Dear New Patient,

On behalf of my office staff, and myself I welcome you to my practice! We look forward to meeting you and working with you to achieve all of your health goals.

I have found it extremely helpful to have you prepare some information before your first appointment, to insure that the visit is as thorough and useful as possible. Please complete all of the pages of the questionnaire between now and your scheduled visit. **Please remember to bring it with you to your appointment with your insurance card (if applicable)** as experience has shown that it facilitates the initial visit greatly. At any time throughout the questionnaire should you need more room to list items or for further explanation, please feel free to attach additional pages. Recent labs from previous doctors can also be helpful. Thank you for putting your time into this preparation.

If you need to cancel or reschedule this or any appointment, please call at least 2 business days in advance for your initial visit. For your follow-up appointments, we ask that you call at least 1 business day in advance. Barring emergencies, there will be a charge for missed appointments that are not cancelled at least 1 business day prior to your appointments.

Our office is in the Historic Highland Building, in downtown Boulder. The building is surrounded by tall trees and a wrought iron fence and can easily be missed. We are proud of our building and grounds, but know that parking can sometimes be difficult. We have arranged for patient parking in the lot off of 9th street. If the lot is full, you may park in front of the garages or anywhere you feel your car will be safe. *(In this instance, tell the receptionist on the main level where you have parked and who you are seeing.)* The following are directions to assist you in your travels.

***From Hwy 36 & Denver*:** Traveling west, Hwy 36 becomes 28th Street when you enter Boulder. Follow 28th to Arapahoe Ave, and turn left. Turn right on 9th St, and make an immediate left into the parking lot. (If you cross Boulder Creek, you've gone too far!)

***From Hwy 93*:** Traveling north, Hwy 93 becomes Broadway when you come into Boulder. Follow Broadway until it intersects with Baseline Road, and turn left. Follow Baseline to 9th Street, turn right and continue down 9th street. Cross Arapahoe and make an immediate left into the parking lot. (If you cross Boulder Creek, you've gone too far!)

***From Longmont*:** Traveling south on the Diagonal, exit right on Diagonal where the road splits into two parts (Foothills Parkway & Diagonal). Travel west and the road becomes Iris. Follow Iris until it intersects with Broadway and turn left. Follow Broadway south until it intersects with Canyon. Turn right and follow Canyon to 9th Street. Turn left and head south on 9th Street. Immediately after crossing Boulder Creek turn right, through the iron gates and into our parking lot.

If you still have questions or concerns, please give us a call! I look forward to meeting you.

W. David Lue

W.David Luce, M.D., P.C.
885 Arapahoe Ave
Boulder, CO 80302

Phone: 303-444-5689
Fax: 303-449-2933
E-mail: office@drdavidluce.net

PATIENT DEMOGRAPHICS

Patient Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ ☐ Check Primary Birth Date: _____
Work Phone: _____ ☐ SSN: _____
Cell Phone: _____ ☐ Sex: _____ Marital Status: _____
E-mail: _____ Referred by: _____

Emergency Contact: _____
(Name) (Phone)
Nearest Relative *not living with you:* _____
(Name)

_____
(Address) (Phone)

INSURANCE INFORMATION

Policy Holder: _____ Employer: _____
Insurance Company: _____ Cust Service #: _____
Claims Address: _____
Member ID # _____ Group #: _____

Copay: _____ Deductible: _____ PCP : _____

For Office Use Only: Eff. Date: Confirmed: By: Account #:

FOR INSURANCE PATIENTS

I declare that the information I have supplied on this form is true and correct. I hereby authorize payments of medical benefits directly to W. David Luce, M.D. A photocopy of this assignment shall be considered as valid as the original. This signature shall be valid for all subsequent claims. I hereby authorize the release of any medical records or information necessary to process my claim to my insurance company.

Signature: _____ **Date:** _____

Any typed name, followed by the last 4 digits of your SS#, is a valid electronic signature.

FOR CASH PATIENTS ONLY

Until further advised, the office of W. David Luce, MD, PC, considers me a Cash Patient. All services rendered will be due and payable at the time of service. I hereby authorize any payment of medical benefits directly to myself, the patient.

Signature: _____ Date: _____

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Electronic Communication (E-mail) Agreement

Electronic (online) communications include e-mail, webmail, secure messaging, electronic file transfer, text messaging and internet "portal" to exchange information between computers, tablets, smartphones. These can be useful ways for patients and healthcare providers to communicate, in addition to more usual visits and phone calls.

Advantages

- E-mail is a simple, convenient and popular way of connection; many people use it regularly
- Messages can be sent and received without needing both parties online at the same time
- Messages can be saved, copied, and forwarded; they keep a record of what was said
- Some messaging systems are encrypted to help keep information private
- Some questions and issues can be handled by online messaging without needing a phone call or visit

Disadvantages

- E-mail devices and connections can fail, messages can be lost or sent to the wrong person
- There is no way to know if a message was ever received
- Messages can contain typing mistakes
- If the other party is away or their device is turned off, messages might not be seen promptly
- It is possible for a dishonest person to send a false message or impersonate a patient or a doctor
- If both parties are not online at the same time, there is no opportunity to clarify misunderstandings
- Saved copies or messages sent in error can't be erased or retracted
- Messages can contain viruses that can damage systems or steal information
- Some medical questions and issues cannot be handled through online messaging

Our E-mail Policies

1. **No emergencies or urgent messages.** E-mail is not to be used for emergencies or urgent messages. We do not monitor our In-Box constantly. You can send a message any time, but we may not read it until the next business day. We check messages during regular work hours, and answer them in the order received. We try to deal with messages within 1 work day, but circumstances could cause us to fall behind. Use the telephone if you need a response right away. Of course, in a life-threatening emergency all 911.

2. **Uses.** Our practice accepts E-mail messages for these purposes:

   a. **General messages** like making or changing appointments, billing issues, or other questions that can be answered by an appropriate staff person. [Use **office@drdavidluce.net**]

   b. **Medical questions.** Our providers may give their professional E-mail addresses to you for medical questions. Although they might sometimes reply after hours, you should not expect providers to monitor their mail continuously. Even on-call it is likely the provider is not sitting at a computer. Again, if you have a problem that needs attention right away, use the telephone. [Use **office@drdavidluce.net**]

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3. **Part of the record.** E-mail messages are considered part of your medical record. Our policies for record privacy and appropriate uses of medical information apply to messages we send to each other.

4. **Security.** You need to protect the E-mail address you give us, to make sure our communications remain private. This is the only way we can trust that messages from your E-mail are really from you, and messages we send are not going to someone else. If we are not sure about a message, we will try to contact you in some other way.

5. **Availability.** If you ask us to use E-mail to communicate with you, we will assume that you check your In-Box at reasonable intervals. We do not guarantee that we will respond to your messages and we understand you cannot guarantee that you will respond to ours. In cases of uncertainty, we will try other ways of communicating.

6. **Sensitive medical information.** We cannot always know what information you consider especially private. We take care with all medical records, but we know that some facts are more sensitive than others. Because E-mail cannot be guaranteed 100% secure, please do not put extremely sensitive matters in messages without considering this.

7. **Voluntary.** Using E-mail is voluntary for both of us. If we feel you are using E-mail inappropriately (or, if we think your address has been hacked by an imposter), we may block your messages. If you decide you do not want to receive E-mail form us any longer, just let us know.

8. **Changes of address.** If your E-mail address changes, you need to let us know.

9. **Non-essential uses.** We will only use your E-mail address for important communications related to our practice. We will not give your E-mail address to anyone who is not part of our practice. Please do not send non-essential messages to us, because they slow down our ability to respond to the important ones.

10. **Mistakes.** Mistakes happen. If you believe you have received or sent a message by mistake, or one that contains errors, please let us know. You should delete messages that are not intended for you.

11. **Other risks.** In addition to those above, electronic communication can have other risks and disadvantages that might cause inconvenience or harm. Everyone using E-mail needs to use good judgment about these valuable technologies, and must remember that there are alternatives that would be better for some situations.

Acknowledgement and Agreement

I acknowledge that I have read this form. I understand that electronic (online) communication has risks, including possible risks not mentioned above. I agree to abide by the policies described above. I agree to use reasonable judgment with regard to any messages I send or received. I do not have any unanswered questions about what this Agreement requires.

Patient (or legal representative) name: _____

Signature: _____ Date: _____

E-mail address to be used: _____

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Please provide your pharmacy information below. This information will be used when prescriptions are given to you, so that the office staff knows where to send it.

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Secondary Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

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Patient Name: _____ Date of Birth: _____

We are committed to providing you with the best possible care. In order to contain rising costs, we need your assistance and your understanding of our payment policy.

- If you are not using insurance, payment is due at the time services are rendered.
- We accept cash, check, and all major credit cards.
- We will be happy to provide you with a copy of the charges to submit to your insurance carrier for your reimbursement.
- We cannot become part of a third-party billing situation.
- There will be a $35.00 charge for returned checks.
- Charges may also be incurred of $150.00 or more for missed appointments or appointments cancelled without 24 hours notice.
- Please note that for a New Patient visit a charge of about $395.00 may apply for no shows or cancellations without 48 hours notice.

We will gladly answer questions relating to your insurance, however we would like you to note

- Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
- Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of the UCR, which is defined as the "usual, customary, and reasonable" cost of service. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to current standards and cost of care in this area.
- If you have insurance in which we are participating, we will submit your bills after we have confirmed your coverage. Please present your current proof of insurance prior to your appointment.
- Not all procedures or practitioners are covered by the different plans. We will try to help you determine what is covered. However, if your insurance company denies the claim, you will be responsible for payment.
- You must make all co-payments at the time of service
- Insurance credits will be applied to your account balance, and will not be refunded until your account is paid in full.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact the office promptly for assistance in the management of your account.

By signing below, I acknowledge that I have read the Financial and Cancellation Policy above, and understand it, and agree to the terms set forth, including my personal responsibility for all bills incurred at W. David Luce, M.D., P.C.

Patient Signature: _____ **Date:** _____

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Lab and Testing Agreement

Patient Name: _____ Date of Birth: _____

You may be advised to have laboratory testing done based on the problems and goals that you have discussed with Dr. Luce. The testing will help to determine your diagnosis and may also dictate what treatment is prescribed.

Although we try to order testing that is only necessary to guide correct treatment or to establish a diagnosis, payment for laboratory testing is totally up to the insurance company. We cannot predict whether or not your insurance company will pay for the testing we order from private laboratories.

We will not be held responsible in any way if your insurance company refuses to pay for some of the testing ordered from our office.

If you have concerns about the testing that we've ordered, or if you have concerns about whether or not your insurance company will pay for the testing, we urge you to ask any questions before you get your blood drawn. There will be a 15% restocking fee on any specialty test kit that is returned to our office within 90 days of purchase. After 30 days, the test kit is non-refundable.

Dr. Luce may also recommend supplements for you to use. We sell many of the supplements at our office, and most of these are available elsewhere. It is your choice where you purchase these items.

If you choose to purchase supplements from our office, please be advised that we are unable to accept returns, or to issue refunds.

By signing below, you acknowledge that Dr. Luce has discussed the testing you are to receive and the supplements he has recommended. You understand that any uncovered portions of the testing will be your responsibility to work out with your insurance company and not W. David Luce, M.D., P.C., nor the employees of W. David Luce, M.D., P.C.

I acknowledge that I have read the above acknowledgements that I am choosing to do in accordance with my treatment plan with Dr. W. David Luce, M.D., P.C.

Patient Signature: _____ **Date:** _____

Office Signature: _____ **Date:** _____

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Privacy Rights and Release

Patient Name: _____ Date of Birth: _____

Your Rights Regarding the Privacy of Your Health Information

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to

- Request restrictions on certain uses and disclosures. However, W. David Luce is not obligated to agree to requested restrictions.
- Receive confidential communications of protected health information
- Inspect and copy your protected health information with some limited exceptions;
- Amend your health information;
- Receive an accounting of disclosures of your health information
- Obtain a copy of this notice;

W. David Luce, MD, PC, Duties Regarding the Privacy of Your Health Information

Subject to limitations outlined by law, W. David Luce, MD, has certain duties related to your protected health information, including:

- Maintaining the privacy of protected health information and providing individuals with notice of our legal duties and privacy practices with respect to protected health information;
- Abiding by the terms of the privacy notice that is currently in effect;
- W. David Luce, MD, reserves the right to change a privacy practice described in this notice and to make such change effective for all health information. Revised notice will be posted in our office and available upon request.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting the Office Manager or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

Acknowledgement

I acknowledge that I have received a copy of this notice regarding the use and disclosure of my health information.

Patient Signature: _____ **Date:** _____

Persons Allowed Access to Medical Information

By checking the following, I hereby allow access to my medical information. I allow this/these person/s to discuss my information with W. David Luce, MD, PC. This is done with my full knowledge of the HIPAA Privacy Regulations.

☐ No One

☐ Please List Name and Relation of Person/s Allowed Access

_____

_____

_____

_____

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Name: _____ Date: _____ Age: _____ Birth Date: _____
Height _____ Weight: _____ Occupation: _____

Main Reason for Visit

Do you consider your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor *Check one*
What is your outlook on life in general? ☐ Excellent ☐ Good ☐ Fair ☐ Poor *Check one*

What health concerns, symptoms, complaints, and/or goals would you like to have discussed.

A. _____

B. _____

C. _____

Previous/Present Doctors: _____
List, with specialty: _____

Past Medical History

☐ **Yes Have you ever been hospitalized or had major surgery?**
Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____

☐ **Yes Have you had any of the following?**
Broken bones: _____
Accidents: _____
Head Injury: _____
Serious Illness: _____
Blood Transfusion: _____

Medications and Allergies

☐ **Yes Are you allergic or sensitive to any medication, drug, or substance?** *Please list:*

☐ **Yes Have you been exposed to any of the following?** *Please check all that apply:*
☐ Chemicals ☐ Radiation ☐ Paints ☐ Fumes ☐ Dust ☐ Solvents
Unpurified: ☐ Water ☐ Food Travel to: ☐ 3rd World country ☐ Wilderness area
Other: _____

List all medications you are taking: *(include over the counter drugs and birth control, past or present)*
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____

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List any vitamin, herb or supplement you are taking:

Name: _____ Dose: _____ Reason: _____
Name: _____ Dose: _____ Reason: _____
Name: _____ Dose: _____ Reason: _____
Name: _____ Dose: _____ Reason: _____

Family

Describe any major illness or disease that a member of your family has/had. Indicate relationship, age, and overall health. *(i.e. cancer, heart disease, depression, drug/alcohol, epilepsy, high blood pressure, mental illness, obesity, stroke, etc…)*

Age	Relationship	Overall Health	Illness
		.	
		.	
		.	
		.	
		.	

Do you live: ☐ With Family ☐ Alone ☐ With roommate(s) ☐ In a care facility
Are you married? _____ Do you consider your marriage to be: ☐Excellent ☐Good ☐Fair ☐ Poor
Do you have children? _____ *If yes, please list below*

Name	Age	Sex	Health
		____	_____
		____	_____
		____	_____
		____	_____
		____	_____

Lifestyle

Do you smoke? ☐ Yes ☐No How much?_____ Date Quit: _____
Do you get regular exercise? _____ How often? _____
Aerobic: Type: _____ Duration: _____
Resistance: Frequency: _____ Duration: _____
What do you do to relax? _____
Do you fall asleep easily and soundly? _____ *Explain:* _____
What time do you: Go to bed?_____ Awaken? _____ *Explain:* _____
Do you live in a healthy environment? _____
☐Home ☐Apartment ☐Mobile Home ☐Condo/Townhome ☐Other
Explain: _____
Do you work in a healthy environment? _____ *Explain:*
What is your source of drinking water? ☐Filtered ☐Bottled ☐Municipal ☐Well
What is your total daily water intake per day?_____ Is it adequate?_____
(Recommend at least ½ ounce per lb of body weight. E.g. if you weigh 140 lbs, then 70oz of water is recommended)

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What else do you drink?

Drink	Type(s)	Times/d-wk-mo
Soda Pop		
Juice		
Milk		
Tea		
Coffee		
Alcohol		

Do you feel you have a drinking problem? *Explain:*

Do you have an adequate energy level? _____ *Explain:*
Are you presently sexually active?_____ Sexual Preference (optional):
How many times to you urinate each day?_____ Does it burn?
Do you get up at night to urinate? Do you have a urinary tract infection?
Do you have at least 2 bowel movements per day?_____ If no, how many per day?
What is the color of your bowel movement? ☐Brown ☐Green ☐Yellow or Red ☐Black
What is the consistency? ☐Soft ☐Hard ☐Medium *Comments?*
How many hours per week do you work?_____ Are you satisfied with your job?
How many hours per week do you have for free time?
What is your favorite pastime/hobby?

Diet

Are you on a diet or do you diet frequently? _____ *Explain:*
Diet name/type: Recommended by:
Has this been successful? _____ *Explain:*
Do you maintain a healthy diet? _____ *Explain:*
Do you regularly eat:

Meal	Yes/No	What Time?	Sample of Typical Meal
Breakfast?	-		
Lunch?	-		
Dinner?	-		
Snacks?	-		

Processed Foods? *Describe:*

Which of the following five food groups do you prefer to eat the most?
☐Meat, eggs, beans ☐Vegetables ☐Fruits ☐Dairy Products ☐Breads, grains, cereals

Which of the following five food groups would you be most likely to skip?
☐Meat, eggs, beans ☐Vegetables ☐Fruits ☐Dairy Products ☐Breads, grains, cereals

Do you have a problem with gas/belching? _____ *Explain:*
Do any foods cause you discomfort? _____ *List:*
Are you allergic to any foods? _____ *Explain:*

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Which of the following foods do you regularly eat and how often? (indicate portion size if oz is unknown)

	Food - Servings	Per Day	Per Week	Oz/serving	Portion Size(sm, med, lg)
High Protein Foods	Beef				
	Pork				
	Poultry				
	Fish				
	Cheese				
	Eggs				
	Nuts				
	Whole grains				
	Beans/peas				
	Tofu				
High Calcium Foods	Sardines				
	Salmon				
	Milk				
	Buttermilk				
	Yogurt				
	Cottage Cheese				
	Soft Cheeses				
	Hard Cheeses				
Oxalate	Spinach				
	Beet Greens				
	Rhubarb				
	Swiss chard				
Purine	Liver				
	Kidney				
	Sweetbreads				
	Fish roe				
High Citrate Foods	Lemons (whole)				
	Lemon juice				
	Oranges (whole)				
	Orange juice				
	Grapefruit (whole)				
	Grapefruit juice				
Carbohydrates	Potatoes				
	Bread				
	Rice				
	Pasta				
	Cereals				
	Cake, Pies				
	Cookies				
	Ice Cream				
Fats	Margerine				
	Butter				
	Yoghurt Spread				
	Vegetable oil				
	Olive oil				
	Cream				

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Health Checklist

Please indicate if you Currently have, or have had in the Past, the following conditions:

P C

General
- ☐ ☐ Fever, chills, sweats
- ☐ ☐ Night Sweats
- ☐ ☐ Fatigue
- ☐ ☐ Nervousness/anxiety
- ☐ ☐ Irritability
- ☐ ☐ Depression
- ☐ ☐ Generally feel "run down"
- ☐ ☐ Sexual abuse (opt.)
- ☐ ☐ Emotional abuse (opt)
- ☐ ☐ Loss of weight

Skin
- ☐ ☐ Non-healing sore
- ☐ ☐ Hives, rash
- ☐ ☐ Eczema, psoriasis
- ☐ ☐ Frequent inf, or boils
- ☐ ☐ Abnormal pigmentation
- ☐ ☐ Moles
- ☐ ☐ Warts
- ☐ ☐ Oral herpes
- ☐ ☐ Genital herpes
- ☐ ☐ Shingles
- ☐ ☐ Skin cancer or melanoma
- ☐ ☐ Brittle or weak nails

Endocrine
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid disease
- ☐ ☐ Heat or cold intolerance
- ☐ ☐ Dry skin
- ☐ ☐ Change in hair growth/texture
- ☐ ☐ Excessive thirst or urination
- ☐ ☐ Sexual problems
- ☐ ☐ Hormone Therapy
- ☐ ☐ Low or high sex drive
- ☐ ☐ Radiation to neck or face area
- ☐ ☐ Low blood sugar

Head/Eyes/Ears/Nose/Throat
- ☐ ☐ Sinus headache
- ☐ ☐ Tension headache
- ☐ ☐ Migraine headache
- ☐ ☐ Head feels "heavy
- ☐ ☐ Loss of memory
- ☐ ☐ Light bothers eyes
- ☐ ☐ Light-headedness/"spaciness"
- ☐ ☐ Eye disease or injury
- ☐ ☐ Blurry vision
- ☐ ☐ Double vision
- ☐ ☐ Loss of vision
- ☐ ☐ Glaucoma, cataracts
- ☐ ☐ Loss of balance
- ☐ ☐ Dizziness or Vertigo
- ☐ ☐ Loss of hearing
- ☐ ☐ Ear disease
- ☐ ☐ Impaired hearing
- ☐ ☐ Ring/buzz in ears
- ☐ ☐ Ear pain
- ☐ ☐ Discharge from ear
- ☐ ☐ Runny nose
- ☐ ☐ Nosebleeds
- ☐ ☐ Chronic sinus trouble
- ☐ ☐ Snoring
- ☐ ☐ Sore throats
- ☐ ☐ Hoarseness
- ☐ ☐ Tooth/gum problems
- ☐ ☐ Loss of taste
- ☐ ☐ Sores in mouth
- ☐ ☐ Sore tongue

Respiratory
- ☐ ☐ Frequent "colds"
- ☐ ☐ Difficulty breathing
- ☐ ☐ Chronic/frequent cough
- ☐ ☐ Asthma/wheezing
- ☐ ☐ Emphysema
- ☐ ☐ Spitting up blood
- ☐ ☐ Pain with breathing
- ☐ ☐ Pneumonia
- ☐ ☐ Coughing up sputum

Cardiovascular
- ☐ ☐ High Blood Pressure
- ☐ ☐ Palpitation, irregular HB
- ☐ ☐ Rheumatic fever
- ☐ ☐ Chest pain (angina)
- ☐ ☐ Shortness of breath/walking
- ☐ ☐ Difficulty walking 2 blocks
- ☐ ☐ Heart trouble
- ☐ ☐ Heart attack
- ☐ ☐ Swelling of hands/feet/
- ☐ ☐ Pain in calves w/ walking
- ☐ ☐ Need more than one pillow
- ☐ ☐ Varicose veins

Hematologic
- ☐ ☐ Anemia
- ☐ ☐ Phlebitis/blood clots
- ☐ ☐ Cuts/bruises slow to heal
- ☐ ☐ Excessive bleeding after surgery
- ☐ ☐ Mononucleosis

Gastrointestinal
- ☐ ☐ Heartburn/indigestion
- ☐ ☐ Food sticks in throat
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Vomiting blood or food
- ☐ ☐ Ulcer (stomach or duodenal)
- ☐ ☐ Gallbladder disease or stones
- ☐ ☐ Liver trouble/hepatitis
- ☐ ☐ Diarrhea or loose stools
- ☐ ☐ Constipation
- ☐ ☐ "Nervous" stomach
- ☐ ☐ Nausea and/or vomiting
- ☐ ☐ Bloating in stomach after eating
- ☐ ☐ Bloating or gas in lower abdomen
- ☐ ☐ Thin or ribbon-like stools
- ☐ ☐ Hard or difficult bowel movement
- ☐ ☐ Bloody or black stools
- ☐ ☐ Painful bowel movements

Genitourinary
- ☐ ☐ Involuntary loss of urine
- ☐ ☐ Frequent urination
- ☐ ☐ Burning or painful urination
- ☐ ☐ Blood in urine
- ☐ ☐ Straining to urinate
- ☐ ☐ Hernia
- ☐ ☐ Sexually transmitted disease
- ☐ ☐ Kidney stones
- ☐ ☐ Kidney infection

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P C

Female

- ☐ ☐ Pelvic pain or infection
- ☐ ☐ Excess discharge
- ☐ ☐ PMS
- ☐ ☐ Menstrual cramping
- ☐ ☐ Irregular cycle
- _____ Last menstrual period
- _____ Currently pregnant?
- _____ Age periods started
- _____ Duration of periods in days
- _____ Frequency of periods
- _____ Number of pregnancies
- _____ Number of children
- _____ Number of ectopic pregnancies
- _____ Number of miscarriages
- _____ Number of abortions
- ☐ ☐ DES exposure
- ☐ ☐ Uterine fibroids
- ☐ ☐ Hysterectomy
- _____ Date of menopause
- ☐ ☐ Hot flashes
- ☐ ☐ Menopausal bleeding
- ☐ ☐ Breast pain
- ☐ ☐ Breast lumps
- ☐ ☐ Nipple Discharge or bleeding

Male

- ☐ ☐ Testicular pain/swelling
- ☐ ☐ Urinary Frequency
- ☐ ☐ Difficulty starting urine stream
- ☐ ☐ Discharge from penis
- ☐ ☐ Frequent night urination
- ☐ ☐ Prostate pain/swelling
- ☐ ☐ Undescended testicle
- ☐ ☐ Impotence

P C

Mental, Emotional, Neuro

- ☐ ☐ Fainting spells
- ☐ ☐ Epilepsy/seizures
- ☐ ☐ Stroke or mini-stroke
- ☐ ☐ Paralysis
- ☐ ☐ Weakness of an arm/leg
- ☐ ☐ Insomnia/trouble sleeping
- ☐ ☐ Tendency for sadness/grief
- ☐ ☐ Tendency for anger/irritability
- ☐ ☐ Tendency for anxiety/fear
- ☐ ☐ Tendency for mental overload

Neck

- ☐ ☐ Pain
- ☐ ☐ Pain with forward movement
- ☐ ☐ Pain with backward movement
- ☐ ☐ Pain with turning movement
- ☐ ☐ Pain with bending movement
- ☐ ☐ Pinched nerve in neck
- ☐ ☐ Neck feels out of place
- ☐ ☐ Muscle spasms in neck
- ☐ ☐ Grinding sounds in neck
- ☐ ☐ Popping sounds in neck
- ☐ ☐ Arthritis in neck

Mid-back and Chest

- ☐ ☐ Mid-back pain
- ☐ ☐ Pain between shoulder blades
- ☐ ☐ Sharp stabbing pain
- ☐ ☐ Dull ache
- ☐ ☐ Pain from front to back
- ☐ ☐ Muscle spasms in mid-back
- ☐ ☐ Pain in kidney area
- ☐ ☐ Chest pain
- ☐ ☐ Shortness of breath
- ☐ ☐ Pain around ribs

Low Back

- ☐ ☐ Upper lumbar pain
- ☐ ☐ Lower Lumbar pain
- ☐ ☐ Sacroiliac pain
- ☐ ☐ Back pain is worse when working
- ☐ ☐ Worse when lifting
- ☐ ☐ Worse when stooping
- ☐ ☐ Worse when standing
- ☐ ☐ Worse when sitting
- ☐ ☐ Worse when bending
- ☐ ☐ Worse when coughing
- ☐ ☐ Worse when lying down
- ☐ ☐ Worse when walking
- ☐ ☐ Worse other( )
- ☐ ☐ Pain relieved with ice, heat
- ☐ ☐ Relieved with movement
- ☐ ☐ Relieved with physical therapy
- ☐ ☐ Relieved with topical analgesics
- ☐ ☐ Relieved with medications
- ☐ ☐ Relieved other ( )
- ☐ ☐ Slipped Disc
- ☐ ☐ Low back feels out of place
- ☐ ☐ Muscle spasms

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P	C	Past/Current	Left/Right	L	R
		Shoulders			
☐	☐	Pain in Shoulder Joint		☐	☐
☐	☐	Pain across shoulders		☐	☐
☐	☐	Bursitis		☐	☐
☐	☐	Arthritis		☐	☐
☐	☐	Can't raise arm above shoulders		☐	☐
☐	☐	Can't raise arm over head		☐	☐
☐	☐	Tension in Shoulders		☐	☐
☐	☐	Pinched Nerve in shoulders		☐	☐
☐	☐	Muscle spasm in shoulders		☐	☐
		Arms and Hands			
☐	☐	Pain in upper arm		☐	☐
☐	☐	Pain in elbow		☐	☐
☐	☐	Movement aggravates pain		☐	☐
☐	☐	Tennis elbow		☐	☐
☐	☐	Pain in forearm		☐	☐
☐	☐	Pain in hands		☐	☐
☐	☐	Pain in fingers		☐	☐
☐	☐	Feeling of pins/needles in arms		☐	☐
☐	☐	Pins/needles in fingers		☐	☐
☐	☐	Numbness in arms		☐	☐
☐	☐	Numbness in fingers		☐	☐

P	C	Past/Current	Left/Right	L	R
☐	☐	Fingers go to sleep		☐	☐
☐	☐	Hands cold		☐	☐
☐	☐	Swollen joints in fingers		☐	☐
☐	☐	Sore joints in fingers		☐	☐
☐	☐	Arthritis in fingers		☐	☐
☐	☐	Loss of grip strength		☐	☐
		Hips, Legs, and Feet			
☐	☐	Pain in buttocks		☐	☐
☐	☐	Pain in hip joint		☐	☐
☐	☐	Pain down leg		☐	☐
☐	☐	Knee pain		☐	☐
☐	☐	Leg cramps		☐	☐
☐	☐	Cramps in feet		☐	☐
☐	☐	Pins/Needles in legs		☐	☐
☐	☐	Numbness of leg		☐	☐
☐	☐	Numbness of feet		☐	☐
☐	☐	Numbness of toes		☐	☐
☐	☐	Feet feel cold		☐	☐
☐	☐	Swollen ankles		☐	☐
☐	☐	Swollen feet		☐	☐

P	C	**Theurapeutic Techniques**
☐	☐	Acupuncture
☐	☐	Herbal medicine
☐	☐	Homeopathy/Bach flower
☐	☐	Hellerwork
☐	☐	Rolfing/Structural Integration
☐	☐	Massage
☐	☐	Chiropractor
☐	☐	Psychotherapy (optional)
☐	☐	Visualization/Guided imagery
☐	☐	Biofeedback
☐	☐	Feldenkrais

P	C	
☐	☐	Raiki
☐	☐	Polarity
☐	☐	Tragerwork
☐	☐	Craniosacral Therapy
☐	☐	Osteopathic
☐	☐	Physical Therapy
☐	☐	Therapeutic Exercise
☐	☐	Movement Therapy
☐	☐	Nutrition
☐	☐	Other

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Rate each of the following symptoms based upon your typical health profile for the <u>past 30 days.</u>

Point scale:
0 – *Never* or *almost never* have the symptom
1 – *Occasionally* have it, effect is *not severe*
2 – *Occasionally* have it, effect is *severe*
3 – *Frequently* have it, effect is *not severe*
4 – *Frequently* have it, effect is *severe*

HEAD
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia

TOTAL:

EYES
- ☐ Watery or Itchy eyes
- ☐ Swollen, reddened or sticky eyelids
- ☐ Bags or dark circles under eyes
- ☐ Blurred or tunnel vision

TOTAL:

NOSE
- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Hay fever
- ☐ Sneezing attacks
- ☐ Excessive mucus formation

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:

SKIN
- ☐ Acne
- ☐ Hives, rashes, dry skin
- ☐ Hair loss
- ☐ Flushing, hot flashes
- ☐ Excessive sweating

TOTAL:

HEART
- ☐ Irregular or skipped heartbeat
- ☐ Rapid or pounding heartbeat
- ☐ Chest pain

TOTAL:

LUNGS
- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing

TOTAL:

DIGESTIVE TRACT
- ☐ Nausea, vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloated feeling
- ☐ Belching, passing gas
- ☐ Heartburn
- ☐ Intestinal/stomach pain

TOTAL:

JOINT/MUSCLE
- ☐ Pain or aches in joints
- ☐ Arthritis
- ☐ Stiffness, Limited movement
- ☐ Pains or aches in muscles
- ☐ Feeling of weakness or tired

TOTAL:

WEIGHT
- ☐ Binge eating/drinking
- ☐ Craving certain foods
- ☐ Excessive weight
- ☐ Compulsive eating
- ☐ Water retention
- ☐ Underweight

TOTAL:

ENERGY/ACTIVITY
- ☐ Fatigue, sluggishness
- ☐ Apathy, lethargy
- ☐ Hyperactivity
- ☐ Restlessness

TOTAL:

MIND
- ☐ Poor memory
- ☐ Confusion, poor comprehension
- ☐ Poor concentration
- ☐ Poor physical coordination
- ☐ Difficulty in making decisions
- ☐ Stuttering or stammering
- ☐ Slurred speech
- ☐ Learning disabilities

TOTAL:

OTHER
- ☐ Frequent illness
- ☐ Frequent or urgent urination
- ☐ Genital itch or discharge

TOTAL:

GRAND TOTAL:

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DIET DIARY

Please list everything you eat or drink for three full days.

Day One	
Breakfast	
Lunch	
Dinner	
Snacks	

Day Two	
Breakfast	
Lunch	
Dinner	
Snacks	

Day Three	
Breakfast	
Lunch	
Dinner	
Snacks	

How many times a week do you eat in a restaurant? Breakfast Lunch Dinner
What type of restaurant? _____
Do you crave sweets? _____ When? _____
Do you salt your food? _____ Before or after tasting? _____
Favorite foods? _____ Food dislikes? _____

Are you presently on a specific type of diet? _____
Do you feel good about your weight? _____
Would you like to increase or decrease your weight? _____
When did you last have a significant weight change? _____

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TIMELINE

Please write a brief timeline, in outline form, of your own history. Begin with birth or early childhood, include major illnesses, injuries, or hospitalizations, significant turning points or major events in your life, any periods of heavy usage of alcohol, cigarettes, coffee, and pharmaceutical or recreational drugs. For women, please include events related to your reproductive system (first period, pregnancies, abortions, birth control, menopause, etc.). If you are filling this out for your child, please include any notable information about the pregnancy and nursing.

Birth:
Childhood:
Teen Years:
Adult Years:
Middle Years:
Senior Years:

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Please shade the areas where you are experiencing pain in the following diagram.