Form# 87

Acworth Wellness Center
2487 Cedarcrest Rd., Suite 913
Acworth, GA 30101
(770) 974-2405

Name:			Date:		
Address:			Unit:		
City:		State:		Zip:	
PHONE	Home:		Mobile:	Work:	
Email Address:					
Are you currently pregnant? Yes No			Are you currently a smoker? Yes No		
When was the last time you smoked a cigarette?					

Date of Birth:		Gender:	☐Male ☐Female

Age:		Height:		Weight:	

Status:
- ☐Married
- ☐Separated
- ☐Divorced
- ☐Widowed
- ☐Single
- ☐Partnership

Live with:
- ☐Spouse
- ☐Partner
- ☐Parents
- ☐Children
- ☐Friends
- ☐Alone

Education:

Occupation: Work Hours per week: ☐Retired

Employer | Work Address

In case of emergency, whom should we contact?

Name	Relationship	Address	Phone

How did you hear about our Wellness and Nutrition Program?

What is your major complaint. Please List when each symptom began and be as descriptive as possible

What are your current medications?

What are your current vitamins and/or supplements?

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

Is there anything else in your medical history that you consider to be relevant? (Even from childhood)

What is your employment history? Please provide brief summary <u>including dates</u> if possible.

List all of your past and current hobbies.

Please list past or present allergies, including allergies to medications.

Please list all past surgeries and the condition each surgery was for, including dates.

Please explain your housing history (type of homes and their age, from birth until present, where and when).

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

☐Yes	☐No	Do you have amalgam (silver) fillings in your teeth? If yes, How many?
☐Yes	☐No	Have you ever had an amalgam removed? If Yes, How many
☐Yes	☐No	If you had amalgams removed, was it done by a biological dentist using a safe protocol?
☐Yes	☐No	Did your mother have amalgam when pregnant with you?
☐Yes	☐No	Have you ever worked in a dental office? If so, how long?
☐Yes	☐No	Have you had any dental crowns? If yes, how many
☐Yes	☐No	Have you had any bridges?
☐Yes	☐No	Have you had any root canals?
☐Yes	☐No	Have you had any tooth extractions?
☐Yes	☐No	Do you have any dental implants, retainers or other metal in your mouth? Explain:
☐Yes	☐No	Did you wear contact lenses during the 1980's or early 1990's?
☐Yes	☐No	Did you take oral contraceptives during the 1980's or early 1990's?
☐Yes	☐No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
☐Yes	☐No	Have you noticed any adverse reactions to these shots?
☐Yes	☐No	Do you have any tattoos with red ink?
☐Yes	☐No	Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead

☐Yes	☐No	Does your occupation involve soldering or metal salvage?
☐Yes	☐No	Have you done any old home repair or sandblasting? If so, When
☐Yes	☐No	Do you do a lot of painting?
☐Yes	☐No	Were any of the homes you lived in built before 1978?
☐Yes	☐No	Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment)
☐Yes	☐No	Are you around a lot of fake leather, or vinyl?
☐Yes	☐No	Do you get stomach aches in the morning?

General Toxicity

☐Yes	☐No	Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
☐Yes	☐No	Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
☐Yes	☐No	Do you have your house sprayed with pesticides for pest control?
☐Yes	☐No	Do you spray herbicide (weed killers) in or around your home?
☐Yes	☐No	Do you use conventional insect repellants on yourself or family?
☐Yes	☐No	Do you use conventional sunscreen?
☐Yes	☐No	Do you use conventional perfume or cologne every day?
☐Yes	☐No	Do you get your hair colored? If so, is it on the scalp?
☐Yes	☐No	Do you use aerosol hairspray?
☐Yes	☐No	Do you get your nails done? If so, how often?
☐Yes	☐No	Do you use air freshener in your house, work or car?
☐Yes	☐No	Do you drink filtered water? If so, what type of filter do you have?
☐Yes	☐No	Do you drink bottle water if so what kind?
☐Yes	☐No	Do you have a water filtration system for your entire house or shower filtration? If so, what type?
☐Yes	☐No	Does <u>your spouse or other family members</u> work around chemicals?
☐Yes	☐No	Can you think of any other toxic exposures you may have had?
☐Yes	☐No	Are you a current smoker?
☐Yes	☐No	Have you smoked in the past?

For how long?_____

Mold

How old is the house you are living in? _____ How long have you lived there? _____
Have you noticed any new symptoms since moving in? _____ If so, what? _____

☐Yes	☐No	Do you see mold growing at home, work or school?
☐Yes	☐No	Have you ever had water damage at home, work or school?
☐Yes	☐No	Does your home, workplace or school have a damp or mildew smell?
☐Yes	☐No	Does spending time in your basement cause or worsen your symptoms?
☐Yes	☐No	Does your basement ever get wet?
☐Yes	☐No	Do you have a crawl space?
☐Yes	☐No	Does your basement or crawl space have a sump pump?
☐Yes	☐No	Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
☐Yes	☐No	Does your car have a mildew smell?
☐Yes	☐No	Does anyone in your home have asthma like symptoms?
☐Yes	☐No	Does anyone in your family have chronic sinus infections or irritations?

Lyme Disease

☐Yes	☐No	Have you ever been diagnosed with Lyme Disease?
☐Yes	☐No	Have you had dry sockets or infected tooth extractions?
☐Yes	☐No	Do you have small joint pain?
☐Yes	☐No	Have you ever been bitten by a tick or recluse spider?
☐Yes	☐No	Have you ever seen a bulls-eye rash appear on any part of your body?
☐Yes	☐No	Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
☐Yes	☐No	Was your mother ever diagnosed with Lyme Disease?
☐Yes	☐No	Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

☐Yes	☐No	Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
☐Yes	☐No	Does anyone in your family experience similar symptoms to yours?
		What is your birth order (i.e. first born, second, third, etc.)? _____.
☐Yes	☐No	Do you have any history of kidney dysfunction?
☐Yes	☐No	Do you or any immediate family member have a history with cancer?
☐Yes	☐No	Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
☐Yes	☐No	Are you currently having any thoughts of suicide?
☐Yes	☐No	Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
☐Yes	☐No	Do you have a history of strokes?
☐Yes	☐No	Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?
☐Yes	☐No	Have you ever been in an auto accident, fallen or received a major physical injury?
☐Yes	☐No	Are you in menopause?

Microbiome Health

☐Yes	☐No	Do you get foul or sulfur smelling gas (distention, bloating, belching, feeling full and a noisy gut) after eating carbohydrates (ie. grains and vegetables) or fermented foods and/or probiotics?
☐Yes	☐No	Does your gut temporarily feel better after a round of antibiotics?
☐Yes	☐No	Do you bloat 30 minutes after eating?
		How many times a day are you having a bowel movement? _____
☐Yes	☐No	Do you often have gas that has a sulfur or foul smell?
☐Yes	☐No	Are you sensitive to supplements?
☐Yes	☐No	Have you ever been vegan or vegetarian for any length of time?
☐Yes	☐No	Can you tolerate Meat?
☐Yes	☐No	Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?
☐Yes	☐No	Have you taken birth control or Hormone replacement therapy for any length of time?
☐Yes	☐No	If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?
☐Yes	☐No	Have been on antibiotics for any extended period of time or often as a child or adult?
☐Yes	☐No	Were you caesarian delivered?
☐Yes	☐No	Were you breast fed? If so, How long _____
☐Yes	☐No	Are you dairy sensitive?

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

Column #1	
	Anxiety
	Mood swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5°)
	Insomnia (can't get to sleep or return to sleep
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound
	Total
	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)
	Total

Column #2	
	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Bad night vision or seeing halos around lights
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Blurred vision at times
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep
	Total
	Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain-not necessarily true arthritis-can move from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)
	Total
	Total Columns 1 & 2