New Patient Application and Case History

Name _____ Age _____ Sex: M F DOB _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ e-mail: _____

May we leave a voice mail? Y N Height _____ Weight:_____

How Did You Hear About Us? _____

Employer _____ Occupation _____ Length of Employment _____

Present Complaints

1. Main Problem(s): _____

2. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your own opinion what do you think the real problem is : _____

3. Have you received a diagnosis? _____
   What diagnostic tools were used to achieve your diagnosis:

4. What are the three things your condition has caused you to miss most:

5. Symptoms(list all):

6. Severity of problem (circle):
   Minimal (annoying but causing no limitation)
   Slight (tolerable but causing a little limitation)
   Moderate (sometimes tolerable but definitely causing limitation)
   Severe (causing significant limitation)
   Extreme (causing near constant limitation (>80% of the time))

7. What relieves your symptoms or causes them to return:

8. Describe the first time you remember having symptoms:

9. If your symptoms include pain:
   What is the quality (sharp, dull, stabbing, color, etc.): _____
   Does the pain radiate: Y N where: _____

10. Do your symptoms occur at a specific time, place, or environment: Y N
    When and for how long do symptoms last each episode:

11. What types of treatment have you received:
    Prescription/Drug therapy _____
    Nutritional _____
    Alternative/Holistic _____

12. List your health goals in order of Importance:

    Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10

13. What are you hoping happens today as a result of your consultation:

14. How often are you aware of your main problem (circle one):
    Occasionally (25% of the time) Frequently (75% of the time)
    Intermittently (50% of the time) Constantly (100% of the time)

15. If you cannot find a solution to your problem what do you think will happen?

16. Due to your condition have you lost time from (describe how much time and what tasks have been limited)?
    Work: Y N Describe: _____
    Family: Y N Describe: _____

Leisure Activities Y N Describe: _____

Blood Sugar (if diabetic)

HIGHEST your blood sugar gets WITHOUT medication _____
LOWEST your blood sugar gets WITHOUT medication _____

HIGHEST your blood sugar gets WITH medication _____
LOWEST your blood sugar gets WITH medication _____

Medications

(List all prescription, over-the-counter, **botanicals, homeopathic, and supplements**)

_____ _____
_____ _____
_____ _____

Medical and Social History

Surgeries/Hospitalizations Date

_____
_____
_____

Trauma Date

_____
_____
_____

Past/Recent Illness Date

_____
_____

Marital Status: S/ M/W/Sep./D Spouse_____

Children / ages:

_____

Family History (mother, father, siblings, spouse, children) Date

_____
_____

Do you use: Alcohol Y N Tobacco Y N Caffeine Y N

___ drinks/week ___ pack/day ___ cups/day

Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced)

CONSTITUTIONAL

PC Fatigue
PC Recent weight change
PC Fever

EYES

PC Blurred/double vision
PC Glasses/contacts
PC Eye disease or injury

EAR/NOSE/MOUTH/THROAT

PC Swollen glands in neck
PC Hearing loss or ringing
PC Earaches or drainage
PC Chronic sinus problems or rhinitis
PC Nose bleeds
PC Mouth sores / Bleeding gums
PC Bad breath / bad taste
PC Sore throat or voice change

CARDIOVASCULAR

PC High or Low Blood Pressure
PC Shortness of breath walking/lying
PC Heart disease
PC Chest pain or angina pectoris
PC Palpatation
PC Mitral Valve Prolapse
PC Feet or ankle swelling
PC Shortness of breath
PC Spitting up blood

PSYCHIATRIC

PC Insomnia
PC Memory loss or confusion
PC Nervousness
PC Depression

GENITOURINARY

PC Frequent urination
PC Burning or painful urination
PC Blood in urine
PC Change in force or strain urinating
PC Kidney stones
PC Sexual difficulty
PC Male : testicle pain
PC Female: pain / irregular periods
PC Female: pregnant
PC Bladder Infections
PC Kidney Disease
PC Hemorrhoids

GASTROINTESTINAL

PC Abdominal pain
PC Nausea or Vomiting
PC Rectal bleeding/blood in stool
PC Painful bm / constipation
PC Ulcer
PC Change in bowel movement
PC Frequent diarrhea
PC Loss of appetite

RESPIRATORY

PC Chronic or frequent cough
PC Spitting up blood
PC Pneumonia / Bronchitis
PC Shortness of breath
PC Wheezing
PC Asthma

ENDOCRINE

PC Glandular or hormone problem
PC Excessive thirst or urination
PC Heat or cold intolerance
PC Skin becoming dryer
PC Change in hat or glove size
PC Diabetes
PC Thyroid Disease

MUSCUOSKELETAL

PC Back pain
PC Joint pain
PC Joint stiffness and swelling
PC Muscle pain or cramps
PC Muscle or joint weakness
PC Difficulty walking
PC Cold extremities

INTEGUMENTARY (skin, breast)

PC Change in skin color
PC Change in Hair or Nails
PC Varicose veins
PC Breast pain / discharge
PC Breast lump
PC Hives or Eczema
PC Rash or itching

NEUROLOG ICAL

PC Freq./ recurring headaches
PC Migraine headache
PC Convulsions or seizures
PC Numbness or tingling
PC Tremors
PC Paralysis
PC Head injury
PC Light headed or dizzy
PC Stroke

HEMATOLOGIC/LYMPHATIC/OTHER

PC Slow to heal after cuts
PC Easy bleeding or bruising
PC Anemia
PC Phlebitis
PC Past transfusion
PC Enlarged glands
PC Blood or Plasma Transfusions
PC Hepatitis
PC Cancer
PC Infectious Mono
PC AIDS or HIV+
PC Venereal
PC Chicken pox

ALLERGIES / OTHER(drugs, food, or environmental) _____

_____

_____

RECENT TESTS(lab work, x-rays, CT, MRI) _____

_____

_____

OTHER PROVIDERS

_____

_____

Doctor's Notes

_____

_____

_____

_____

_____

_____

Metabolic Assessment Form™

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

PART I

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

1. _____

2. _____

3. _____

4. _____

5. _____

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

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

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

SMGEMAF04(062513)

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

Category XI

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

Category XII

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

Category XIII

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

Category XIV

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

Category XV

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

Category XV *(Cont.)*

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

Category XVI *(Males Only)*

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

Category XVII *(Males Only)*

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

Category XVIII *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32	Yes	No
days) Shortened menstrual cycle (less than	Yes	No

24 days) 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	0	1	2	3
menses Pelvic pain during menses	0	1	2	3
Irritable and depressed during	0	1	2	3
menses Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine	Yes	No		
bleeding? 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 Painful	0	1	2	3
intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic 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 do you eat raw nuts or seeds per week? _____

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

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

Rate your stress level on a scale of 1-10 during the _____

average week: How many times do you eat fish per week?

How many times do you work out per week? _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:
