AGELESS ENERGETICS

GENERAL INFORMATION

Name: _____

Preferred Name: _____

Date of Birth: _____

Age: _____ Gender: ○Male ○Female

Genetic Background: ○African ○European ○Native American ○Mediterranean ○Asian
○Ashkenazi ○Middle Eastern ○ _____

Job Title: _____

Nature of Business: _____

Primary Address: _____

City: _____ State: _____ Zip:_____

Alternate Address: _____

City: _____ State: _____ Zip:_____

Home Phone 1: _____

Home Phone 2: _____

Work Phone: _____

Cell Phone: _____

Fax: _____

Email: _____

EMERGENCY CONTACT

Name: _____Phone Number: _____

PHYSICIAN

Name: _____

Phone Number: _____

Fax: _____

REFERRED BY

○Book ○Website ○Media ○Mediterranean ○Friend or Family ○_____

PHARMACY INFORMATION

Primary Pharmacy:_____

Address: _____

City: _____ State: _____ Zip:_____

Fax: _____

Email: _____

COMPOUNDING/ SUPPLEMENT PHARMACY

Primary Pharmacy:_____

Address: _____

City: _____ State: _____ Zip:_____

Fax: _____

Email: _____

CREDIT CARD INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____

Preferred Method of Payment (please circle one): ○Cash ○Check ○Credit Card

Credit card Type (please select one): ○Visa ○Mastercard ○Discover

Primary Card

Name on card: _____

Credit card Type (please select one): ○Visa ○Mastercard ○Discover

Account Number: _____

Expiration Date: _____CVV#: _____

Secondary Card

Name on card: _____

Credit card Type (please select one): ○Visa ○Mastercard ○Discover

Account Number: _____

Expiration Date: _____CVV#: _____

MEDICAL MALPRACTICE NOTIFICATION LETTER

EFFECTIVE SEPTEMBER 18, 2006

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. The physicians of Glades Medical Group have decided not to carry medical malpractice insurance. This is permitted under Florida Law, subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. See FLA.STAT.458.320(5)(G)5.

By signing below, I am acknowledging that I have been made aware of the above.

Signature: _____

Date: _____

MEDICAL QUESTIONNAIRE

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS/ CONCERNS

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

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

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?

_____

LIST CURRENT AND ONGOING PROBLEMS

Describe problem	Mild	Mod	Severe	Describe problem/ Approach	Mild	Mod	Severe

MEDICAL HISTORY: DISEASE/ DIAGNOSIS/CONDITIONS

Please check appropriate box and provide date of onset. ☐ = Past condition ☐ = Ongoing condition

GASTROINTESTINAL

☐ ☐ Irritable Bowel Syndrome _____
☐ ☐ Inflammatory Bowel Disease _____
☐ ☐ Crohn's _____
☐ ☐ Ulcerative Colitis _____
☐ ☐ Gastritis or Peptic Ulcer Disease _____
☐ ☐ GERD (reflux) _____
☐ ☐ Celiac Disease _____
☐ ☐ Other _____

CARDIOVASCULAR

☐ ☐ Heart Attack _____
☐ ☐ Other Heart Disease _____
☐ ☐ Stroke _____
☐ ☐ Elevated Cholesterol _____
☐ ☐ Arrhythmia (irregular heart rate) _____
☐ ☐ Hypertension (high blood press.) _____
☐ ☐ Rheumatic Fever _____
☐ ☐ Other _____

METABOLIC/ENDOCRINE

☐ ☐ Type 1 Diabetes _____
☐ ☐ Type 2 Diabetes _____
☐ ☐ Hypoglycemia _____
☐ ☐ Metabolic Syndrome _____
☐ ☐ Hypothyroidism (low thyroid) _____
☐ ☐ Hyperthyroidism (low thyroid) _____
☐ ☐ Endocrine Problems _____
☐ ☐ Polycystic Ovarian Syndrome _____
(PCOS) _____
☐ ☐ Infertility _____
☐ ☐ Weight Gain _____
☐ ☐ Weight Loss _____
☐ ☐ Frequent Weight Fluctuations _____
☐ ☐ Bulimia _____
☐ ☐ Anorexia _____
☐ ☐ Binge Eating Disorder _____
☐ ☐ Night Eating Syndrome _____
☐ ☐ Eating Disorder _____
☐ ☐ Other _____

GENITAL AND URINARY SYSTEMS

☐ ☐ Kidney Stones _____
☐ ☐ Gout _____
☐ ☐ Interstitial Cystitis _____
☐ ☐ Frequent Urinary Tract Infection _____
☐ ☐ Frequent Yeast Infections _____
☐ ☐ Erectile or Sexual Dysfunction _____
☐ ☐ Other _____

MUSCULOSKELETAL/PAIN

☐ ☐ Osteoarthritis _____
☐ ☐ Fibromyalgia _____
☐ ☐ Chronic Pain _____
☐ ☐ Other _____

IMFLAMMATORY/AUTOIMMUNE

☐ ☐ Chronic Fatigue Syndrome _____
☐ ☐ Autoimmune Disease _____
☐ ☐ Rheumatoid Arthritis _____
☐ ☐ Lupus SLE _____
☐ ☐ Immune Deficiency Disease _____
☐ ☐ Severe Infection Disease _____
☐ ☐ Poor Immune Function _____
☐ ☐ Food Allergies _____
☐ ☐ Environmental Allergies _____
☐ ☐ Multiple Chemical Sensitivities _____
☐ ☐ Latex Allergy _____
☐ ☐ Other _____

RESPIRATORY DISEASE

☐ ☐ Asthma
☐ ☐ Chronic Sinusitis _____
☐ ☐ Bronchitis _____
☐ ☐ Emphysema _____
☐ ☐ Pneumonia _____
☐ ☐ Tuberculosis _____
☐ ☐ Sleep Apnea _____
☐ ☐ Other _____
_____

CANCER

- ☐ ☐ Lung Cancer _____
- ☐ ☐ Breast Cancer _____
- ☐ ☐ Colon Cancer _____
- ☐ ☐ Ovarian _____
- ☐ ☐ Prostate Cancer _____
- ☐ ☐ Skin Cancer _____
- ☐ ☐ Other

SKIN DISEASES

- ☐ ☐ Eczema _____
- ☐ ☐ Psoriasis _____
- ☐ ☐ Acne _____
- ☐ ☐ Melanoma _____
- ☐ ☐ Skin Cancer _____
- ☐ ☐ Other _____

NEUROLOGIC/MOOD

- ☐ ☐ Depression _____
- ☐ ☐ Anxiety _____
- ☐ ☐ Bipolar Disorder _____
- ☐ ☐ Schizophrenia _____
- ☐ ☐ Headaches _____
- ☐ ☐ Migraines _____
- ☐ ☐ ADD/ADHD _____
- ☐ ☐ Autism _____
- ☐ ☐ Mild Cognitive Impairment _____
- ☐ ☐ Memory Problems _____
- ☐ ☐ Parkinson's Disease _____
- ☐ ☐ Multiple Sclerosis _____
- ☐ ☐ ALS _____
- ☐ ☐ Seizures _____
- ☐ ☐ Other Neurological Problem _____

Check box if yes/ provide date

PREVENTIVE TESTS AND DATE OF LAST TEST

- ☐ ☐ Full Physical Exam _____
- ☐ ☐ Bone Density _____
- ☐ ☐ Colonoscopy _____
- ☐ ☐ Cardiac Stress Test _____
- ☐ ☐ EBT Heart Scan _____
- ☐ ☐ EKG _____
- ☐ ☐ Hemoccult Test-Stool Test for Blood _____
- ☐ ☐ MRI _____
- ☐ ☐ CT scan _____
- ☐ ☐ Upper Endoscopy _____
- ☐ ☐ Upper GI series _____
- ☐ ☐ Ultrasound _____

SURGERIES

- ☐ ☐ Appendectomy _____
- ☐ ☐ Hysterectomy +/- Ovaries _____
- ☐ ☐ Gall Bladder _____
- ☐ ☐ Hernia _____
- ☐ ☐ Tonsillectomy _____
- ☐ ☐ Dental Surgery _____
- ☐ ☐ Joint Replacement-Knee/Hip _____
- ☐ ☐ Heart Surgery- Bypass Valve _____
- ☐ ☐ Angioplasty or Stent _____
- ☐ ☐ Pacemaker _____
- ☐ ☐ Other _____

INJURIES *Check box if yes.*

- ☐ Back injury
- ☐ Neck Injury
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Other

BLOOD TYPE

- ☐ A
- ☐ B
- ☐ AB
- ☐ O
- ☐ RH+
- ☐ Unknown

HOSPITALIZATIONS

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

COMMENTS _____

GYNECOLOGIC HISTORY- FOR WOMEN ONLY (*Check box if yes and provide number of.)*

OBSTETRIC HISTORY

- ☐ Pregnancies _____
- ☐ Caesarean _____
- ☐ Vaginal delivers _____
- ☐ Miscarriage _____
- ☐ Abortion _____
- ☐ Living Children: _____
- ☐ Post Partum Depression _____
- ☐ Toxemia _____
- ☐ Gestational Diabetes _____
- ☐ Baby over 8 pounds _____
- ☐ Breast Feeding For how long? _____

MENSTRUAL HISTORY

- Age at first period: _____
- Menses Frequency: _____
- Length: _____
- Pain: ☐ Yes ☐ No
- Clotting: ☐ Yes ☐ No
- Ever skipped period? ☐ Yes ☐ No
- For how long? _____
- Last period: _____

Use of hormonal contraception such as: ☐ Birth Control Pill ☐ Patch ☐ Nuva Ring How long? _____

Do you use contraception? ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy ☐ Other: _____

WOMEN'S DISORDERS/ HORMONAL IMBALANCES

- ☐ Fibrocystic Breast
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Infertility
- ☐ Painful periods
- ☐ Heavy periods
- ☐ PMS

Last Mammogram: _____ ☐ Breast Biopsy/ Date:_____

Last PAP Test: _____ ☐ Normal ☐ Abnormal

Date of last Bone Density: _____ Results: ☐ High ☐ Low ☐ Within Normal Range

Are you in Menopause? ☐ Yes ☐ No Age at Menopause: _____

- ☐ Hot Flashes
- ☐ Mood Swings
- ☐ Concentration/Memory Problems
- ☐ Vaginal Dryness
- ☐ Decreased Libido
- ☐ Heavy Bleeding
- ☐ Joint Pains
- ☐ Headaches
- ☐ Weight Gain
- ☐ Loss of Control of Urine
- ☐ Palpitations
- ☐ Use of hormone replacement therapy:

How long? _____

MEN'S HISTORY- FOR 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
- ☐ Difficulty Obtaining Erection
- ☐ Difficulty Maintaining an Erection
- ☐ Nocturia (urination at night) How many times at night?
- ☐ Urgency/Hesitancy/Change in Urinary Stream
- ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel? ☐ Yes ☐ No Where? _____

Wilderness Camping? ☐ Yes ☐ No Where? _____

Have you ever had severe ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you get bloated after meals? ☐ Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature

Pregnancy Complications? _____

Birth Complications: _____

☐ Breast Fed How long? _____

☐ Bottle Fed

Age at introduction of solid foods: _____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No

DENTAL HISTORY

DENTAL SURGERY

☐ Silver Mercury Fillings How Many? _____
☐ Gold Filling
☐ Root Canals
☐ Implants

☐ Tooth Pain
☐ Bleeding Gums
☐ Gingivitis
☐ Problems with chewing
Do you floss regularly?

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS - LAST 10 YEARS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEPATHY)

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin, Tylenol, Acid Blocking - Tagamet, Zantac, Prilosec etc.)? ☐ Yes ☐ No

Frequent antibiotics ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhaler) in the past ☐ Yes ☐ No

Use of oral contraceptives ☐ Yes ☐ No

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age of death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Strokes												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/ Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat
☐ Low Carbohydrate
☐ High Proteins
☐ Low Sodium
☐ Diabetic
☐ No Dairy
☐ No Wheat
☐ Gluten Restricted
☐ Vegetarian
☐ Vegan
☐ Ultrametabolism
☐ Specific Program for Weight Loss/Maintenance
Type: _____ Other: _____

Height (feet/inches): _____ Usual Weight Range +/-5lbs: _____

Highest adult weight: _____ Weight Fluctuations (>10lbs.) ☐ Yes ☐ No

Current weight: _____ Desired Weight Range +/-5lbs: _____

Lowest adult weight: _____ Body fat % _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No

If yes, what was it? _____

Do you avoid any particular foods? ☐ Yes ☐ No If yes, types and reason? _____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? _____

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No If no, who does the cooking? _____

How many meals do you eat per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more that 50% meals away from home
☐ Travel Frequently
☐ Non-availability of health meals
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Significant other or family members don't like health foods
☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night.
☐ Confused about nutrition advice.

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

_____

SMOKING

Currently smoking? ☐ Yes ☐ No

How many years? _____ Packs per day: _____ Attempts to quit: _____

Previous smoking: How many years? _____ Packs per day? _____

2nd Hand smoke exposure: _____

ALCOHOL INTAKE

How many drinks currently per week? (*1=drink = 5 ounces wine, 12oz beer, 1.5 ounces spirits)*

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Previous alcohol intake: ☐ Mild ☐ Moderate ☐ High ☐ None

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you ever take an eye opener? ☐ Yes ☐ No

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

Have you been unable to remember what you did during a drinking episode? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

Caffeine intake: ☐ Yes ☐ No Cups/day: ☐ Coffee ☐ Tea ☐ 1 ☐ 2-4 ☐ >4 a day

Caffeinated sodas or diet sodas intake? ☐ Yes ☐ No

12-ounce can/bottle/day ☐ 1 ☐ 2-4 ☐ >4 a day List favorite type(coke, pepsi, etc): _____

Are you currently using any recreational drugs? ☐ Yes ☐ No

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

EXERCISE - Current exercise program: Activity (list type, number of sessions/week, and duration)

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, Pilates, etc)			
Sports or Leisure Activities			

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

List problems that limit activity: _____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes please describe: _____

Do you usually sweat during exercising? ☐ Yes ☐ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life ? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

STRESS/COPING

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No Describe: _____

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

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

Daily stressors: Rate on scale of 1-10

Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation technique? ☐ Yes ☐ No How often: _____

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer

☐ Other: _____

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

SLEEP/REST

Average number of hours you sleep per night: ☐>10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you fell rested upon awakening? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No Explain: _____

ROLES/RELATIONSHIP

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partnership

List Children:

Child's Name	Age	Gender

Who is living in household? Number _____

Names: _____

Their employment / occupation: _____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

Are satisfied with your sex life? ☐ Yes ☐ No

How well have things been going for you?	Very well	Fine	Poorly	Does not apply
Overall				
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				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No

If yes, describe symptoms _____

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If yes, list all _____

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel ☐ Irritable or wired ☐ Aches and pains

Do you adversely react to: Check all that apply.

☐ Monosodium glutamate (MSG)
☐ Aspartame (Nutrasweet)
☐ Caffeine
☐ Bananas
☐ Garlic
☐ Onion
☐ Cheese
☐ Citrus foods
☐ Chocolate
☐ Alcohol
☐ Red Wine
☐ Sulfite containing foods (wine, dried fruit, salad bars)
☐ Preservatives (ex. Sodium benzoate)
☐ Other: _____

Which of these significantly affect you? Check all that apply.

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Others: _____

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's syndrome or a liver disorder? ☐ Yes ☐ No

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides
☐ Insecticides (Frequent visits of exterminator)
☐ Pesticides
☐ Organic Solvents
☐ Heavy Metals
☐ Other: _____

Chemical Name, Date, and Length of exposure: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

GENERAL
- ☐ Cold hands & feet
- ☐ Cold intolerance
- ☐ Low body temperature
- ☐ Low blood pressure
- ☐ Daytime sleepiness
- ☐ Difficulty falling asleep
- ☐ Early waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat intolerance
- ☐ Nightmares
- ☐ No dream recall

HEAD/EYES/EARS
- ☐ Conjunctivitis
- ☐ Distorted sense of smell
- ☐ Distorted taste
- ☐ Ear fullness
- ☐ Ear pain
- ☐ Ear ringing/buzzing
- ☐ Lid margin redness
- ☐ Eye crusting
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Hearing problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to loud noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL
- ☐ Back muscle spasm
- ☐ Calf cramps
- ☐ Chest tightness
- ☐ Foot cramps
- ☐ Joint Deformity
- ☐ Joint pain
- ☐ Joint redness
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Muscle spasm
- ☐ Muscle stiffness
- ☐ Muscle twitches- eye area
- ☐ Muscle twitches- arms/legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension headache
- ☐ TMJ problems

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory hallucinations
- ☐ Black out
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Difficulty with balance
- ☐ Difficulty with thinking
- ☐ Difficulty with judgment
- ☐ Difficulty with speech
- ☐ Difficulty with memory
- ☐ Dizziness (spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other phobias
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual hallucinations

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't gain weight
- ☐ Can't lose weight
- ☐ Can't maintain healthy weight
- ☐ Frequent dieting
- ☐ Poor appetite
- ☐ Salt cravings
- ☐ Carbohydrate cravings(breads, pastas)
- ☐ Sweets cravings (candy, cookies, cakes)
- ☐ Chocolate cravings
- ☐ Caffeine dependent

DIGESTION
- ☐ Anal spasms
- ☐ Bad teeth
- ☐ Bleeding gums
- ☐ Bloating of lower abdomen
- ☐ Bloating of whole abdomen
- ☐ Bloating after meals
- ☐ Blood in stools
- ☐ Burping
- ☐ Canker sores
- ☐ Cold sores
- ☐ Constipation
- ☐ Cracking at corner of lips
- ☐ Cramps
- ☐ Dentures with poor chewing
- ☐ Diarrhea
- ☐ Alternating diarrhea and constipation
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures

DIGESTION
- ☐ Food "repeat" (reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper abdominal pain
- ☐ Vomiting
- ☐ Intolerance to lactose
- ☐ Intolerance to dairy products
- ☐ Intolerance to wheat
- ☐ Intolerance to gluten (wheat, rye, barley)
- ☐ Intolerance to corn
- ☐ Intolerance to eggs
- ☐ Intolerance to fatty foods
- ☐ Intolerance to yeast
- ☐ Liver disease/Jaundice
- ☐ Lower abdominal pain
- ☐ Mucus in stools
- ☐ Periodontal Disease
- ☐ Sore tongue
- ☐ Strong stool odor
- ☐ Undigested food in stools

SKIN PROBLEMS
- ☐ Acne on back
- ☐ Acne on chest
- ☐ Acne on face
- ☐ Acne on shoulders
- ☐ Athlete's foot
- ☐ Bumps on back of upper arms
- ☐ Cellulite
- ☐ Dark circles under eyes
- ☐ Ears get red
- ☐ Easy bruising
- ☐ Lack of sweating
- ☐ Eczema
- ☐ Herpes (Genital)
- ☐ Hives
- ☐ Jock itch
- ☐ Lackluster skin
- ☐ Moles w/color/size change
- ☐ Oily skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitive to bites

SKIN PROBLEMS
- ☐ Sensitive to poison ivy/oak
- ☐ Shingles
- ☐ Skin darkening
- ☐ Strong body odor
- ☐ Hair loss
- ☐ Vitiligo

ITCHING SKIN
- ☐ Skin in general
- ☐ Anus
- ☐ Arms
- ☐ Ear canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of mouth
- ☐ Scalp
- ☐ Throat

SKIN DRYNESS
- ☐ Eyes
- ☐ Feet cracking
- ☐ Feet peeling
- ☐ Hair
- ☐ Hair and unmanageable
- ☐ Hands with cracking
- ☐ Hands with peeling
- ☐ Mouth/throat
- ☐ Scalp
- ☐ Scalp with dandruff
- ☐ Skin in general

LYMPH NODES
- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other enlarged/tender
- ☐ Lymph nodes

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve up
- ☐ Frayed
- ☐ Fungus-fingers
- ☐ Fungus-toes
- ☐ Pitting
- ☐ Ragged cuticles
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of finger nails
- ☐ Thickening of toenails
- ☐ White spots or lines

RESPIRATORY
- ☐ Bad breath
- ☐ Bad odor in nose
- ☐ Cough – dry
- ☐ Cough- productive
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Hay fever in spring
- ☐ Hay fever in summer
- ☐ Hay fever in fall
- ☐ Hay fever in change of season
- ☐ Nasal Stuffiness
- ☐ Nose bleeds
- ☐ Post nasal drip
- ☐ Sinus fullness
- ☐ Sinus infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter stuffiness

CARDIOVASCULAR
- ☐ Angina /chest pain
- ☐ Breathlessness
- ☐ Heart murmur
- ☐ Irregular pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/ Feet
- ☐ Varicose veins

URINARY
- ☐ Bed wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney disease
- ☐ Leaking/incontinence
- ☐ Pain/burning
- ☐ Prostate infection
- ☐ Urgency

MALE REPRODUCTIVE
- ☐ Discharge from penis
- ☐ Ejaculation problem
- ☐ Genital pain
- ☐ Impotence
- ☐ Prostate or urinary infection
- ☐ Lumps in testicles
- ☐ Poor Libido (Sex drive)

FEMALE REPRODUCTIVE
- ☐ Breast cysts
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Ovarian cyst
- ☐ Poor libido
- ☐ Vaginal discharge
- ☐ Vaginal odor
- ☐ Vaginal itch
- ☐ Vaginal pain with sex

Premenstrual:
- ☐ Bloating breast tenderness
- ☐ Carbohydrate cravings
- ☐ Chocolate cravings
- ☐ Constipation
- ☐ Decreased sleep

FEMALE REPRODUCTIVE
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased sleep
- ☐ Irritability

Menstrual:
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No periods
- ☐ Scanty periods
- ☐ Spotting between

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:

1. Significantly modify you diet: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
2. Take several nutritional supplements each day: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
3. Keep a record of everything you eat each day: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
4. Modify your lifestyle (work demands, sleep habits): ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
5. Practice a relaxation technique: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
6. Engage in regular exercise: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
7. Have periodic lab test to assess your progress: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

Rate on a scale of: 5 – very willing to 1 – not willing

1. How confident are you of your ability to organize and follow through on the above health related activities? : ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

_____

Rate on a scale of: 5 – very willing to 1 – not willing

1. At the present time, how supportive do you think the people on your household will be to your implementing the above changes? : ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

Rate on a scale of: 5 – very willing to 1 – not willing

1. How much on-going support and contact from our professional staff would be helpful to you as you implement your personal health program? : ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

Weight: _____ B.P.: _____ BMI:_____

I affirm that all above health history questionnaire is truthfully and accurately.

Patient Signature: _____

Nurse/M.A: _____

INFORMED CONSENT FOR TREATMENT

I, _____ hereby authorize Dr. _____ physician contracted by Glades Medical Group to use the following to facilitate my diagnosis and treatment:

- **Common diagnostic procedures:** draw blood laboratory
- **Use of nutrition:** therapeutic nutrition, nutritional supplements and intramuscular vitamin injections
- **Botanical medicine:** teas, alcohol and glycerin extracts, solid extracts, capsules, tablets, creams, ointments and suppositories.
- **Prescription medications:** antivirals, hCG, antibiotics, antifungal, hormonal, or other prescription medications.
- **Physical medicine:** massage therapy, muscle energy stretching, trigger point release, manipulation, hydrotherapy, or similar hands-on therapies.
- **Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep and stress.

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: Restoration of health and body's maximum functional capacity without the use if drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential risks: Allergic reactions to prescribed medications, herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injection, venipunctures or procedure, tenderness /soreness or bruising from physical treatments.

Side effects: The HCG side effects to keep an eye out for include the onset of headaches, irritability, restlessness, slight water retention, tenderness of breast tissue, swelling of the injection site, and depression. There are some rare, severe side affects as well which include the development of ovarian hyper stimulation in females. The latter condition requires immediate medical treatment and is accompanied by the following symptoms: tremendous pain in the region of the pelvis, the swelling of feet, legs and hands, abdominal pain, abdominal swelling, difficulty breathing, diarrhea, vomiting, nausea, a diminishing of urination and weight gain. If a user of HCG products notes any side effects it is recommended that he or she cease using the products immediately and that he or she seek out the assistance of a physician.

HCG is not FDA approved as a weight loss use, but is for other uses not associated with weight.

Notice to all pregnant women: All females patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to pregnancy.

Pictures will be taken to visually monitor progress and maybe used for training purposes.

I understand that a record will be kept of health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, my representative, or unless law requires. I understand that I may look at my medical record and can request a copy of my record by paying the appropriate fee. I understand that my medical record will be kept no more than ten years after the date if my last treatment. I understand that the doctor will answer any questions that I might have.

With this knowledge, I voluntary consent to the above procedures. I realize that neither the doctor nor any personnel of Glades Medical Group has made any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I waive my right to future litigation regarding my present health conditions by signing this agreement. No Refunds.

Print Name: _____Date:_____

Signature: _____

Signature of patient representative or guardian:_____

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRATICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Glades Medical Group. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Glades Medical Group reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

In addition, to the allowable disclosure described in the Statement of Privacy Practices. I hereby specifically authorize disclosure of my protected health care information to the persons indicted below. (Please circle)

Any member of the immediate family: ☐ Yes ☐ No
Spouse: ☐ Yes ☐ No
Other (please specify): ☐ Yes ☐ No

Name of patient or personal representative:_____

Signature of patient or personal representative:_____