

SYNERGY HEALTH ASSOCIATES
DR. LORETTA T. FRIEDMANT

Name: _____ DOB: _____

Address _____

City _____ State _____ ZIP _____

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

E-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Marital Status: S M D W Social Sec. No: _____

Children:	Age	Sex	Any Health Issues?
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1. _____	_____	M/F	_____
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2. _____	_____	M/F	_____
----------	-------	-----	-------

3. _____	_____	M/F	_____
----------	-------	-----	-------

4. _____	_____	M/F	_____
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Family History: Diabetes () Cancer () Heart Disease () Other: _____

Your major complaint(s): _____

How long have you had this? _____ Weeks _____ Months _____ Years

Previous treatments for this complaint _____

Surgeries/Accidents _____

Currently under Physician's care for 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Name of Dr(s). 1. _____ 2. _____ 3. _____

Supplements Currently Taking:

1. _____	4. _____	7. _____
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2. _____	5. _____	8. _____
----------	----------	----------

3. _____	6. _____	9. _____
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Do you smoke ?	Yes/No	How many per day? _____
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Do you drink Alcohol ?	Yes/No	How much per week? _____
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Do you drink Coffee ?	Yes/No	How many per day? _____
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I understand that Designed Clinical Nutrition is not a method for diagnosing or treatment of any disease including conditions of cancer, AIDS, infections or other medical conditions, and that these conditions are not being tested for, or treated. I understand the DCN is a means by which the neurological reflexes can be used to determine possible nutritional imbalances, bringing the body to a more optimum state of health.

SIGNED: _____ DATE _____

ALLERGIES

Medication/ Supplement/Food:

Reaction:

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? _____

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

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

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

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

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

MEDICATIONS

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

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

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

[illegible]

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

[illegible]

PAST MEDICAL AND SURGICAL HISTORY

INJURIES	WHEN	COMMENTS
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		

SURGERIES	WHEN	COMMENTS
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

HOSPITALIZATIONS	WHEN	REASON

FEMALE MEDICAL HISTORY (WOMEN ONLY)

OBSTETRICS HISTORY

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

- | | | |
|---|---|--|
| ☐ Pregnancies_____ | ☐ Caesarean_____ | ☐ Vaginal deliveries_____ |
| ☐ Miscarriage_____ | ☐ Abortion_____ | ☐ Living Children_____ |
| ☐ Post partum depression____ | ☐ Toxemia_____ | ☐ Gestational diabetes_____ |

GYNECOLOGICAL HISTORY

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

Painful: Yes_____ No_____ Clotting: Yes_____ No_____

Date of last menstrual period:____/____/____

Do you currently use contraception? Yes_____ No_____ If yes, what please indicate which form:

Non-hormonal

- ☐ Condom
- ☐ Diaphragm
- ☐ IUD (ie copper ParaGard)
- ☐ Partner vasectomy
- ☐ Other (non-hormonal-please describe)_____

Hormonal

- ☐ Birth control pills
- ☐ Patch
- ☐ Nuva Ring
- ☐ IUD (ie Mirena)
- ☐ Other (please describe)_____

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

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle?

Yes_____ No_____

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

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

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

- | | | | |
|-----------------------------------|----------------------------------|---------------------------------------|-------------------------------------|
| ☐ Estrogen | ☐ Ogen | ☐ Estrace | ☐ Other_____ |
| ☐ Premarin | ☐ Porvera | ☐ Progesterone | |

DIAGNOSTIC TESTING

Last PAP test:____/____/____ Normal:_____ Abnormal_____

Last Mammogram____/____/____ Breast biopsy? Date:____/____/____

Date of last bone density____/____/____ Results: High_____ Low_____ Within normal range_____

MALE MEDICAL HISTORY (*MEN ONLY*)

Have you had a PSA done?

Yes _____ No _____

PSA Level:

- ☐ 0 – 2
☐ 2 – 4
☐ 4 – 10
☐ >10

- ☐ Prostate enlargement
☐ Prostate infection
☐ Change in libido
☐ Impotence
☐ Diminished/poor libido
☐ Nocturia (urination at night)
☐ How many times at night? _____
☐ Urgency/Hesitancy/Change in Urinary Stream
☐ Loss of bladder control

- ☐ Infertility
☐ Lumps in testicles
☐ Sore on penis
☐ Genital pain
☐ Hernia
☐ Prostate cancer
☐ Low sperm count
☐ Difficulty obtaining erection
☐ Difficulty maintaining an erection

CHILDHOOD HISTORY

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

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

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

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

Yes___ No___

If yes, why? _____

Experience chronic exposure to second hand smoke in your home?

Yes___ No___

Experience abuse

Yes___ No___

Have alcoholic parents?

Yes___ No___

Fully Vaccinated?

Yes___ No___

How would you describe your diet as a child? _____

DENTAL HISTORY

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

NUTRITIONAL HISTORY

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

How many times per week do you consume the following types of food?

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

Do you currently follow any type of nutritional program or diet? Yes _____ No_____

Please tell us if there is anything special about your diet (ie diabetic diet, paleo, vegan, etc) _____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc?

Yes_____ No_____

If yes, are these symptoms associated with any particular food or supplement?

Yes_____ No_____

If yes, please name the food or supplement and symptom(s). _____

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

Yes___ No___

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

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

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

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

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

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

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

Frequency	√	Color	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
2-3x/week		Greenish color	
1 or fewer x/week		Blood is visible	
		Varies a lot	
Consistency	√	Dark brown consistently	
Soft and well formed		Yellow, light brown	
Often floats		Greasy, shiny appearance	
Difficult to pass		Intestinal gas (check all that apply): ☐ Daily ☐ Occasionally ☐ Excessively ☐ Painful ☐ Foul smelling ☐ Little odor	
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No ____

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

How much? _____

Number of years? _____ If not a current user, year quit _____

Attempts to quit: _____

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

ALCOHOL INTAKE

Have you ever used alcohol? Yes ____ No ____

If yes, how often do you now drink alcohol?

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

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes ____ No ____

Have you ever had a problem with alcohol? Yes ____ No ____

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

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes ____ No ____

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

To your knowledge, have you ever been exposed to toxic metals/chemicals in your job or at home? Yes ____ No ____

If yes, Explain _____

Occupation _____

SLEEP AND REST HISTORY

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

Do you:

- ☐ Have trouble falling asleep?
- ☐ Feel rested upon waking?
- ☐ Have problems with insomnia?
- ☐ Snore?
- ☐ Use sleeping aids?

EXERCISE HISTORY

Do you exercise regularly? Yes_____ No_____

If yes, please indicate:

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

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

SOCIAL HISTORY

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

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes_____ No_____

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

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

If yes, do you believe that you know the source of your stress? Yes_____ No_____

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

Have you ever contemplated suicide? Yes_____ No_____

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

Have you ever sought help through counseling? Yes_____ No_____

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

Did it help?_____

How are the following aspects of your life going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

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

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

Have you ever been involved in abusive relationships in your life? Yes ___ No ___

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

Did you feel safe growing up? Yes ___ No ___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No ___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No ___

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

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

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

If yes, how often? _____

Check all that apply:

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

Hobbies and leisure activities:

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

Yes ___ No ___

PAIN HISTORY

Are you currently in pain? Yes ___ No ___

Is the source of your pain due to an injury? Yes ___ No ___

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

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

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

(0= no pain, 10= severe pain)

Example: Neck

0 1 2 3 4 5 6 7 8 9 10

Area 1. _____
1 2 3 4 5 6 7 8 9 10

Area 2. _____
1 2 3 4 5 6 7 8 9 10

Area 3. _____
1 2 3 4 5 6 7 8 9 10

Area 4. _____
1 2 3 4 5 6 7 8 9 10

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

A = ache

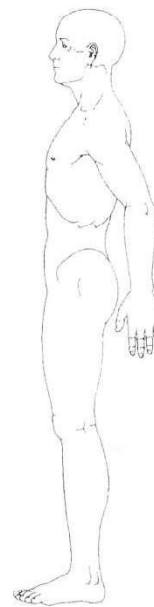
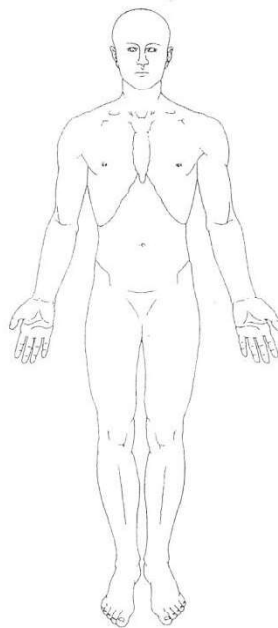
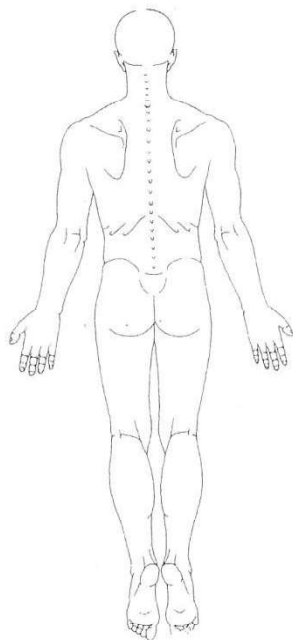
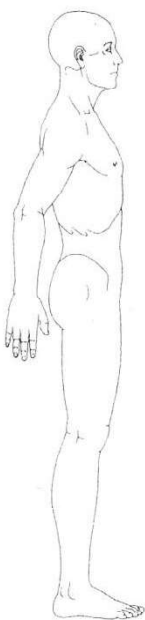
B= burning

N=numbness

S= stiffness

T=tingling

Z=sharp/shooting



Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II Please circle the appropriate number 0 - 3 on all questions below.

0 as the least/never to 3 as the most/always.

Category I					Category V				
Feeling that bowels do not empty completely	0	1	2	3	Greasy or high fat foods cause distress	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3	Lower bowel gas and or bloating				
Alternating constipation and diarrhea	0	1	2	3	several hours after eating	0	1	2	3
Diarrhea	0	1	2	3	Bitter metallic taste in mouth,				
Constipation	0	1	2	3	especially in the morning	0	1	2	3
Hard, dry, or small stool	0	1	2	3	Unexplained itchy skin	0	1	2	3
Coated tongue of fuzzy debris on tongue	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3	Stool color alternates from clay colored				
More than 3 bowel movements daily	0	1	2	3	to normal brown	0	1	2	3
Use laxatives frequently	0	1	2	3	Reddened skin, especially palms	0	1	2	3
					Dry or flaky skin and/or hair	0	1	2	3
Category II					History of gallbladder attacks or stones	0	1	2	3
Excessive belching, burping, or bloating	0	1	2	3	Have you had your gallbladder removed	Yes		No	
Gas immediately following a meal	0	1	2	3					
Offensive breath	0	1	2	3	Category VI				
Difficult bowel movements	0	1	2	3	Crave sweets during the day	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Irritable if meals are missed	0	1	2	3
Difficulty digesting fruits and vegetables;					Depend on coffee to keep yourself going or started	0	1	2	3
undigested foods found in stools	0	1	2	3	Get lightheaded if meals are missed	0	1	2	3
Category III					Eating relieves fatigue	0	1	2	3
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3	Feel shaky, jittery, tremors	0	1	2	3
Do you frequently use antacids?	0	1	2	3	Agitated, easily upset, nervous	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3	Poor memory, forgetful	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Blurred vision	0	1	2	3
Temporary relief from antacids, food,									
milk, carbonated beverages	0	1	2	3	Category VII				
Digestive problems subside with rest and relaxation	0	1	2	3	Fatigue after meals	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus,					Crave sweets during the day	0	1	2	3
peppers, alcohol, and caffeine	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Category IV					Must have sweets after meals	0	1	2	3
Roughage and fiber cause constipation	0	1	2	3	Waist girth is equal or larger than hip girth	0	1	2	3
Indigestion and fullness lasts 2-4					Frequent urination	0	1	2	3
hours after eating	0	1	2	3	Increased thirst & appetite	0	1	2	3
Pain, tenderness, soreness on left side					Difficulty losing weight	0	1	2	3
under rib cage	0	1	2	3					
Excessive passage of gas	0	1	2	3	Category VIII				
Nausea and/or vomiting	0	1	2	3	Cannot stay asleep	0	1	2	3
Stool undigested, foul smelling,					Crave salt	0	1	2	3
mucous-like, greasy, or poorly formed	0	1	2	3	Slow starter in the morning	0	1	2	3
Frequent urination	0	1	2	3	Afternoon fatigue	0	1	2	3
Increased thirst and appetite	0	1	2	3	Dizziness when standing up quickly	0	1	2	3
Difficulty losing weight	0	1	2	3	Afternoon headaches	0	1	2	3
					Headaches with exertion or stress	0	1	2	3
					Weak nails	0	1	2	3

Category IX

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

Category X

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

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
Splitting type headaches	0	1	2	3

Category XIV

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only)

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

Category XVI (Menstruating Females Only)

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

Category XVII (Menopausal Females Only)

How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3

How many alcohol beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Environmental Influences Questionnaire

Name: _____

Date ____/____/____

There are over 70,000 chemicals commercially produced in the United States. The long-term effects of many of these chemicals have never been investigated. But many chemicals are harmful in very low doses. Unless generated by the body (formaldehyde, pentane), the body's level for chemicals should be non-detectable, and not "low level". Chemicals are widespread in our environment, and constant exposure to low levels can cause dysfunction in many systems of the body. The purpose in the following questions is to determine if any of your health problems can be result of chemical toxicity and to measure your **TOTAL TOXIN LOAD**.

Electromagnetic Factors

- ☐ Live or have you lived within 200 yards form high voltage wires or transformers
- ☐ Live or have lived near an electric distribution substation
- ☐ Bed is close to the main electrical current
- ☐ Have a fan directly over your bed
- ☐ Have an alarm clock or radio close to your bed (plugged in)
- ☐ Live or have you lived near a television transmitter
- ☐ Sleep with an electric blanket, heating pad
- ☐ Sleep with an electric blanket, heating pad
- ☐ Sleep on a waterbed

Position of your head of your bed is facing

- ☐ North
- ☐ South
- ☐ East
- ☐ West
- ☐ Work on a computer for longer than six hours/day
- ☐ Use a screening shield over your computer screen
- ☐ Live or have lived near a power generating station
- ☐ Live near a radio tower
- ☐ You use a cellular phone more than 2 hours per day
- ☐ Use microwave ovens
- ☐ Bed has a wooden backboard
- ☐ Have fluorescent light fixtures

Occupation: _____

Toxin Exposure

Trichloroethylene/TCE

- ☐ Work close to a copy machine
- ☐ Worked in a printing shop
- ☐ Drink decaffeinated coffee
- ☐ Use typewriter correction fluid
- ☐ Use rug cleaners
- ☐ Use disinfectants
- ☐ Use carbonless paper
- ☐ Use spot removers
- ☐ Use cleaning supplies
- ☐ Use metal degreasers
- ☐ Do recreational painting

Formaldehyde

- ☐ Wear many dry-cleaned clothes
- ☐ Noticed changes of your health since you moved into your home
- ☐ Wear many polyester clothes and permanent press
- ☐ You use Spray Starch
- ☐ Have foam wall insulation
- ☐ Have particleboard, chip board or interior plywood
- ☐ Put up wallpaper in last 2 years
- ☐ Have foam cushions or foam mattresses
- ☐ Live or lived in a trailer
- ☐ Worked in a laboratory
- ☐ Your home has been insulated since your illness
- ☐ Had new carpets. When? _____
- ☐ Use waxes and polishes on your floor
- ☐ Been around resin glues and plastics
- ☐ Have exterior grade plywood on your home
- ☐ Homemade of stucco, plaster or concrete
- ☐ Have a wood burning stove
- ☐ Have draperies
- ☐ Have used acid-cured resin floor finishes
- ☐ Have fire-proof material in your home
- ☐ Smoke in your home
- ☐ Have a photography darkroom
- ☐ Use nail polish remover
- ☐ Use fingernail hardeners

Pesticides and Herbicides Chemicals

- ☐ Use pesticides
- ☐ Use weed killer
- ☐ You use cleaning fluids, waxes
- ☐ Lived or worked at adry cleaning plant
- ☐ Have been around wood preservatives
- ☐ Drink tap water
- ☐ Work with electrical equipment
- ☐ Have mothballs in your closets
- ☐ Gasoline fumes bother you
- ☐ Eat store bought meat
- ☐ Use insecticides
- ☐ Crop-surface sprays
- ☐ Aerosols
- ☐ Fumigants

Volatile Organic Compounds

- ☐ Had home painted in the last 2 years
- ☐ Use cleaning solvents
- ☐ Have soft vinyl floors
- ☐ Handle propane and butane
- ☐ Get your clothes dry-cleaned
- ☐ Store dry-cleaned clothes in closets
- ☐ Barbecue more than 2 times per month
- ☐ Work in a "tightly sealed building"
- ☐ Work close to a laser printer
- ☐ Use moth balls
- ☐ Have nylon carpet
- ☐ Use air fresheners
- ☐ Have a workshop in the home

Phenols (Do you use the following?)

- ☐ Household cleaners
- ☐ Nasal Sprays
- ☐ Styrofoam cups
- ☐ Cough syrup
- ☐ Decongestants
- ☐ Hair sprays
- ☐ Scented deodorants
- ☐ Scotch tape
- ☐ Newsprint
- ☐ Lysol
- ☐ Epoxy
- ☐ Listerine
- ☐ Chloraseptic throat sprays
- ☐ Noxema
- ☐ Mildew cleaners
- ☐ Perfumes
- ☐ Air fresheners
- ☐ Disinfectants
- ☐ Polishes
- ☐ Glues
- ☐ Waxes
- ☐ Mouthwash
- ☐ Hard saucepan handles
- ☐ Smoke in the house
- ☐ Explain any known chemical exposures

- ☐ Have you had your home treated for termites
when? _____
- ☐ Wash your vehicle by hand

Carbon Monoxide/Nitrogen Oxide/Sulfur Dioxide

- ☐ Have oil or gas stove
- ☐ Have water heaters
- ☐ Chimney is damaged
- ☐ Live near a busy street
- ☐ Garage attached to your home
- ☐ Smoke at home
- ☐ Have an open fireplace
- ☐ Burn candles

Ozone

- ☐ Use an electrical sewing machine
- ☐ Use power tools
- ☐ Use ion generators
- ☐ Work close to a photocopier

Carbon Dioxide

- ☐ Work in a crowded work place
- ☐ Have poor ventilation at work

Asbestos

- ☐ Live in an old home
- ☐ Have old ceiling tiles, plaster, insulation board and heating duct tape
- ☐ Lived in large city with many trucks, buses, etc.
- ☐ Lived near a building which was torn down
- ☐ Mother exposed to any unusual chemicals or drugs during pregnancy
- ☐ Do you have your nails treated? Acrylic Adhesives

Please note the brand of product you use

i.e. Toothpaste: Crest

Shampoo: _____

Toothpaste: _____

Hair Conditioner: _____

Makeup: _____

Lipstick: _____

Make-up Foundation: _____

Deodorant: _____

Perfume: _____

Hairspray: _____

Shaving Cream: _____

Cologne: _____

Facial Creams: _____

Body Creams: _____

Do you have hair permanents? **Yes/No**

Do you have hair colorings? **Yes/No**

Do you use Latex products?

- ☐ Baby bottle nipples
- ☐ Balloons
- ☐ Bandages
- ☐ Diaphragms
- ☐ Hot water bottles
- ☐ Latex gloves
- ☐ Dishwashing gloves
- ☐ Rubber dams for dental work
- ☐ Tires

Heavy Metals, Mold, and General/Miscellaneous Toxins

- ☐ Have basement Molds
- ☐ Home is damp
- ☐ Any water Damage
- ☐ Home flooding
- ☐ Sewage backup
- ☐ Mold on walls and/or bathroom
- ☐ Use a humidifier? Last time cleaned _____
- ☐ Use black hair dye
- ☐ Worked in beauty shop
- ☐ Take illicit drugs as a youth
- ☐ Open your windows at home
- ☐ Work in a machine shop
- ☐ Work in a garden
- ☐ Work or have worked on a farm
- ☐ Have mercury fillings
- ☐ Had mercury fillings removed?. When _____
- ☐ Exposed to radiation? When _____
- ☐ Have a hot tub
- ☐ Use chlorine or bromine
- ☐ Have a well
- ☐ Work around PVC pipe
- ☐ Moved to a new office in the last two years
- ☐ Live in an apartment? How old? _____
- ☐ Eat at salad bars
- ☐ Eat raw fish (sushi)
- ☐ Buy food from street vendors
- ☐ **For Women:** Have breast implants? If yes:
 - ☐ Saline
 - ☐ Silicone
- ☐ Has any type of metal been used in implants or joints replacements in your body?
When & Where _____
- ☐ Notice symptoms at work more than at home or vice versa?
- ☐ Symptoms worse going into a mall
- ☐ Have you ever worked in a mall? When _____
- ☐ Have live plants in your home
- ☐ Have pets in your home that use flea/tick control
- ☐ Owned a new vehicle since your symptoms began
- ☐ Furniture been put in storage or possibly fumigated
- ☐ Stained furniture in last 2 years
- ☐ Have a tool shop in your garage
- ☐ Live on or near a golf course
- ☐ Live in or near an industrial area
- ☐ Lived or traveled outside US.
Where? _____
- ☐ Bought new furniture? Type of
Material _____
- ☐ Installed drop ceilings
- ☐ Painted indoors
- ☐ Sided your home
- ☐ Changed your heating system, stove, clothes dryer or water heater
- ☐ Lived in a brand new home
- ☐ Lived in a new office

- ☐ Noticed changes of your health since you moved into your home
- ☐ Do not have a water purification system?
- ☐ Live near a landfill?
- ☐ Unfiltered shower head

Bedroom contents

Mattress Type: _____

- ☐ Have hardwood floors
- ☐ Have carpeting
- ☐ Have blinds
- ☐ Have draperies
- ☐ Have foam pillow
- ☐ Use a feather pillow
- ☐ Use a Dacron pillow
- ☐ Use wool blankets
- ☐ Use cotton blankets
- ☐ Use quilts
- ☐ Use synthetic blankets
- ☐ Have oil or gas stove
- ☐ Have water heaters
- ☐ Chimney is damaged
- ☐ Live near a busy street
- ☐ Garage attached to your home
- ☐ Smoke at home
- ☐ Have an open fireplace
- ☐ Burn candles
- ☐ Have real plants
- ☐ Have artificial plants
- ☐ Use aromatherapy
- ☐ Burn scented candles
- ☐ Have central heat
- ☐ Have a fireplace
- ☐ Have an electric baseboard
- ☐ Use gas heat
- ☐ Use an air filter in your bedroom
- ☐ Central air conditioning
- ☐ Sleep with your windows open
- ☐ Live close to a high traffic road
- ☐ Smoke in bed
- ☐ Allow any pets in your room
- ☐ Have plugged in air fresheners

Hobbies and other activates

- ☐ Silk-screening
- ☐ Make stained glass
- ☐ Make pottery & ceramic products
- ☐ Make jewelry
- ☐ Buy art and craft supplies
- ☐ Use airbrush and spray paints
- ☐ Do quilting and weaving
- ☐ Gardening
- ☐ Make soapstone carvings
- ☐ Use acrylic paint
- ☐ Golf
- ☐ Paintball

Others: _____

READINESS ASSESSMENT

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

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

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

Comments _____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

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

Sincerely,

LORETTA T. FRIEDMAN, RN,MS,DC,CCN,CNS,DACBN,DCBCN

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records of Dr. _____

Address: _____

Telephone number () ____ - _____ Fax number () ____ - _____

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to _____

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

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

Alcohol or Drug Abuse: ☐ Yes ☐ No

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

Genetic Testing ☐ Yes ☐ No

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

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

I hereby release _____

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

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

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

Patient's Name: _____ D.O.B. _____

Please Print

Signature: _____ Date _____

Records Requested by: Doctor's Name:

Signature: _____

LORETTA T. FRIEDMAN, RN,MS,DC,CCN,CNS,DACBN,DCBCN