Clotting: Yes____ No____

Date of last menstrual period:____/____/_____

Do you currently use contraception? Yes____ No____ If yes, please indicate which form and how long:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant._____

_____

Are you menopausal? Yes_____ No_____ If yes, age of menopause_____

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

❑ Other _____

DIAGNOSTIC TESTING

Last PAP test:_____/_____/_____ Normal:_____Abnormal_____

Last Mammogram_____/_____/_____ Breast biopsy? Date:_____/_____/_____

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FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus, Hashimoto's, Type 1 Diabetes)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes (Indicate Type 1 or 2)									
Eczema									
Emphysema									

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Environmental Sensitivities									
Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

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Perceived Stress Scale

A more precise measure of personal stress can be determined by using a variety of instruments that have been designed to help measure individual stress levels. The first of these is called the **Perceived Stress Scale**.

The Perceived Stress Scale (PSS) is a classic stress assessment instrument. The tool, while originally developed in 1983, remains a popular choice for helping us understand how different situations affect our feelings and our perceived stress. The questions in this scale ask about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer fairly quickly. That is, don't try to count up the number of times you felt a particular way; rather indicate the alternative that seems like a reasonable estimate.

For each question choose from the following alternatives:
0 - never 1 - almost never 2 - sometimes 3 - fairly often 4 - very often

_____ 1. In the last month, how often have you been upset because of something that happened unexpectedly?

_____ 2. In the last month, how often have you felt that you were unable to control the important things in your life?

_____ 3. In the last month, how often have you felt nervous and stressed?

_____ 4. In the last month, how often have you felt confident about your ability to handle your personal problems?

_____ 5. In the last month, how often have you felt that things were going your way?

_____ 6. In the last month, how often have you found that you could not cope with all the things that you had to do?

_____ 7. In the last month, how often have you been able to control irritations in your life?

_____ 8. In the last month, how often have you felt that you were on top of things?

_____ 9. In the last month, how often have you been angered because of things that happened that were outside of your control?

_____ 10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

LOT-R

	Strongly Agree A	B	C	D	Strongly Disagree E
1. In uncertain times I usually expect the best.					
2. It's easy for me to relax.					
3. If something can go wrong for me, it will.					
4. I'm always optimistic about my future.					
5. I enjoy my friends a lot.					
6. It's important for me to keep busy.					
7. I hardly ever expect things to go my way.					
8. I don't get upset too easily.					
9. I rarely count on good things happening to me.					
10. Overall, I expect more good things to happen to me than bad.					

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REVIEW OF SYMPTOMS

Metabolic Assessment Form™

Please circle the appropriate number on ALL the questions below.
0 as the least/never to 3 as the most/always

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Please circle the appropriate number on ALL the questions below.
0 as the least/never to 3 as the most/always

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XV *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVIII *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

Brain Health and Nutritional Assessment Form™

Please circle the appropriate number on ALL the questions below.
0 as the least/never to 3 as the most/always

SECTION 1

- Low brain endurance for focus and concentration 0 1 2 3
- Cold hands and feet 0 1 2 3
- Must exercise or drink coffee to improve brain function 0 1 2 3
- Poor nail health 0 1 2 3
- Fungal growth on toenails 0 1 2 3
- Must wear socks at night 0 1 2 3
- Nail beds are white instead of pink 0 1 2 3
- The tip of the nose is cold 0 1 2 3

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals 0 1 2 3
- Feel energized after meals 0 1 2 3
- Difficulty eating large meals in the morning 0 1 2 3
- Energy level drops in the afternoon 0 1 2 3
- Crave sugar and sweets in the afternoon 0 1 2 3
- Wake up in the middle of the night 0 1 2 3
- Difficulty concentrating before eating 0 1 2 3
- Depend on coffee to keep going 0 1 2 3

SECTION 3

- Fatigue after meals 0 1 2 3
- Sugar and sweet cravings after meals 0 1 2 3
- Need for a stimulant, such as coffee, after meals 0 1 2 3
- Difficulty losing weight 0 1 2 3
- Increased frequency of urination 0 1 2 3
- Difficulty falling asleep 0 1 2 3
- Increased appetite 0 1 2 3

SECTION 4

- Always have projects and things that need to be done 0 1 2 3
- Never have time for yourself 0 1 2 3
- Not getting enough sleep or rest 0 1 2 3
- Difficulty getting regular exercise 0 1 2 3
- Feel that you are not accomplishing your life's purpose 0 1 2 3

SECTION 5

- Dry and unhealthy skin 0 1 2 3
- Dandruff or a flaky scalp 0 1 2 3
- Consumption of processed foods that are bagged or boxed 0 1 2 3
- Consumption of fried foods 0 1 2 3
- Difficulty consuming raw nuts or seeds 0 1 2 3
- Difficulty consuming fish (not fried) 0 1 2 3
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats 0 1 2 3

SECTION 6

- Difficulty digesting foods 0 1 2 3
- Constipation or inconsistent bowel movements 0 1 2 3
- Increased bloating or gas 0 1 2 3
- Abdominal distention after meals 0 1 2 3
- Difficulty digesting protein-rich foods 0 1 2 3
- Difficulty digesting starch-rich foods 0 1 2 3
- Difficulty digesting fatty or greasy foods 0 1 2 3
- Difficulty swallowing supplements or large bites of food 0 1 2 3
- Abnormal gag reflex Yes or No

SECTION 7

- Brain fog (unclear thoughts or concentration) Yes or No
- Pain and inflammation Yes or No
- Noticeable variations in mental speed Yes or No
- Brain fatigue after meals 0 1 2 3
- Brain fatigue after exposure to chemicals, scents, or pollutants 0 1 2 3
- Brain fatigue when the body is inflamed 0 1 2 3

SECTION 8

- Grain consumption leads to tiredness 0 1 2 3
- Grain consumption makes it difficult to focus and concentrate 0 1 2 3
- Feel better when bread and grains are avoided 0 1 2 3
- Grain consumption causes the development of any symptoms 0 1 2 3
- A 100% gluten-free diet Yes or No

Please circle the appropriate number on ALL the questions below.
0 as the least/never to 3 as the most/always

SECTION 9

A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease	**Yes or No**
Family members who have been diagnosed with an autoimmune disease	**Yes or No**
Family members who have been diagnosed with celiac disease or gluten sensitivity	**Yes or No**
Changes in brain function with stress, poor sleep, or immune activation	**0 1 2 3**

SECTION 10

A loss of pleasure in hobbies and interests	**0 1 2 3**
Feel overwhelmed with ideas to manage	**0 1 2 3**
Feelings of inner rage or unprovoked anger	**0 1 2 3**
Feelings of paranoia	**0 1 2 3**
Feelings of sadness for no reason	**0 1 2 3**
A loss of enjoyment in life	**0 1 2 3**
A lack of artistic appreciation	**Yes or No**
Feelings of sadness in overcast weather	**0 1 2 3**
A loss of enthusiasm for favorite activities	**0 1 2 3**
A loss of enjoyment in favorite foods	**0 1 2 3**
A loss of enjoyment in friendships and relationships	**0 1 2 3**
Inability to fall into deep, restful sleep	**0 1 2 3**
Feelings of dependency on others	**0 1 2 3**
Feelings of susceptibility to pain	**0 1 2 3**

SECTION 11

Feelings of worthlessness	**0 1 2 3**
Feelings of hopelessness	**0 1 2 3**
Self-destructive thoughts	**0 1 2 3**
Inability to handle stress	**0 1 2 3**
Anger and aggression while under stress	**0 1 2 3**
Feelings of tiredness, even after many hours of sleep	**0 1 2 3**
A desire to isolate yourself from others	**0 1 2 3**
An unexplained lack of concern for family and friends	**0 1 2 3**
An inability to finish tasks	**0 1 2 3**
Feelings of anger for minor reasons	**0 1 2 3**

SECTION 12

A decrease in visual memory (shapes and images)	**Yes or No**
A decrease in verbal memory	**0 1 2 3**
Occurrence of memory lapses	**0 1 2 3**
A decrease in creativity	**0 1 2 3**
A decrease in comprehension	**0 1 2 3**
Difficulty calculating numbers	**0 1 2 3**
Difficulty recognizing objects and faces	**0 1 2 3**
A change in opinion about yourself	**0 1 2 3**
Slow mental recall	**0 1 2 3**

SECTION 13

A decrease in mental alertness	**0 1 2 3**
A decrease in mental speed	**0 1 2 3**
A decrease in concentration quality	**0 1 2 3**
Slow cognitive processing	**0 1 2 3**
Impaired mental performance	**0 1 2 3**
An increase in the ability to be distracted	**0 1 2 3**
Need coffee or caffeine sources to improve mental function	**0 1 2 3**

SECTION 14

Feelings of nervousness or panic for no reason	**0 1 2 3**
Feelings of dread	**0 1 2 3**
Feelings of a "knot" in your stomach	**0 1 2 3**
Feelings of being overwhelmed for no reason	**0 1 2 3**
Feelings of guilt about everyday decisions	**0 1 2 3**
A restless mind	**0 1 2 3**
An inability to turn off the mind when relaxing	**0 1 2 3**
Disorganized attention	**0 1 2 3**
Worry over things never thought about before	**0 1 2 3**
Feelings of inner tension and inner excitability	**0 1 2 3**

PAIN ASSESSMENT

Are you currently in pain? Yes ___ No___

Is the source of your pain due to an injury? Yes___ No___

If yes, please describe your injury and the date in which it occurred:_____

_____

If no, please describe how long you have experienced this pain and what you believe it is attributed to:_____

Please use the area(s) and illustration below to describe the severity of your pain.

(0= no pain, 10= severe pain)

Example:_____**Neck**_____

0 1 2 3 4 5 6 7 8 9 10

Area 1._____

1 2 3 4 5 6 7 8 9 10

Area 2._____

1 2 3 4 5 6 7 8 9 10

Area 3._____

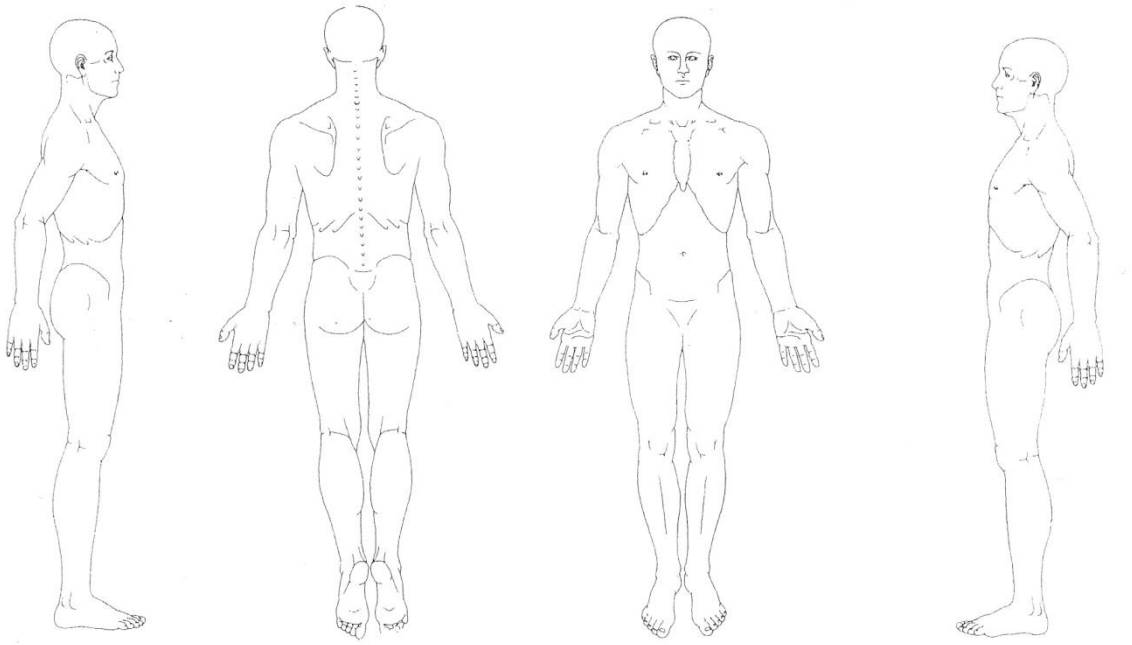
1 2 3 4 5 6 7 8 9 10

Area 4._____

1 2 3 4 5 6 7 8 9 10

Use the letters provided to mark your area(s) of pain on the illustration.

A = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting



Right Side Back Front Left side

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ENVIRONMENTAL EXPOSURE

HAVE YOU EVER LIVED OR WORKED IN A BUILDING WITH:

- ❑ Past water damage
- ❑ Current water damage
- ❑ Faulty ventilation
- ❑ Moisture control problems
- ❑ Condensation on the walls
- ❑ Musty smell (throughout or only in certain places like the basement or under the sink)
- ❑ A dehumidifier always running

- ❑ Visible mold:
- ❑ Current
- ❑ Past
    - ❑ In the basement
    - ❑ In the closet
    - ❑ Under the sink(s)
    - ❑ Around the bathtub(s)
    - ❑ Inside cupboards

- ❑ That caused symptoms such as:
    - ❑ Nausea
    - ❑ Anxiety
    - ❑ Headache
    - ❑ Brain Fog
    - ❑ Vertigo
    - ❑ Excessive Fatigue
    - ❑ Shortness of Breath

Do you experience excessive shocks from static electricity? YES_____ NO_____

Are you constantly thirsty? YES_____ NO_____

Do you urinate more often than you would consider normal? YES_____ NO_____

Are you experiencing short term memory lapses? YES_____ NO_____

Have you experienced an unexplainable decrease in the ability to exercise or perform normal daily tasks? YES_____ NO_____

If YES, do you find yourself fatigued and short of breath? YES_____ NO_____

Are you an exceptionally flexible person?

Is there a family history of Marfan's Syndrome, Ehlers-Danlos III, or Celiac Disease? YES_____ NO_____

If YES, which one(s)? _____

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DENTAL HISTORY

	Yes	No
Problem with sore gums (gingivitis)?		
Ringing in the ears (tinnitus)?		
Have TMJ (temporal mandibular joint) problems?		
Metallic taste in mouth?		
Problems with bad breath (halitosis) or white tongue (thrush)?		
Previously or currently wear braces?		
Problems chewing?		
Floss regularly?		
Do you have amalgam dental fillings? How many?		
Did you receive these fillings as a child?		

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

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NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
❑ None	❑ None	❑ None
❑ Bacon/Sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Coffee	❑ Brown rice
❑ Butter	❑ Eat in a cafeteria	❑ Butter
❑ Cereal	❑ Eat in restaurant	❑ Carrots
❑ Coffee	❑ Fish sandwich	❑ Coffee
❑ Donut	❑ Fried foods	❑ Fish
❑ Eggs	❑ Hamburger	❑ Green vegetables
❑ Fruit	❑ Hot dogs	❑ Juice
❑ Juice	❑ Juice	❑ Margarine
❑ Margarine	❑ Leftovers	❑ Milk
❑ Milk	❑ Lettuce	❑ Pasta
❑ Oat bran	❑ Margarine	❑ Potato
❑ Sugar	❑ Mayo	❑ Poultry
❑ Sweet roll	❑ Meat sandwich	❑ Red meat
❑ Sweetener	❑ Milk	❑ Rice
❑ Tea	❑ Pizza	❑ Salad
❑ Toast	❑ Potato chips	❑ Salad dressing
❑ Water	❑ Salad	❑ Soda
❑ Wheat bran	❑ Salad dressing	❑ Sugar
❑ Yogurt	❑ Soda	❑ Sweetener
❑ Oat meal	❑ Soup	❑ Tea
❑ Milk protein shake	❑ Sugar	❑ Vinegar
❑ Slim fast	❑ Sweetener	❑ Water
❑ Carnation shake	❑ Tea	❑ White rice
❑ Soy protein	❑ Tomato	❑ Yellow vegetables
❑ Whey protein	❑ Vegetables	❑ Other: (List below)
❑ Rice protein	❑ Water	
❑ Other: (List below)	❑ Yogurt	
	❑ Slim fast	
	❑ Meal replacement shake	
	❑ Protein shake	

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? Yes____ No_____

- ❑ Paleo
- ❑ Diabetic
- ❑ Gluten Free
- ❑ Vegetarian
- ❑ Vegan
- ❑ FODMAPS
- ❑ Other (describe)_____

Please tell us if there is anything special about your diet that we should know._____

_____

Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc?
Yes___ No____
If yes, are these symptoms associated with any particular food or supplement?
Yes___ No____
If yes, please name the food or supplement and symptom(s). _____

_____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

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Does skipping meals greatly affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes _____ No _____ If yes, what food(s) _____

_____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) _____

_____

Please complete the following chart as it relates to your bowel movements:

Frequency	√	**Color**	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

Intestinal gas:

- ❑ Daily
- ❑ Occasionally
- ❑ Excessive
- ❑ Present with pain
- ❑ Do you experience gas and/or bloating after meals?
- ❑ Have you made changes to your diet because of gas/bloating after meals and no longer experience it?

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LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much?_____

Number of years?_____If not a current user, year quit_____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain:_____

_____

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From_____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____

If yes, what type(s) and method? (IV, inhaled, smoked, etc)_____

_____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___No___

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?
- ❑ Wake multiple times in the night?

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EXERCISE HISTORY

Do you exercise regularly? Yes____ No____

If yes, please indicate:	Times/week				Length of session			
Type of exercise	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

_____

_____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

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

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? _____ When was the last time?_____

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc)_____

Did it help?_____

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
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					

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _____

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

Hobbies and leisure activities:

_____

_____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes_____ No_____

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READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Take nutritional supplements each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Keep a record of everything you eat each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Modify your lifestyle (e.g. work demands, sleep habits)	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Practice relaxation techniques	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Engage in regular exercise	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Have periodic lab tests to assess progress	5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments _____

_____

_____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone. **As the final piece of the history, please provide me with a timeline (preferably typed) in your own words of your health challenge(s) from the beginning to current day**.

We look forward to helping you achieve lifelong health and well being.

Sincerely,
Dr. John Bartemus

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