INITIAL INTAKE FORM

Date: _____

The intake process is comprehensive and important for many reasons. Our goal is to learn as much about YOU as we can in order to:

- Determine the PATTERNS that led you to seek our care
- To offer you a PERSONALIZED and PRECISE path forward
- To gather information and data that will help change YOUR health care as an INDIVIDUAL

So, allow yourself at least an hour and kindly share with us the story of YOU.

PATIENT REGISTRATION

Name: _____

(last) (first) (middle)

Address: _____

(street) (city) (State) (zip)

DoB: _____

DD/MM/YYYY

Gender: ☐Male ☐Female

☐ Other: _____

In order to understand genetic predispositions, please list your Ethnicity/Race:

How did you hear about us?

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Email: _____

Employer: _____

Address: _____

(street)

_____

(city) (state) (zip)

☐ Married ☐ Single ☐ Divorced (Year: _____) ☐ Widowed (Year: _____)

Present marriage/# of years: _____ Previous marriage/# of years: _____

Education:_____

Spouse Occupation: _____

Do you have a living will/Advanced Directive/POLST? ☐ No ☐ Yes (please provide a copy)

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SPOUSE/NEXT OF KIN DETAILS

Spouse/Next of Kin Name:

_____

Mobile Phone:

_____

Work Phone:

_____

Email:

_____

Spouse/Next of Kin Employer:

_____

Address:

_____

(street)

(city) (state) (zip)

Children Names & Ages, Living at home?

PRIMARY CARE PROVIDER & INSURANCE INFORMATION

Primary Care Provider
Name:_____

Address:

_____

(Street) (city) (State) (zip)

Phone: _____ Fax: _____

Referring Physician (if not PCP)

Address:

_____

(Street) (city) (State) (zip)

Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of friend/relative not living with you:

_____

Address: _____

(Street) (city) (State) (zip)

Phone: _____ Relationship to you: _____

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INSURANCE INFORMATION

Name of Insured:

_____

(last) (First) (middle)

Relationship to Parent: _____ Phone: _____

Address:

_____

(Street) (city) (State) (zip)

Name of Employer: _____ Work Phone: _____

Primary Insurance Company:

_____

ID#: _____ Group #: _____

Address:

_____

(Street) (city) (State) (zip)

*Many therapies, tests, diagnostics offered may not be covered by insurance and may be out of pocket expenses that will be up to the patient to do their due diligence and confirm with their insurance company.

Secondary Insurance Company:

_____

ID#: _____ Group #: _____

Address:

_____

(Street) (city) (State) (zip)

Are you able to commit to a 3-hour IV infusion on Monday, Wednesday, and Friday? ☐ No ☐ Yes

*Please be aware that therapies often required to enhance clinical outcomes may require a time commitment as well as a financial one.

Primary Language: _____Preferred Language of Communication (if different): _____

Needs Interpreter: ☐ No ☐ Yes (comfortable communicating with English)

Should We Contact Someone to Obtain Your Records?

	Physician/Hospital/Other Facility	Physician/Hospital/Other Facility	Physician/Hospital/Other Facility
Name			
Address			
Telephone			
Study (CT, MRI, Biopsy, etc)			

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PERSONAL HABITS

Are you motivated to make necessary diet and lifestyle changes to enhance your outcomes? ☐ No ☐ Yes

Please rate your motivation on a scale of 1 – 10, 10 being the most motived: _____

Do you have an instinct on what might have contributed to your diagnosis and current health issues? Please explain.

*If more space needed please attach list to this page

_____

_____

_____

_____

_____

_____

THREE DAY DIET ACCOUNT

Please give a detailed account of your diet for the last three days including brand, amount, whether or not organic, gluten free, etc.

Day 1:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Medical Food Supplements: (Examples: Ensure, Pulmocare, KetoKind, KetoCal) _____

Day 2:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Medical Food Supplements: (Examples: Ensure, Pulmocare, KetoKind, KetoCal) _____

Day 3:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

METABOLIC TERRAIN INSTITUTE OF HEALTH

Medical Food Supplements: (Examples: Ensure, Pulmocare, KetoKind, KetoCal) _____

Do you count your macronutrients with an app like Cronometer or MyFitnessPal? ☐No ☐Yes

Do you test your blood glucose levels ☐No ☐Yes If Yes, what are your levels on average?_____

Do you test your urine ketone levels ☐No ☐Yes If Yes, what are your levels on average? _____

Do you test your blood ketone levels ☐No ☐Yes If Yes, what are your levels on average?_____

Do you test your breath ketone levels ☐No ☐Yes If Yes, what are your levels on average? _____

Do you use Tobacco? ☐No ☐Yes If yes, How many packs/chew/pipe each day? _____

# of years? _____ or year quit: _____

Alcohol? ☐No ☐Yes If yes, what kind? _____How many per week? _____

Have you ever used 'street' (illegal) intravenous drugs? ☐No ☐Yes

Have you ever been tested for the HIV/AIDS virus ☐No ☐Yes If yes, what was the result? _____

Have you ever been tested for Hepatitis? ☐No ☐Yes If yes, what was the result? _____

Allergies: (Medications, food, dust pollen, etc.)

_____

_____

_____

_____

CURRENT MEDICATIONS (include non-prescription):

Name of Medication	Strength of Dose (mg)	Intake Method	Frequency Taken	Time of Last Dose	Reason for Use

METABOLIC TERRAIN INSTITUTE OF HEALTH

LIFESTYLE FACTORS

Please circle ALL the factors that apply to your previous OR current lifestyle and eating habits, circle (P)revious, (C)urrent, circle both if applies or leave as is if neither apply:

P / C : Fast eater P / C : ❑ Erratic eating pattern P / C: Eat too much P / C: Late night eating

P / C: Dislike healthy food P / C: Time constraints P / C: Eat more than 50% meals away from home

P / C: Travel frequently P / C: Non-availability of healthy foods P / C: Do not plan meals or menus

P / C: Poor snack choices P / C: Love to eat P / C: Eat because I have to

P / C: Have a negative relationship to food P / C: Struggle with eating issues

P / C: Emotional eater (eat when sad, lonely depressed, bored). P / C: Reliance on convenience items

P / C: Eat too much under stress Eat too little under stress P / C: Don't care to cook

P / C: Eating in the middle of the night P / C: Confused about nutrition advice

P / C: Significant other or family members don't like healthy foods

P / C: Significant other or family members have special dietary needs or food preference

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

EXERCISE Current exercise program: (List type of activity, number of sessions/weeks, and duration)

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (Yoga, Pilates, etc.)			
Sports			
Leisure Activities			

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

List problems that limit activity:

HEALTH CONCERNS

In order of importance, list your health concerns. Include physical, emotional and psychological.
Please add more lines on the back if needed.

RANK	HEALTH CONCERN	DATE BEGAN
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

FAMILY MEDICAL HISTORY

ALL ABOUT YOUR PARENTS

Fill out the forms below with your biological (birth) parents' information (living and deceased).

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

ALL ABOUT YOUR SIBLINGS

Fill out the forms below with your siblings' information (living and deceased).

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

Name:

Relationship:

Date of birth:

Blood type:

Ethnic origin:

Known health problems:

Onset age:

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?

☐ Stroke ☐ Other

☐ Other ☐ Other

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?

If yes, of what cause?

List any questions or concerns you may have about their medical history:

Name:

Relationship:

Date of birth:

Blood type:

Ethnic origin:

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

ALL ABOUT YOUR PATERNAL GRANDPARENTS

Fill out the forms below with your paternal grandparents' information (living and deceased).

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

ALL ABOUT YOUR MATERNAL GRANDPARENTS

Fill out the forms below with your maternal grandparents' information (living and deceased).

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin: _____

Known health problems: _____

_____

_____

Onset age: _____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind? _____

☐ Stroke ☐ Other _____

☐ Other _____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age? _____

If yes, of what cause? _____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

Name: _____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin: _____

Known health problems: _____

_____

_____

Onset age: _____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind? _____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

ALL ABOUT YOUR PATERNAL UNCLES

Fill out the forms below with your paternal grandparents' information (living and deceased).

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

ALL ABOUT YOUR MATERNAL UNCLES

Fill out the forms below with your maternal grandparents' information (living and deceased).

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

ALL ABOUT YOUR PATERNAL AUNTS

Fill out the forms below with your paternal grandparents' information (living and deceased).

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

_____

_____

_____

_____

ALL ABOUT YOUR MATERNAL AUNTS

Fill out the forms below with your maternal grandparents' information (living and deceased).

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

_____

_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

Name:_____

Relationship: _____

Date of birth: _____

Blood type: _____

Ethnic origin:_____

Known health problems:_____

Onset age:_____

☐ Alcohol abuse ☐ Drug Abuse ☐ Allergies ☐ Asthma ☐ Depression

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol

☐ Mental Illness ☐ Cancer, If yes, what kind?_____

☐ Stroke ☐ Other _____

☐ Other_____ ☐ Other _____

Does he or she smoke? ☐ Yes ☐ No Is he or she deceased? ☐ Yes ☐ No

If yes, at what age?_____

If yes, of what cause?_____

List any questions or concerns you may have about their medical history:

CANCER SPECIFIC HISTORY & PHYSICAL

Have you been diagnosed with cancer: ☐ No ☐ Yes

If Yes what type: _____

If Yes which institution/clinic/hospital treated you: _____

Onset of illness: _____ Date: _____

Initial Symptoms: _____

Current Symptoms: _____

_____

Do you have any know genetic/predisposition to disease? ☐ No ☐ Yes

If Yes please explain: _____

Are you currently enrolled in a clinical trial? ☐ No ☐ Yes Have you ever participated in clinical trial? ☐ No ☐ Yes

If Yes where was the trial conducted? _____

Dates of enrollment in clinical trial: _____

Have you ever received corticosteroids (Celestone, Prednisone, Intensol, Orapred, Prelone, Dexamethasone)?

☐ No ☐ Yes, If Yes where did you receive the corticosteroid: _____

Dates: _____

Have you ever received non-steroidal anti-inflammatory drugs (Aleve, Tylenol, aspirin, ibuprofen Oxaprozin, Etodolac, Naproxen, Indomethacin) therapy? ☐ No ☐ Yes If Yes, Where: _____ Dates: _____

_____

_____

_____

Please list past surgeries or biopsies including where (facility) surgery was performed and dates:
*If more space needed please attach list to this page

_____

_____

_____

Did you have your tissue sent off for pathology? ☐ No ☐ Yes ☐ I don't know
If Yes, please share the highlights and attach reports.

_____

Was fresh tissue obtained for molecular profiling and/or tumor genomics? ☐ No ☐ Yes ☐ I don't know

Fresh liquid blood biopsy obtained for molecular profiling, tumor genomics and circulating tumor cell count?

☐ No ☐ Yes ☐ I don't know

Were initial tumor markers obtained prior to surgery or initiating treatment? If Yes, which ones and were they elevated?
☐ No ☐ Yes ☐ I don't know

Have you ever received Hormone Therapy? (e.g. birth control pills, bHRT, HRT, NuvaRing) ☐ No ☐ Yes ☐ I don't know

If Yes, Where:

_____

Dates:_____

Have you ever had Mistletoe (Viscum Album Extract/VAE) Therapy? ☐No ☐Yes ☐ I don't know

If Yes,
Where:_____

In regards to mistletoe, what form (tree host), dose, and application such as subcutaneous, intratumoral, intravesicular, IV etc.:

_____

Dates: _____

Have you ever had Chemotherapy? ☐No ☐Yes ☐ I don't know

If Yes, Where:

_____

Which therapy, and how many treatments?

_____

Dates:

_____

Medical Oncologist Name:

_____

Address:

_____

(Street) (city) (State) (zip)

Have you ever had Immunotherapy for any disease or treatment ☐No ☐Yes ☐ I don't know

If Yes, Where:

_____

Was the MDA Prognostic Score for response to immune therapies done prior to use of this treatment?
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5886120/

☐No ☐Yes ☐ I don't know

Which therapy, how many treatments?

_____

Dates:

_____

What was your experience with it?

_____

_____

_____

Have you ever received hormone blocking therapies? (SERMs like Tamoxifen, AI's like Arimidex, ADT such as Zoladex, Casodex, Zytiga, or Lupron?) treatment ☐No ☐Yes ☐ I don't know

Have you received bone metastasis treatment and prevention therapies like bisphonate drugs like Zometa and denosumab?

☐No ☐Yes ☐ I don't know

Have you ever had targeted therapy for any disease or treatment ☐ No ☐ Yes ☐ I don't know
Examples: Herceptin, Parjeta, Avastin, Everolimus, Gleevac

If Yes, which and how many treatments? _____

Where: _____

Dates:

_____

What was your experience with it?

_____

_____

_____

_____

_____

How many X-Rays have you received?_____ PET scans?_____ CT scans?_____ Mammography?_____
DEXA?_____

Have your ever-received Radiation Therapy? ☐ No ☐ Yes ☐ I don't know

Radiation Oncologist Name: _____

Where: _____ Date: _____

What area received radiation therapy? _____

What was your experience with it? _____

Have you ever been diagnosed with an autoimmune disease (e.g. Psoriasis, Lupus, Crohn's Disease, Ulcerative Colitis)

☐ No ☐ Yes If Yes, what was your diagnosis: _____

Date of diagnosis: _____ Treatment offered: _____

What was your experience with the treatment?_____

_____

SYMPTOM REVIEW

Please circle ALL current symptoms, circle (P)revious, (C)urrent, circle both if applies or leave as is if neither apply:

GENERAL

P / C: Cold Hands & Feet
P / C: Cold Intolerance
P / C: Low Body Temperature
P / C: Low Blood Pressure
P / C: Daytime Sleepiness
P / C: Difficulty Falling Asleep
P / C: Early Waking
P / C: Fatigue
P / C: Fever
P / C: Flushing
P / C: Heat Intolerance
P / C: Night Waking
P / C: Nightmares
P / C: No Dream Recall

HEAD, EYES & EARS

P / C: Conjunctivitis
P / C: Distorted Sense of Smell
P / C: Distorted Taste
P / C: Ear Fullness
P / C: Ear Pain
P / C: Ear Ringing/Buzzing
P / C: Lid Margin Redness
P / C: Eye Crusting
P / C: Eye Pain
P / C: Hearing Loss
P / C: Hearing Problems
P / C: Headache
P / C: Migraine
P / C: Sensitivity Loud Noises
P / C: Vision problems
P / C: Macular Degeneration
P / C: Vitreous Detachment
P / C: Retinal Detachment

MUSCULOSKELETAL

P / C: Back Muscle Spasm
P / C: Calf Cramps
P / C: Chest Tightness
P / C: Foot Cramps
P / C: Joint Deformity
P / C: Joint Pain
P / C: Joint Redness
P / C: Joint Stiffness
P / C: Muscle Pain
P / C: Muscle Spasms
P / C: Muscle Stiffness
P / C: Muscle Twitches Eyes
P / C: Muscle Twitches Arms
P / C: Muscle Twitches Legs
P / C: Muscle Weakness
P / C: Neck Muscle Spasm
P / C: Tendonitis
P / C: Tension Headache
P / C: TMJ Problems

MENTAL/EMOTIONAL

P / C: Agoraphobia
P / C: Anxiety
P / C: Auditory Hallucinations
P / C: Black-out
P / C: Depression
P / C: Fearfulness
P / C: Irritability
P / C: Paranoia
P / C: Suicidal Thoughts
P / C: Tremor/Trembling
P / C: Visual Hallucinations

Have you ever been diagnosed with a mental illness?_____ If so, what and how treated?

NEUROLOGICAL Difficulty with:

P / C: Concentrating
P / C: With Balance
P / C: With Thinking
P / C: With Judgment
P / C: With Speech
P / C: With Memory
P / C: Dizziness (Spinning)
P / C: Numbness
P / C: Fainting
P / C: Seizures
P / C: Light-headedness
P / C: Tingling

EATING

P / C: Binge Eating
P / C: Bulimia
P / C: Can't Gain Weight
P / C: Anorexia
P / C: Nausea
P / C: Vomiting
P / C: Can't Lose Weight
P / C: Can't Maintain Healthy Weight
P / C: Frequent Dieting
P / C: Poor Appetite
P / C: Salt Cravings
P / C: Chocolate Cravings
P / C: Caffeine Dependency
P / C: Carbohydrate Craving (breads, pastas)
P / C: Sweet Cravings (candy, cookies, cakes)

DIGESTION

P / C: Anal Spasms
P / C: Bad Teeth
P / C: Bleeding Gums
P / C: Bloating Lower Abdomen
P / C: Bloating Whole Abdomen
P / C: Bloating After Meals
P / C: Blood in Stools
P / C: Burping
P / C: Canker Sores
P / C: Cold Sores
P / C: Constipation
P / C: Cracking Corner of Lips
P / C: Cramps
P / C: Dentures w/Poor Chewing
P / C: Diarrhea
P / C: Difficulty Swallowing
P / C: Rectal Itching
P / C: Alternating Diarrhea/Constipation
P / C: Dry Mouth
P / C: Excess Flatulence/Gas
P / C: Fissures
P / C: Foods: Repeat (Reflux)
P / C: Foods: Gas
P / C: Foods: Heartburn
P / C: Hemorrhoids
P / C: Foods: Indigestion
P / C: Foods: Nausea
P / C: Foods: Upper Abdominal Pain
P / C: Foods: Vomiting
P / C: Lactose Intolerance
P / C: Intolerance All Dairy
P / C: Intolerance Wheat
P / C: Intolerance Gluten
P / C: Intolerance Corn
P / C: Intolerance Eggs
P / C: Intolerance Fatty Foods
P / C: Intolerance Yeast
P / C: Abnormal Liver Function Tests
P / C: Lower Abdominal Pain
P / C: Mucus in Stools
P / C: Periodontal Disease
P / C: Sore Tongue
P / C: Strong Stool Odor
P / C: Undigested Food in Stool
P / C: Liver Disease/Jaundice (Yellow Eyes or Skin)

Have you ever been diagnosed with a GI disease like IBD, UC, IBS, CRC:_____

SKIN PROBLEMS

P / C: Acne on Back
P / C: Acne on Chest
P / C: Acne on Face
P / C: Acne on Shoulders
P / C: Athlete's Foot
P / C: Bumps Back Upper Arms
P / C: Cellulite
P / C: Dark Circles Under Eyes
P / C: Ears Get Red
P / C: Easy Bruising
P / C: Lack of Sweating
P / C: Eczema
P / C: Hives
P / C: Jock Itch
P / C: Lackluster Skin
P / C: Moles w/Color/Size Change
P / C: Oily Skin
P / C: Pale Skin
P / C: Patchy Dullness
P / C: Rash
P / C: Red Face
P / C: Sensitivity to Bites
P / C: Sensitivity to Poison Ivy/Oak
P / C: Skin Tags
P / C: Shingles
P / C: Skin Darkening
P / C: Strong Body Odor
P / C: Hair Loss
P / C: Vitiligo
P / C: Sunburns easily
P / C: Crepe-like Skin

ITCHING SKIN

P / C: Skin in General
P / C: Anus
P / C: Arms
P / C: Ear Canals
P / C: Eyes
P / C: Feet
P / C: Hands
P / C: Legs
P / C: Nipples
P / C: Nose
P / C: Penis
P / C: Roof of Mouth
P / C: Scalp
P / C: Throat

SKIN, DRYNESS OF

P / C: Eyes
P / C: Feet Cracking?
P / C: Feet Peeling?
P / C: Hair Unmanageable?
P / C: Hands Cracking?
P / C: Hands Peeling?
P / C: Mouth/Throat
P / C: Scalp Dandruff?
P / C: Skin In General

LYMPH NODES

P / C: Enlarged/neck
P / C: Tender/neck
P / C: Other Enlarged/Tender
P / C: Lymph Nodes

Please describe regions where you have enlarged lymph nodes (can be groin, abdomen, supraclavicular area, behind ears, etc.:_____

NAILS

P / C: Bitten
P / C: Brittle
P / C: Curve Up
P / C: Frayed
P / C: Fungus-Fingers
P / C: Fungus-Toes
P / C: Pitting
P / C: Ragged Cuticles
P / C: Ridges
P / C: Soft
P / C: Thickening of Fingernails
P / C: Thickening of Toenails
P / C: Thickening of White Spots/Lines
P / C: Thickening of Lines
P / C: Moons Missing
P / C: Discolored

RESPIRATORY

P / C: Bad Breath
P / C: Bad Odor in Nose
P / C: Cough-Dry
P / C: Cough-Productive
P / C: Hoarseness
P / C: Sore Throat
P / C: Hay Fever Spring
P / C: Hay Fever Summer
P / C: Hay Fever Fall
P / C: Hay Fever Change of Season
P / C: Nasal Stuffiness
P / C: Nose Bleeds
P / C: Postnasal Drip
P / C: Sinus Fullness
P / C: Sinus Infection
P / C: Snoring
P / C: Wheezing
P / C: Winter Stuffiness

Have you been diagnosed with anything like: Asthma, COPD, Shortness of breath, pneumonia, bronchitis:

CARDIOVASCULAR

P / C: Angina/chest pain
P / C: Breathlessness
P / C: Heart Murmur
P / C: Irregular Pulse
P / C: Palpitations
P / C: Phlebitis
P / C: Swollen Ankles/Feet
P / C: Varicose Veins

URINARY

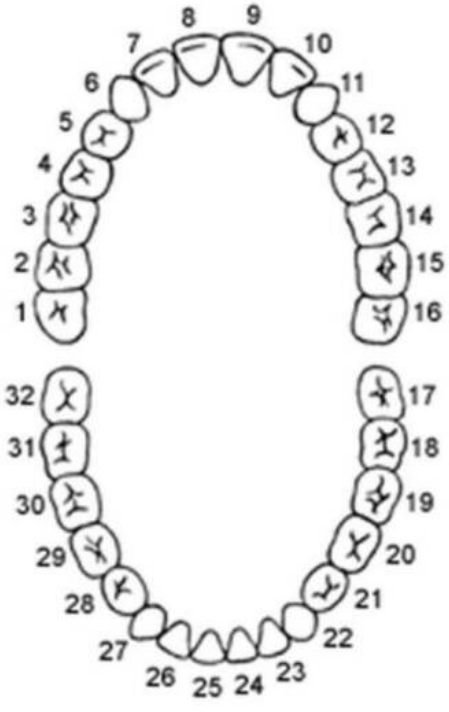
P / C: Bed Wetting
P / C: Hesitancy (trouble getting started)
P / C: Nighttime Urination
P / C: Infection
P / C: Kidney Disease
P / C: Leaking/Incontinence
P / C: Pain/Burning
P / C: Prostate Infection
P / C: Urgency

DENTAL WORK HISTORY

Please list all dental work, such as root canals, mercury or ceramic fillings, implants, caps, or dentures. As well as note what side of mouth, upper or lower and if possible, the tooth number – see chart below

	Dental Work	Work Performed by Bio-Dentist? Yes or No?	Date
1			
2			
3			
4			
5			
6			
7			
8			

Tooth Chart



1. 3rd Molar (wisdom tooth)
2. 2nd Molar (12-yr molar)
3. 1st Molar (6-yr molar)
4. 2nd Bicuspid (2nd premolar)
5. 1st Bicuspid (1st premolar)
6. Cuspid (canine/eye tooth)
7. Lateral incisor
8. Central incisor
9. Central incisor
10. Lateral incisor
11. Cuspid (canine/eye tooth)
12. 1st Bicuspid (1st premolar)
13. 2nd Bicuspid (2nd premolar)
14. 1st Molar (6-yr molar)
15. 2nd Molar (12-yr molar)
16. 3rd Molar (wisdom tooth)
17. 3rd Molar (wisdom tooth)
18. 2nd Molar (12-yr molar)
19. 1st Molar (6-yr molar)
20. 2nd Bicuspid (2nd premolar)
21. 1st Bicuspid (1st premolar)
22. Cuspid (canine/eye tooth)
23. Lateral incisor
24. Central incisor
25. Central incisor
26. Lateral incisor
27. Cuspid (canine/eye tooth)
28. 1st Bicuspid (1st premolar)
29. 2nd Bicuspid (2nd premolar)
30. 1st Molar (6-yr molar)
31. 2nd Molar (12-yr molar)
32. 3rd Molar (wisdom tooth)

WOMEN ONLY

Are you now, or is there a possibility that you might be pregnant? ☐No ☐Yes

Are you currently sexually active? ☐No ☐Yes

Are you content with your sex life? ☐No ☐Yes Sexual Preference:_____

Do you experience any sexual difficulties like low libido, vaginal dryness, painful intercourse, challenge with partner, etc?

☐No ☐Yes Initials:_____ Date:_____

Number of pregnancies: _____ Number of live births:_____ Please explain below if pregnancies were not brought to term:

_____

Any issues with fertility? ☐No ☐Yes Did you use fertility treatments, ☐No ☐Yes
If Yes which ones?_____

Any complications in pregnancy, delivery (vaginal or C-Section and why if the latter) ☐No ☐Yes
If Yes, Explain:

_____

Did you Breastfeed? ☐No ☐Yes Any issues with lactation? ☐No ☐Yes Mastitis? ☐No ☐Yes

Poor milk production? ☐No ☐Yes Latching on issues? ☐No ☐Yes

How long did you breast feed each child?

_____

Have you ever taken Hormones? (bHRT, Birth Control pills, NuvaRing, IUD, etc.) ☐ No ☐ Yes

If yes, what type and for how long?

_____

Do you still have menstrual periods? ☐No ☐Yes

Date of last period_____ How long are your cycles? _____
Heavy periods, irregularity, spotting, pain, or discharge? ☐ No ☐Yes

If Yes, Explain:

_____

Are you currently on birth control? ☐ No ☐Yes If Yes, What Method?_____

Any PMS like breast tenderness ☐ No ☐ Yes mood changes ☐ No ☐ Yes

headaches ☐ No ☐ Yes appetite changes ☐ No ☐ Yes GI changes ☐ No ☐ Yes

If Yes to any PMS symptoms, please elaborate.

_____

STI History? ☐ No ☐ Yes History of sexual abuse? ☐ No ☐ Yes

Do you do your own breast exams? ☐ No ☐ Yes Do you feel skilled at performing these self-exams? ☐ No ☐ Yes

(Breast exams, US, mammograms, MRIs) Dates:

_____

Results:

_____

SYMPTOM REVIEW

Circle ALL the symptoms below that apply to you previously OR currently, circle (P)revious, (C)urrent, both if both or leave as is if neither apply:

FEMALE REPRODUCTIVE

P / C: Breast Cysts	P / C: Breast Lumps	P / C: Breast Tenderness
P / C: Ovarian Cyst	P / C: Poor Libido (Sex Drive)	P / C: Vaginal Discharge
P / C: Vaginal Odor	P / C: Vaginal Itch	P / C: Vaginal Pain with Sex

Premenstrual:

P / C: Bloating Breast Tenderness	P / C: Carbohydrate Cravings	P / C: Chocolate Cravings
P / C: Constipation	P / C: Decreased Sleep	P / C: Diarrhea
P / C: Fatigue	P / C: Increased Sleep	P / C: Irritability

Menstrual:

P / C: Cramps	P / C: Heavy Periods	P / C: Irregular Periods
P / C: No Periods	P / C: Scanty Periods	P / C: Spotting Between

MEN ONLY

Do you use any form of birth control like condoms? ☐No ☐Yes Do you have a vasectomy? ☐No ☐Yes

Changes in libido? ☐ No ☐ Yes Changes in erectile dysfunction? ☐ No ☐ Yes

Changes in ejaculate? ☐ No ☐ Yes Changes in urinary habits such as more often, up at night? ☐ No ☐ Yes

Enlarged Prostate? ☐ No ☐ Yes STI history? ☐ No ☐ Yes If Yes, what diagnosis and how treated?

Are you content with your sex life? ☐ No ☐ Yes History of sexual abuse? ☐ No ☐ Yes

Ever had a digital rectal exam? ☐ No ☐ Yes If Yes, results?

Had baseline PSA? ☐ No ☐ Yes If Yes, results?

SYMPTOM REVIEW

Please circle ALL current symptoms, circle (P)revious, (C)urrent, circle both if applies or leave as is if neither apply:

MALE REPRODUCTIVE

P / C: Discharge From Penis	P / C: Ejaculation Problem	P / C: Genital Pain
P / C: Impotence	P / C: Prostate or Urinary Infection	P / C: Lumps In Testicles
P / C: Poor Libido (Sex Drive)		

PATTERN EVALUATION QUESTIONNAIRES

We realize this is a tedious process, but the more we know about YOU, the better equipped we are to helping you understand where you have come from, where you are currently, and where we need to go to change your health outcomes.

TRADITIONAL CHINESE MEDICINE EVALUTAION

These Ten Questions have been an integral part of Traditional Chinese Medicine diagnosis for centuries and further elucidates patterns that help us determine the best treatment approaches. The first recorded list of ten questions was compiled by Zhang Jie-bing in 1624, during the Ming dynasty. Though exact phrasing and number of the questions has varied over the centuries, this is the general framework to guide pattern recognition and treatment options.
Please review the questions and explain your details in the right column.

1. Do you experience sensation of Cold or Heat, Chills or Fever? And when (time of day or night) and where (in your body) do you notice these temperature patterns, and how are they tolerated?	
2. Do you experience night sweats or spontaneous perspiration without physical activity, high fever without perspiration, or sweating of palms and soles of feet, or lack of sweat with workouts or sauna?	
3. Do you have pain in your head and/or body? What is the location of pain, such as lower back, knees, chest, front sides or back of the head? What is the quality of pain such as an uncomfortable feeling of fullness in the chest or abdomen; type of pain (sharp, dull), and whether the pain is relieved or worsened by application of cold, heat or pressure?	
4. Describe the quality of your urine and bowel movements such as frequency of bowel movements and urination (times per day), constipation, diarrhea,	

or alternating between the two; frequent copious urination, scanty dark urination, incontinence, or needing to get up one or more times at night to urinate.	
5. Regarding diet and appetite- Do you lack an appetite, experience constant insatiable hunger, bloating after eating, desire for hot or cold foods, craving certain tastes such as sweet, sour, salty or spicy, habitual intake of sugar, caffeine or alcohol? Do you ever experience a particular taste in the mouth, such as metallic or bitter?	
6. Describe your thirst- excessive thirst, lack of thirst, thirst with no desire to drink, or constant desire for cold drinks or preference for warm drinks?	
7. Please describe your current mental or emotional state (Is this new? Usual?)- Traditional Chinese Medicine recognizes that the emotional and physical are interrelated, and emotional states such as grief, anger, worry or fear can affect physical well-being. Conversely, physical imbalance can bring about emotional responses.	
8. Ever experience hearing changes like tinnitus (ringing or other sounds in the ears), sudden or gradual hearing loss, or sound distortion?	
9. How would you qualify and quantify your sleep? Do you desire to sleep excessively,	

TRADITIONAL CHINESE MEDICINE EVALUTAION	
difficulty falling asleep, or waking in the middle of the night (please note the time if you are aware) and being unable to fall back asleep? Do you wake refreshed? What wakes you in the middle of the night? Hunger? Anxiety/busy mind? Hypervigilance? Poor sleep/room hygiene like light pollution or sharing the bed with a pet? Restless legs? Pain? What time do you go to bed and wake?	
10. Gynecological issues mostly geared to women- are (were) your cycles typically early or late, irregular, with flow that is light or heavy, with color that is light or dark, and do you experience pain or cramps during menstruation or breast tenderness before?	

AYURVEDIC MEDICAL EVALUTAION

This is a five thousand-year-old medical system that also looks for patterns to better understand terrain and help devise a proper road map to health. Please circle the letter (v, p or k) next to the answer based on the state of your natural being throughout your life. Example: focus is you, the real you, not what happens to be true recently (unless you've been through a life-changing transformation) nor what you wish to be. You may fall between two answers and in that case, pick both. Add up the totals for each v, p, and k at the end. This test will tell you if your Dosha (constitution) is more Vata, Pitta, Kapha or any combination of the three.

PHYSIQUE	SKIN	HAIR
v) I am a slender person and I hardly gain weight p) I am medium build k) I am well built and I gain weight no matter what I do v:_____ p:_____ k:_____	v) My skin is dry, thin, and itches often p)My skin looks flushed; I have lots of moles and freckles on my body k) My skin is smooth and soft, it looks pale sometimes v:_____ p:_____ k:_____	v)My hair is dry, thin and brittle p)My hair is neither dry nor oily (men, receding hairline) k) My hair is thick, full, lustrous, and slightly oily v:_____ p:_____ k:_____
FACE	**EYES**	**HANDS**
v) My face is oval p) My face is triangular (pointed chin, prominent jaw line) k) My face is round v:_____ p:_____ k:_____	v) My eyes are small; they feel dry often and have a bit of dullness (usually brown) p) My eyes are medium in shape; sharp & penetrating (usually blue) k) My eyes are big and round in shape, full eyelashes v:_____ p:_____ k:_____	v) My hands are generally dry, rough; slender fingers; dry nails p) My hands are generally moist, pink; medium fingers; soft nails k) My hands are generally firm, thick; thick fingers; strong & smooth nails v:_____ p:_____ k:_____
JOINTS	**ACTIVITIES**	**ACTIONS**
v) My joints are small, prominent bones, and often crack p) My joints are medium and loose k) My joints are large, sturdy, with lots of muscle surrounding v:_____ p:_____ k:_____	v) I am a very active person (always on the go, mind constantly thinking) p) I like to think before I do anything k) I am steady and graceful (I don't like to rush) v:_____ p:_____ k:_____	v) I walk fast and talk fast p) My actions are very thoughtful and precise k) I like a slower pace and I take my time to accomplish things v:_____ p:_____ k:_____

AYURVEDIC MEDICAL EVALUTAION

SLEEP

v) I do not sleep soundly at night. I tend to toss and turn. I wake up early in the morning

p) I am a light sleeper but if something wakes me up, I can go back to sleep easily

k) I am a heavy sleeper

v:_____ p:_____ k:_____

APPETITE

v) Varies, sometimes I feel hungry, sometimes not, I feel anxious if I don't eat

p) I always feel hungry. If I don't eat I get irritable and angry

k) I don't feel very hungry. I can go without food easily for a day

v:_____ p:_____ k:_____

BOWEL MOVEMENT

v) I tend to have constipation and can go a day or two without a bowel movement

p) I am regular and sometimes stools are loose (tend to get diarrhea)

k) I have no problem. I wake up to go to the bathroom.

v:_____ p:_____ k:_____

VOICE

v) My voice tends to be weak or hoarse

p) I have a strong voice, I may get loud sometimes

k) My voice is deep, has good tone

v:_____ p:_____ k:_____

EMOTIONS

v) I am a born worrier, I often feel anxious and nervous

p) If things don't happen my way, I feel irritable and angry

k) I am a happy person, very caring and loving

v:_____ p:_____ k:_____

WEATHER PREFERENCE

v) I love warm and humid weather

p) I enjoy cool weather, I dislike a warm climate

k) I like warm but dry weather

v:_____ p:_____ k:_____

SWEATING

v) I sweat little but not much

p) I sweat profusely and it might have an unpleasant odor

k) I never sweat, unless working very hard

7. v:_____ p:_____ k:_____

MEMORY

v) I remember quickly and forget quickly

p) I remember what I want to remember and never forget

k) It takes me a while to remember, but once I do I never forget

v:_____ p:_____ k:_____

ACTIONS

v) I tend to be spontaneous

p) I am a list maker, unless I plan,I don't do anything

k) I don't like to plan, I prefer to follow others

v:_____ p:_____ k:_____

STAMINA

v) I like to do things in spurts and I get tired very easily

p) I have medium stamina

k) I can work long hours and maintain good stamina

v:_____ p:_____ k:_____

MIND

v) My mind gets restless easily

p) I get impatient easily

k) It takes a lot to for me to get mad, I usually feel very calm

v:_____ p:_____ k:_____

DECISION MAKING

v) I change my mind more often and will take time to make a decision

p) I can make a decision easily and stick with it

k) I want others to make the decisions

v:_____ p:_____ k:_____

AYURVEDIC MEDICAL EVALUTAION		
PERSONALITY v) "can I change my mind?" p) "it's my way or the highway!" k) "don't worry be happy!" v:_____ p:_____ k:_____	**SPORTS** v) I like action p) I like to win k) I like to have fun v:_____ p:_____ k:_____	**HEALTH PROBLEMS** v) My symptoms are mainly pain, constipation, anxiety and depression p) I often get skin infections, fevers, heart burn, hypertension k) I tend to get allergies, congestion, weight gain and digestive problems v:_____ p:_____ k:_____
HOBBIES v) I like art (drawing, painting, dance) and travel p) I like sports, politics, and things that get my adrenaline pumping k) I like nature, gardening, reading, and knitting. v:_____ p:_____ k:_____		
Total V:	Total P:	Total K:

ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE	If Yes, provide details
Before your 18th birthday, did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that might be physically hurt? ☐Yes ☐No	
Before your 18th birthday, did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured? ☐Yes ☐No	
Before your 18th birthday, did an adult or person at least five years older than you ever…Touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you? ☐Yes ☐No	

ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE	If Yes, provide details
Before your 18th birthday, did you often or very often feel that… No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other? ☐Yes ☐No	
Before your 18th birthday, did you often or very often feel that… You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ☐Yes ☐No	
These next few questionnaires may feel redundant and time consuming, but they are very important for us to establish patterns within you and within your diagnosis type which allows us to serve you better while learning how to apply this to others as well.	
Before your 18th birthday, was a biological parent ever lost to you through divorce, abandonment, or other reason? ☐Yes ☐No	
Before your 18th birthday, was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or Ever repeatedly hit over at least a few minutes or threatened with a gun or a knife? ☐Yes ☐No	
Before your 18th birthday, did you live with anyone who was a problem drinker or alcoholic, or who used street drugs? ☐Yes ☐No	
Before your 18th birthday, was a household member depressed or mentally ill, or did a household member attempt suicide? ☐Yes ☐No	
Before your 18th birthday, did a household member go to prison? ☐Yes ☐No Rehab? ☐Yes ☐No Mental Institution? ☐Yes ☐No Detained? ☐Yes ☐No	

ELECTROMAGNETIC FIELD (EMF) SYNDROME QUESTIONNAIRE

1	Hours spent at home per week (0 to 168)	
2	Overall sense of health (1=very sick to 10=very healthy)	
3	Overall energy level (1=no energy to 10=lots of energy)	
4	Overall mood (1=poor mood to 10=very positive mood)	
5	Overall stress level (0=no stress to 10=severe stress)	
	How many days in the week did you experience the following symptoms? (0 to 7)	
6	Allergic Reactions (0 to 7)	
7	Back Pain (0 to 7)	
8	Chest Pain (0 to 7)	
9	Cold, Numb or Tingling Extremities (hands or feet) (0 to 7)	
10	Constipation (0 to 7)	
11	Cramps (0 to 7)	
12	Depression (0 to 7)	
13	Diarrhea (0 to 7)	
14	Difficulty Concentrating (0 to 7)	
15	Difficulty Sleeping (0 to 7)	
16	Dizziness or Vertigo (0 to 7)	
17	Dry/Dehydrated Skin (0 to 7)	
18	Ear Pain or Pressure (0 to 7)	
19	Excessive Salivation (0 to 7)	
20	Eye Focus Problems/Irritation/Pain (0 to 7)	
21	Facial Flushing, Prickling, Swelling (0 to 7)	
22	Fatigue (0 to 7)	
23	Feelings of Agitation, Anxiety or Aggressiveness (0 to 7)	
	Totals	

24	Foul (metallic) Taste in Mouth (0 to 7)	
25	Headache (0 to 7)	
26	Heart Palpitations/Racing Heart (0 to 7)	
27	High Blood Pressure (0 to 7)	
28	Hoarse Voice/Cough with No Infection (0 to 7)	
29	Impaired Sense of Smell (0 to 7)	
30	Impaired Sense of Taste (0 to 7)	
31	Inflammation or Swelling of Joints (0 to 7)	
32	Irritability and/or Aggressiveness (0 to 7)	
33	Itchiness (0 to 7)	
34	Joint Pain (0 to 7)	

35	Low Blood Pressure (0 to 7)	
36	Low Energy (0 to 7)	
37	Memory Difficulties (0 to 7)	
38	Migraine (0 to 7)	
39	Muscle Tension, Weakness or Pain (0 to 7)	
40	Nausea (0 to 7)	
41	Night-Time Urination (0 to 7)	
42	Nose, Bleeding (0 to 7)	
43	Restless Legs (0 to 7)	
44	Sensation of Flu or Cold (0 to 7)	
45	Sinus Congestion (0 to 7)	
46	Skin Irritation, Rash, Burning Sensation (0 to 7)	
47	Swelling of Hands and/or Feet (0 to 7)	
48	Tightness, Pressure, Heaviness Around Head (0 to 7)	
49	Tinnitus, Ringing in Ears (0 to 7)	
50	Tremors (0 to 7)	
	Totals	

ELECTROSMOG EXPOSURE IN THE HOME

This is important because the closer you are to neighbors who use wireless technology, the greater your exposure to electromagnetic radiation. Check the type of home you live in? Check only one.

☐ Detached home at least 100 meters from neighbors: ☐ Detached family home with neighbors closer than 100 meters

☐ Semi-detached home, ☐ Row housing (multiple single unit dwellings attached on both sides)

☐ Multiple unit dwelling (apartment or condominium)

Hours spent at home Monday to Friday (hours during 5 days out of a possible 120 hours):_____

Hours spent at home during the weekend (hours during 4 days out of a possible 48 hours):_____

NOTE: Your answers above will change from day to day. Indicate the time that is most representative of your current situation.

How many days (on average) do you spend at home each month: ☐ < 7 ☐ 8–14 ☐ 15–21 ☐ >22 days

Please check as many as apply to your home:	I don't know	within 10 meters of your home	within 100 meters of your home	within 400 meters of your home
Electricity Power (distribution) Lines				
High Voltage Transmission Lines				
Cellular Antennas/Towers				
Amateur Radio Transmitter				
Radar Antennas (near airport)				

Broadcast Antennas for Radio or TV				
Street Car				
Train Tracks				
Subway				
Transformers on Electrical Poles or the Ground				
Electricity Substations				
Electric Fence (farm animals or pets)				

I have	I use	Which of the following devices do you have/use in your home?
		Microwave Oven
		iPad or iPod Touch
		Computer (Desktop or Laptop)
		Cordless Mouse & Keyboard
		Wi-Fi Wireless Router
		Wireless Baby Monitor
		Compact Fluorescent Light (CFL) Bulbs
		Wireless Games (Wii for example)
		Other Wireless/Blue Tooth Devices:_____

Do you use a cell phone at home or at work? ☐Yes ☐No How long have you been using it? years) _____

How much do you use it to make calls per day? (minutes) _____

Do you hold your phone to your head? ☐Yes ☐No

Wear plugged in ear buds? ☐Yes ☐No

Use speaker only? ☐Yes ☐No

Keep on your body (like a pocket or a bra)? ☐Yes ☐No

Have you noticed any relation to your health problems?

_____

_____

Do you use a cordless phone (DECT) at home or at work? ☐Yes ☐No

How long have you been using it? (years) _____

How much do you use it to make calls per day? (minutes) _____

Have you noticed any relation to your health problems?

_____

_____

Do you use Bluetooth headset or car speaker? ☐Yes ☐No If yes, how long have you been using them? _____

Have you noticed any relation to your health problems?

_____

_____

Which of the following devices do you have attached to your home? (please check each one)

Smart Meter for Electricity ☐Yes ☐No ☐ Unsure
Smart Meter for Water ☐Yes ☐No ☐ Unsure
Smart Meter for Gas ☐Yes ☐No ☐ Unsure

THE TERRAIN TEN QUESTIONNAIRE

GENETICS AND EPIGENETICS	Yes/No/I don't know	If Yes, provide details
Have you been tested for BRCA1 or 2 mutation or Lynch Syndrome, ATM, CHEK2 and what were the results? Please share all that apply.		
Have you tested positive for other types of cancer genes/molecular markers such as p53, MSH2, EGFR, VEGF, PDL-1, IDH-1, MLH1, MSH6, MEK, PIK3CA, PTEN, KRAS, BRAF, epCAM, other? Please share all that apply.		
Are you heterozygous or homozygous for MTHFR mutation(s)?		
Are you heterozygous or homozygous for VDR, CYPR21, COMT, CYP1B1, CYP1A1, ESR2, GST mutations? Please share all that apply.		
Do you have a family history of cancer? Please expand on this.		
Were your parents or grandparents impacted by the Great Depression, other natural disasters, famine, or major stressful periods (like concentration camps or being put on a reservation?)		
Were your parents exposed to any amount of stress, environmental, occupational toxins? And where did they grow up before they conceived you?		
Did your mother smoke or take any types of medications (like DES) or drugs or alcohol during her pregnancy with you?		
Did you experience any type of trauma in childhood? (ACE Score)		

Are you on any pharmaceutical drugs, including over the counter medications such as NSAIDS, TUMS, Benadryl or taken a round of chemotherapy or Cipro in the last year? Please share all that apply.		
Do you have a personal or family history of thyroid dysfunction, cardiovascular disease, diabetes, Alzheimer's, osteoporosis/penia, mental illness, or addictions? If so please share all that apply.		
Do you have evidence or history of orthostatic hypotension (dizziness/lightheadedness when suddenly standing or stretching) and/or a history of low blood pressure? If yes, is it occasional or frequent?		
Do you have a history of migraines? If yes, please describe (severity, frequency, duration, triggers, what makes better):		
Do you have evidence or history of exercise-induced asthma? If yes, please describe:		
Do you have evidence or history of sulfur food sensitivities (like garlic, onions (cooked or raw), red wine, or dried fruit)? If yes, please describe reaction and list which foods:		
Can you tolerate cheese, pickled foods, chocolate, shellfish, citrus foods, red or sparkling wine, smoked meats? If no, please describe reaction and list which foods:		
Can you tolerate alcohol? If no, please describe reaction:		
Do you have evidence or history of seasonal allergies or chronic allergies? If yes, please describe:		
How do you feel after exercise (Invigorated, fatigued, etc)? How long does it take for your muscles to recover/soreness to improve?		
(Childbearing Females) Did you experience postpartum depression? If yes, please describe:		
BLOOD SUGAR BALANCE	Yes/No/I don't know	If Yes, provide details
Do you have a self-professed sweet tooth?		
Do you find it difficult to fall asleep without an evening or late-night snack or wake in the night hungry?		
Do you get "hangry" if you skip or delay a meal?		

Do you regularly skip breakfast?		
Do you crave and regularly eat carbohydrates (breads, potatoes, pasta, fruit?)		
Do you consume more than 25g (2 tbsp.) of sugar per day in any form?		
Is your body fat content over 25% (not to be confused with BMI)? Height: _____ Weight: _____		
Do you feel tired after a meal?		
Do you or any family members have a history or diagnosis of metabolic syndrome, hypoglycemia, prediabetes, insulin resistance, polycystic ovarian disease, fatty liver, pancreatic cancer, pancreatitis, Type I or Type II Diabetes? Please share all that apply.		
Do you consume alcohol? If so, what form, how much and how often?		
TOXIC BURDEN	Yes/No I don't know	If Yes, provide details
Do you currently or were you raised near any agriculture, toxic waste, factories, busy roadways, military bases, industries or airports, golf courses, gas stations, landfill, mining? Please share all that apply.		
Do you feel sensitive to odors such as perfume and diesel fumes?		
Do you use a microwave, cell phone, cell towers, Wi-Fi, laptop computer more than 3 hours/day and, or have a Smart Meter? Or had recent or past x-rays, scans, and mammography, DEXA or radiation treatment? Please share all that apply.		
Do you use herbicides (such as RoundUp), pesticides, insecticides in, on or around your home or on your pets (flea/tick powders, collars, shampoos)?		
Do you use commercial body care products and household cleaning products, fabric softeners, hair dyes, canned foods, and artificial sweeteners? Please list all that apply.		
Do you have your clothes dry-cleaned?		

Do you use Teflon/non-stick cookware? Do you drink RO filtered water? If not, what is, if any, your water filtration system?		
Do you have mercury fillings, eat fish more than 3 times per week, been exposed to heavy metals or any other industrial metals/toxins? Please list all that apply.		
Do you find it difficult to sweat?		
MICROBIOME AND DIGESTIVE FUNCTION	Yes/No I don't know	If Yes, provide details
Were you born C-Section?		
Were you fed infant formula before the age of 1?		
Have you ever tested positive for a parasite, c.diff, or H.pylori infection?		
Have you ever or do you now use hand sanitizer and antimicrobial soap?		
Do you have any digestive symptoms including gas, bloating, diarrhea, constipation, SIBO (Small Intestine Bacterial Overgrowth), colitis, diverticulitis, reflux? Please list all that apply. And please describe the quality of your stools (soft, firm, pebbles, odor, color and how often?)		
Do you currently use Roundup near your home and eat organic grains and legumes or drink wine from the US?		
Do you eat non-organic meat and dairy products?		
Do you take NSAIDS (aspirin, ibuprofen), Tylenol, or antacids more than a few times per year?		
Do you eat less than 25g/d of fiber?		
Have you ever taken the recommended oral prep for colonoscopy? Please share the date(s).		
IMMUNE FUNCTION	Yes/No I don't know	If Yes, provide details

Have you had a vitamin D3 tested in the past and was the level under 50?		
Do you have a personal or family history of autoimmune disease, including thyroid disease? Please elaborate.		
Do you experience fevers when you are ill and do you suppress or let them run wild?		
Do you have a history of mono, HPV, Sexually Transmitted Infections, parasites, and/or herpes? Please list all that apply and share if/how treated.		
Do you have seasonal allergies, asthma, hives or a childhood history of ear infections? If yes, please explain.		
Have you been diagnosed with Celiac or gluten intolerance? And how were you diagnosed/tested?		
Have you had all of your recommended vaccinations? Example - flu shots, shingles shots, travel vaccines? Or received immunotherapies i.e., allergy shots, checkpoint inhibitors, Mistletoe?		
Have you ever taken steroids? (Topical, inhaled or oral?) of any kind for any duration and why?		
Do you have a child under the age of 5 or an elder over the age of 75 living in your home; or work in a school, hospital or medical setting?		
INFLAMMATION	Yes/No I don't know	If Yes, provide details
Any history of eczema, psoriasis, acne, flushing or rashes?		
Every diagnosed or suspicious of arthritis?		
Any physical pain patterns that are constant or intermittent and where? Are you aware of the cause for this pain?		
Do you have inflammatory bowel disease (IBS, Ulcerative Colitis, Crohn's?)		
Do you eat fried or fast foods? Do you have known food allergies or sensitivities? Please describe.		
Do you have any injuries or wounds that are or were difficult to heal?		

Do you experience high amounts of stress?		
Do you often incorporate vigorous exercise into your daily routine?		
Do you eat less than 5 servings of vegetables per day?		
BLOOD CIRCULATION AND ANGIOGENESIS	Yes/No I don't know	If Yes, provide details
Do you bruise easily?		
Have you ever been diagnosed with a clotting disorder? If so, which?		
Have you ever been diagnosed or your family members, with hemochromatosis or elevated ferritin (iron storage?)		
Do you have a history of deep vein thrombosis? If so, when?		
Do you have a history of pulmonary emboli? If so, when?		
Do you have high or low blood pressure, and do you take any blood pressure medication?		
Are you anemic? If yes, do you know what form of anemia it is?		
Do you take any pharmaceutical blood thinners like Coumadin or a daily aspirin?		
Do you exercise less than 30 minutes three times per week, and do you spend more than a few hours sitting each day?		
HORMONE BALANCE	Yes/No I don't know	If Yes, provide details
Do you have a history of birth control pills, bio-identical or hormone replacement therapy, hormonal barrier methods like NuvaRing or Marina IUD, steroids, fertility treatment or hormone blockade therapies? Please list all that apply and approximate dates of use.		
For women: Do you have a history of irregular periods, PMS, fibrous breasts or menopausal symptoms? Please list all that apply.		
Female: Describe your menstrual history (age of onset, length of cycle, # of days of flow, clots, color of blood, PMS, breast tenderness, other symptoms like mood and food cravings?)		
Female: Circle all that apply: Any history of hysterectomy, D&C, tubal ligation, ablation, irregular PAP, fibroids, irregular bleeding, vaginal		

discharge, herpes, yeast infections, interstitial cystitis, infertility, pain with intercourse, dryness with intercourse, mastectomy, breast augmentation, breast reconstruction, breast implants, lumpectomy, clip placement at biopsy site?		
Pregnancy Hx: Number of pregnancies? Termination? Miscarriage? Difficulty conceiving? Complications with pregnancy, delivery, lactation? Describe?		
If menopausal: age of onset and was this natural, medical or surgically induced? Any symptoms associated with this? Describe?		
For men: Do you have issues with sexual function, erectile function, nighttime urination, and/or difficult urination?		
Do you have a low libido (sex drive?)		
Any history of fertility issues? Please elaborate and note any treatment.		
Ever diagnosed with a thyroid disorder? When and what and how treated?		
Any weight fluctuations? Dates?		
Do you handle receipts, drink out of plastic water bottles, store food in plastic containers, eat non-organic animal products? Please list all that apply.		
Do you now or have you ever followed a low-fat diet? Date?		
STRESS AND BIORHYTHMS	Yes / No	If Yes, provide details
Did any of your symptoms, labs or diagnosis change after a stressful period of time? Please elaborate.		
Are you a night owl, ever work a nightshift job or had multiple sleepless nights? List all that apply and dates.		
Do you travel through time zones often? Please elaborate.		
Do you have streetlights, TV or computer screen exposure after sunset?		
Are you easily fatigued?		
Do you crave salt?		

Do you sleep less than eight hours and/or go to bed after 11pm at night (what time do you go to bed and wake up?)		
Do you have problems falling asleep or staying asleep? And if you do wake up—do you note the time?		
Do you spend less than 15 minutes outdoors daily?		
Do you feel you experience a high level of stress regularly?		
MENTAL AND EMOTIONAL HEALTH	Yes / No	If Yes, provide details
Do you experience irritability, mood swings or unstable emotions?		
Have you been diagnosed with a mental disorder such as bipolar, depression or anxiety? And have you been treated? When?		
Are you easily offended? Give an example.		
Are you sensitive to other people's energy and reactions?		
Do you experience racing, repetitive thoughts?		
Do you find it difficult to speak your truth in certain situations?		
Have you ever self-medicated with drugs, sex, alcohol, shopping, TV, gambling or Internet?		
Do you feel you have a good support system? Please elaborate.		
Do you have a spiritual practice?		

ENVIRONMENTAL EXPOSURES

ENVIRONMENTAL HISTORY	If Yes, please explain
Do you live next to or near an industrial plant, commercial business, dump site, or nonresidential property? ☐Yes ☐No	
If industrial, do you know what chemicals might have been used at the site, or what type of industry it was?	

Do you ever smell chemicals in the air? ☐Yes ☐No	
Have you ever smelled any chemicals in your water? ☐Yes ☐No	
What is the source of your home and drinking water?	
Do you know if your water supply has ever been tested for contamination? If yes, do you know the outcome of that test?	
Which of the following do you have in your home: *Please select that apply:* ☐ Air conditioner ☐ Air purifier ☐ Central Heating (☐ Gas ☐ Oil) ☐ Gas Stove ☐ Electric Stove ☐ Fireplace ☐ Wood Stove ☐ Humidifier	
Have your recently acquired new furniture or carpet, refinished furniture, or remodeled your home or office? ☐Yes ☐No	
Have you weatherized your home recently? ☐Yes ☐No	
Do you (or any household member) have a hobby or craft? ☐Yes ☐No	
Do you work on your car? ☐Yes ☐No	
Have you ever changed your residence because of a health problem? ☐Yes ☐No	
Does your food come from somewhere other than a grocery store? ☐Yes ☐No	
Approximately what year was your home built?	
EXPOSURE HISTORY	If Yes, please explain
Are you currently exposed to any of the following: ☐ Metals ☐ Dust or Fibers ☐ Chemicals ☐ Fumes ☐ Radiation and/or Radon ☐ Biological Agents including chemotherapy or other pharmaceuticals ☐ Loud noise or vibrations ☐ Extreme heat or cold	

Are pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden? Or on pets? ☐Yes ☐No	
Have you been exposed to any of the above in the past ☐Yes ☐No	
Do any household members have contact with metals, dust, fibers, chemicals, fumes, radiation, or biological agents? ☐Yes ☐No	
Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to?	If yes, list them here
Do you get the material on your skin or clothing? ☐Yes ☐No	
Are your work clothes laundered at home? ☐Yes ☐No	
Do you shower at work? ☐Yes ☐No	
Can you smell the chemical or material you are working with? ☐Yes ☐No	
Do you use protective equipment such as gloves, masks, respirator, or hearing protectors? ☐Yes ☐No	
Have you been advised to use protective equipment? ☐Yes ☐No	If yes, list the protective equipment used
Have you been instructed in the use of protective equipment? ☐Yes ☐No	
Do you wash your hands with solvents? ☐Yes ☐No	
Do you smoke at the workplace or at home? ☐Yes ☐No	
Do you eat at the workplace? ☐Yes ☐No	
Do you know of any co-workers experiencing similar or unusual symptoms? ☐Yes ☐No	
Are family members experiencing similar or unusual symptoms? ☐Yes ☐No	

Has there been a change in the health or behavior of family pets? ☐Yes ☐No	
Do your symptoms seem to be aggravated by a specific activity? ☐Yes ☐No	
Do your symptoms get either worse or better at work? ☐Yes ☐No	
Do your symptoms get either worse or better at home? ☐Yes ☐No	
Do your symptoms get either worse or better on weekends? ☐Yes ☐No	
Do your symptoms get either worse or better on vacation? ☐Yes ☐No	
Has anything about your job changed in recent months (such as duties, procedures, overtime) ☐Yes ☐No	
Do you use any (such as herbs or natural supplements) alternative medicines? ☐Yes ☐No	
Have you or your child ever eaten non-food items such as paint, plaster, dirt and/or clay? ☐Yes ☐No	

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)? If *yes*, please check the box beside the name

☐ Acids ☐ Alcohols (Industrial) ☐ Alkalies ☐ Ammonia ☐ Arsenic ☐ Asbestos ☐ Benzene

☐ Beryllium ☐ Cadmium ☐ Carbon tetrachloride ☐ Chlorinated napthalenes ☐ Chloroform

☐ Chloroprene ☐ Chromates ☐ Coal dust ☐ Dichlorobenzene ☐ Ethylene dibromide

☐ Ethylene dichloride ☐ Fiberglass ☐ Halothane ☐ Isocyanates ☐ Ketones ☐ Lead ☐ Mercury

☐ Methylene Chloride ☐ Nickel ☐ PBBs ☐ PCBs ☐ Perchloroethylene ☐ Pesticides ☐ Phenol

☐ Phosgene ☐ Radiation ☐ Rock dust ☐ Silica powder ☐ Solvents ☐ Styrene ☐ Talc ☐ Toluene

☐ TDI or MDI ☐ Trichloroethylene ☐ Trinitrotoluene ☐ Vinyl chloride ☐ Welding fumes ☐ X-rays

☐ Other (specify)

FINAL THREE KEY QUESTIONS

For what are you grateful?

What brings you joy?

What did you come here to do (purpose)?

METABOLIC TERRAIN INSTITUTE OF HEALTH

Anything else you would like to share that was not asked?

_____

_____

_____

_____

_____

We invite you to include a picture of yourself, family, pets, home/environment, whatever you want to share so we have a deeper "knowing" of who you are. Congratulations on completing this form and taking this important step in your healing journey. Thank you for taking the time to invest in yourself to offer up as much information as possible to determine your terrain patterns to help us determine the best terrain treatments, and to enhance your best possible outcomes.

Patient Signature:_____ Date:_____

If completed by someone other than patient:

Name: _____

Relationship: _____