Please read and complete the following paperwork prior to your appointment at The Block Center

Please select the appropriate history form as well. The child's form is for age birth to 18 years of age. The adult form is for over 18 years old.

The Block Center
PROVIDER NOTICE
OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact The Block Center.

Individual rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $25.00(twenty five dollars) for the first twenty pages, $0.50 (50 cents) for each page thereafter, and $9.40 to mail certified with return receipt. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact The Block Center You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:
The Block Center
1750 Norwood Drive
Hurst, Texas 76054
Phone: (817) 280-9933

I hereby declare that I have received and read the copy of The Block Center's Provider Notice of Information Practices.

Patient's printed name_____

Signature of patient or parent (if minor child) _____

Date_____

The Block Center
1750 Norwood Drive, Hurst, TX 76054
817-280-9933

IT IS IMPORTANT THAT YOU OR ANYONE COMING WITH YOU NOT WEAR ANY PERFUME, COLOGNE, AFTERSHAVE OR FRAGRANCES OF ANY KIND TO THE OFFICE. THIS ALSO INCLUDES TOBACCO ODORS, SHAMPOO, HAIR SPRAY AND FABRIC SOFTENER WITH FRAGRANCE. DUE TO THE SENSITIVITIES OF DR. BLOCK AND OTHERS IN OFFICE, YOU WILL BE UNABLE TO ENTER THE OFFICE IF YOU ARE WEARING ANY FRAGRANCE. IF YOU DO COME TO THE OFFICE WITH ANY FRAGRANCE ON, ARRIVE MORE THAN 15 MINUTES LATE OR DO NOT HAVE YOUR PAPERWORK FILLED OUT COMPLETELY, YOU WILL BE REQUIRED TO RESCHEDULE YOUR APPOINTMENT AND FORFEIT YOUR DEPOSIT.

Payment is due at the time service are rendered and is payable by cash, check, MasterCard, or Visa.

We require 24 hours notice for rescheduling appointments. If you have any questions about your appointment please call during office hours so that we may clarify them prior to your visit.

We look forward to your visit.

I understand that The Block Center does not accept insurance for payment and that I am responsible for payment of all of my medical care. I understand that payment is due at the time of service.

If you will be filing claims with your insurance company you will need to sign an authorization to release information. Many times your insurance company will request more information from our office before they will process your claim. Please fill out the attached authorization with your insurance information. Without this signed consent we will be unable to release the information and your claim will not be processed. If your insurance company requests copies of your medical records, you will be billed for the cost of making the copies and mailing them to the insurance company. The charge approved by the State of Texas for this service is $25.00 for the first 20 pages and $0.50 for each page thereafter. There will also be fees for mailing the records. These fees include a certified fee, a returned receipt fee and the postage fee. These fees vary in price depending upon how much the copies weigh and the location or 'zone' they are being mailed to. We mail all medical records certified, return receipt so that we have proof that your insurance company did in fact receive your records.

Please initial below:

_____ I agree to have the Block Center mail copies of my medical records to my insurance company and I agree to pay the fees as outlined above each time my insurance company requests copies of my medical records.

_____ I do not want The Block Center to send copies of my medical records to my insurance company.

_____ _____

Signature of Patient or Responsible Party Date

The Block Center
1750 Norwood Drive, Hurst, TX 76054
817-280-9933

PATIENT RECORD OF DISCLOSURE

In general the HIPPA privacy rule gives patients the right to request on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- □ **Home/Cell Telephone _____**
- □ **O.K. to leave message with detailed information**
- □ **Leave name/doctor with call back number only**
- □ **Work number_____**
- □ **Leave detailed message on work voice mail**
- □ **Leave name/doctor with call back number only**
- □ **When unable to contact me by phone, a written communication may be sent to my home address**
- □ **Other_____**

_____ _____
Print name of patient Birth Date

_____ _____
Signature of patient or guardian Date

Healthcare providers must keep records of PHI disclosures.

Medicaid Release Information

I, _____,
(Patient or parent/guardian of patient) understand that Dr. Mary Ann Block is not a Medicaid provider. I understand that my relationship with The Block Center is based on private pay and that I am responsible for all fees related to medical care. I understand that these fees are due at the time of service. I understand that no Medicaid claims will be or can be filed on my behalf for any services at The Block Center.

_____ _____
(Signature of patient or parent/guardian of patient) Date

The Block Center
1750 Norwood Drive, Hurst, TX 76054
817-280-9933

Welcome to Testing

Dear Family:

You or your child will be undergoing various tests for either foods, inhalants or histamine sensitivities. In order to receive the most benefit from testing, your help and cooperation is essential. **Please do not wear cologne or anything with any scent including tobacco smoke or fabric softeners. You will be unable to enter the testing room if you have any fragrances on.** You will be required to take your child's or your pulse during the testing process. You will be asked to observed behavioral changes, changes in appearance, and any other symptoms you or your child may be experiencing. You will be given a timer to be set after each dose you or your child receives. Testing is done by intradermal injections. The timer will beep at five minute at which time you will need to take you or your child's pulse for 15 seconds and record it on the symptoms sheet then have your child sign his/her name or you will sign your name. If your child is too young to be able to write his/her name, you may have your child draw a picture. Have appropriate concentration work ready. Restart the timer for 5 minutes for concentration work. When the timer beeps after the five minutes have expired note any symptoms you observed or you or your child felt thought out the 10 minutes. Next please see the tester with your or your child's chart for evaluation and possible next injection. Your keeping accurate notes during the testing process will enable the tester to obtain the best results possible.

Our goal is to discover what sensitivities your child has and how these sensitivities affect your child's ability to function. We want the most for your child and you. For some children identifying theses sensitivities and treating them enables the child to concentrate more easily, ease some of their frustrations, and yours, and help life to be more enjoyable.

If you have any questions or concerns during this process, please feel at ease to discuss them with the tester and/or Dr. Block.

We look forward to having you and your child work with us to help make your testing experience a rewarding one.

YOU MUST SEE THAT YOU OR YOUR CHILD TAKE NO ANTIHISTAMINES OR HERBS, HOMEOPATHIC DRUGS FOR ALLERGIES FOR ONE WEEK OR VITAMIN C FOR 72 HOURS PRIOR TO THE TESTING APPOINTMENT. You will be here for several hours so come dressed in warm comfortable clothes. Room temperature stays at 70 degrees. Please write down all the foods you or your child has eaten that day. Make sure you or your child have eaten 4 or 5 of the foods that you eat on a regular basis. We will either be testing these foods or histamine, so if you have certain foods you want tested, please be sure to speak to the tester about this. You or your child will need to wear something with short sleeves. The testing will be done on their upper arm. The tester will be glad to teach you to take your or your child's pulse. Please bring some school work or age appropriate concentration work for you or your child to work on during testing so you can evaluate changes in concentration. Please bring a mid morning and /or mid afternoon protein snack (nuts, eggs, meat, cheese). We look forward to seeing you and your child in your testing department.

You will be here from 8:30am to 11:30am and then from 1:30pm to 4:00pm. Thank you.

_____ _____

Signature Date

_____

Name of Patient

_____

Name of Parent or Guardian

New Patient Personal Information Sheet

Personal Information: Date_____

_____ _____ ____/____/_____ _____ _____ _____

Patient's Full Legal Name Sex Birth Date Race Age Marital Status

_____ _____ _____

Patient's Social Security No. Patient's Driver's License No. Spouse's Name

_____

Patient's Permanent Street Address City/State Zip Code

_____ _____ _____

Home Phone No. Cell Phone No. E-Mail Address

I give permission for The Block Center to send me information and updates. I understand that if I receive emails from The Block Center that I cannot contact The Block Center through this email address. It is for information sent to me only.

_____ _____

Signature Date

Financial Information:

_____

Responsible Party Name (First) (Middle) (Last) Telephone No./Ext

_____ _____ _____

Social Security No. Work No. Driver's License No.

Please check the payment method you will be paying for your services:

( ) Cash ( ) Check ( ) Visa ( ) Master Card

Credit card number for **phone appointments** or **supplement orders**

_____Exp date _____ Security Code_____

IN CASE OF EMERGENCY, NOTIFY:

_____ _____

Name Phone Number

Email address

Child's History Form
Mary Ann Block, DO, PA
1750 Norwood Drive, Hurst, TX 76054
817-280-9933

Today's Date_____

This questionnaire is to help me evaluate your child's symptoms. This history is the single most important source of information about your child. It is estimated that 70% of health problems can be solved from the history, 20% from the physical exam and 10% from lab and X-rays. If there is a question you would rather discuss personally, without your child present, mark those with an asterisk (*).

General Information
Name of child_____Date of birth_____

Address_____(City)_____(State)_____(Zip)_____

Phone(_____)_____Age_____Grade_____

Name of person completing questionnaire_____Relationship_____

1. How did you hear about The Block Center?_____
2. Name of primary care physician_____
3. Describer problems which prompted you to call The Block Center:

_____ _____

_____ _____

_____ _____

4. Have you tried other professionals for this complaint?_____If Yes, explain_____

_____

5.Has child had any treatment for this problem?_____If Yes, explain_____

_____

6. What do you wish to accomplish?_____

_____

7. Has child had all vaccines required? Yes_____No_____

8. Has child had a medical check-up in last 12 months? Yes_____No_____

9. Any current health problems? Yes_____No_____If yes, explain_____

_____

10. Has child had any psychological or educational testing? Yes_____No_____If Yes, explain_____

_____

11. List all medications and supplements child is taking_____

Pregnancy and Birth History

1. Did mother have medical problems during pregnancy? Yes_____No_____

2. Was labor/delivery difficult? Yes_____No_____3. Medications during pregnancy? Yes____No____

4. Was labor induced? Yes_____No_____ 5. Was suction or forceps used? Yes_____No____

6. Length of pregnancy_____months 7. Duration of labor?_____hours

8. C-Section? Yes_____No_____ 9. Any complications during or after labor? Yes_____No_____

10. Birth weight_____pounds_____ounces 11. APGAR Scores if known_____ _____

12. Was infant born _____Head first? _____Feet first? _____Breech?

13. Did infant require any special treatment at birth? Yes_____No_____, If Yes, explain_____

_____

14. If child is adopted, age of adoption_____, Country adopted from _____

Infancy

1. Breast fed? Yes_____No_____, If Yes, how long?_____2. Breast plus formula? Yes_____No____

3. Formula only? Yes____No_____ 4. Formula changes? Yes____No___

5. Normal weight gain? Yes____No_____6. Nursing or feeding problems? Yes_____No_____

7. Age when solid food introduced_____

8. Check problems that apply to first year of life:

____ Asthma	____Congestion	____Skin Rashes	____Constipation
____Colic	____Colds	____Diarrhea	____Constipation
____Vomiting	____Excess Crying	____Diaper Rash	____Irritability
____Overactive	____Ear Infections	____Pneumonia	____Croup
____Hives	____Eczema	____Antibiotics	____Trouble Sleeping

Developmental-Approximate Age of the Following:

____Crawled ____Sat Alone ____Said Single Words ____Walked without Support

____Dressed Self ____Fed Self with Spoon ____Said Understandable Short Sentences

Problems That Apply After One Year of Age:

____Asthma ____Congestion ____Skin Rashes ____Diarrhea ____Clumsy ____Picky Eater

____Constipation ____Vomiting ____Colds ____Ear Infections ____Strep Throat ____Gas

____Pneumonia ____Aggression ____Bloating ____Loss of Language ____Sensitive to Light & Noise

____Headaches ____Nervous ____Hives ____Uncoordinated ____Trouble Sleeping

Has child had ____Tonsillectomy? ____Adenoidectomy?____ Ear Tubes?_____ Age_____

Has child taken prednisone or other steroids? Yes_____No_____

Does exposure to perfumes, pesticides or other chemicals bother child? Yes____No___ If Yes, what happens?

_____

Has child taken antibiotics at any time? Yes_____No_____ Does child crave sweets? Yes_____No_____

Systems Review-Check All That Child Currently Has:

General

____Recent weight loss or gain (Circle which) ____Over eats ____Fatigue ____Nightmares

____Trouble Sleeping

Eyes

____Tearing ____Circles Under ____Double Vision ____Burning

____Crossed ____Squints ____Itching ____Blurred Vision

____Wears Glasses ____Has Had Eye Surgery

Ears

____Itching ____Draining ____Stopped Up ____Tubes

____Pain ____Ringing ____Infections ____Difficulty Hearing

Nose

____Congestion ____Discharge ____Picks Nose ____Sneezing

____Bleeding ____Infections ____Postnasal Drip ____Wax

Mouth/Throat

____Canker Sores ____Chapped Lips ____Bad Teeth ____Thrush

____Sore Gums ____Coated Tongue ____Fever Blisters ____Bad Breath

____Grinds Teeth ____Sore Throat ____Hoarse ____Mouth Breather

____Clears Throat ____Swollen Glands ____Thyroid Disease ____Strep Throat

Heart/Lungs

____Heart Murmur ____Cough ____Bronchitis ____Asthma

____Wheezing ____Pneumonia ____Chest Pain ____Short of Breath

____Heart Palpitations

Stomach

____Nausea ____Constipation ____Diarrhea ____Blood in Stools

____Pain ____Over Eats ____Vomiting ____Rectal Itching

____Gas ____Soiling ____Belching ____Bloating

Systems Review-Check All That Child Currently Has:

KidneyBladder

____Urgency ____Frequent Urination ____Daytime Wetting ____Nighttime Wetting

____Pain/Burning with Urination ____History of Urinary Tract Infections

Age when Dry _____Daytime _____Nighttime

Nerves/Musculoskeletal

____Headaches ____Seizures ____Dizziness ____Painful Joints

____Uncoordinated ____Tics ____Growing Pains ____Accident Prone

Skin

____Dry ____Oily ____Rashes ____Acne ____Easy Bruising

Behavior-Check All That Apply:

____Overactive ____Destructive ____Lies ____Steals ____Negative School Reports

____Unhappy ____Aggressive ____Fights ____Argues ____Talks Excessively

____Has Run Away ____Mood Swings ____Temper ____Hard to Discipline

____Disrupts Family ____Fire Setting ____Dislikes School ____Sexual Inappropriateness

____Short Attention ____Doesn't Listen ____Doesn't Like Self ____Learning Problems

Amount of television by child _____hours per day; _____hours per week

Amount of time spent on computer games _____hours per day; _____hours per week

List things child does well:_____

List Child's greatest problems, frustrations:_____

List all medications child has been prescribed: _____

List side effects caused by medications: _____

Cooperation and consistency between child's parents:____Excellent____Good____Fair____Poor

How would you describe the child's school situation? ____Excellent____Good____Fair____Poor

Family History

Length of current marriage _____Years Any marital problems? ____Yes ____No

Do parents agree about child's treatment? ____Yes ___No Stepparent in home? ____Yes ____No

Anyone else live in house? ____Yes ____No Does anyone smoke? ____Yes ____No

Prior marriages-Mother? ____Yes ____No Father? ____Yes ____No

Birth father's Height_____ Weight_____ Birth mother's Height_____ Weight_____

Allergy

Has child had any allergy testing? ____Yes ____No, If Yes, what type? ____Skin ____Blood

Is child taking any type of allergy treatment currently? ____Yes ____No, If yes, what?

____Prescription_____

____Over-the-counter _____

____Allergy Injections ____Avoidance

Has child been to emergency room for allergies or asthma? ____Yes ____No How often?_____

How long has child lived in area? _____

Environment

Do you live in ____House ____Apartment ____Other How long in this residence?_____

Is garage attached ____Yes ____No Is there much vegetation(trees, weeds, etc.)? ____Yes ____No

Is there a lot of dust in the home? ____Yes ____No Does home have basement? ____Yes ____No

Is there mold/mildew in home? ____Yes ____No Is HVAC System? ____Gas ____Electric

Any pets? ____Yes ____No What kind?_____

Are child's symptoms worse:

____Outdoors ____Indoors ____Rainy Days ____Windy Days

____Fall ____Summer ____Spring ____Winter

____At Night ____Weather Changes

Do you use?____Strong smelling cleaning chemicals ____Floor/Furniture Wax ____Pesticides

Is home regularly treated for insects? ___Yes ___No Do you use electric blankets? ____Yes ____No

Do you live near a power generating station/high voltage tower/transmitter? ____Yes ____No

What kind of water do you drink? ____Tap ____Filtered ____Plastic Bottled ____Glass Bottled

IMMEDIATE FAMILY

Instructions: Please include all information you know related to the following areas.
You may need to ask your parents for a complete history.

					Maternal		Paternal	
	Father	Mother	Brother	Sister	Grandmother	Grandfather	Grandmother	Grandfather
Age if living								
Age at death								
Cause of death								
Type of work								

Mark an "X" for any positive answer

Asthma								
Allergy Hives								
Eczema								
Hayfever								
Weight Problem								
Smokers								
Alcohol Abuse								
Mental illness								
Cancer								
Diabetes								
Hypertension								
Heart problem								
High cholesterol								
Thyroid disease								
Blood disease								
Bowel problem								
Ulcers								
Arthritis								
Migraines								
Other								

Food

Is child a picky eater? ____Yes ____No Most Meals Eaten at _____Home ____Out

Favorite Foods:

_____

Meal Times on a school day:

Breakfast _____AM Morning Snack _____AM Lunch _____AM/PM

Snack_____PM Dinner_____PM Evening Snack_____PM

Diet Diary: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Sunday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Monday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Tuesday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Wednesday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Thursday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Friday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Saturday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Mark all items:	DAILY	3 X WEEK	1-2 X WEEK	SELDOM	NEVER	CRAVE	LIKE	NEUTRAL	MAKES ILL	CHILL
milk										
cheese										
orange juice										
apple juice										
grape juice										
corn syrup										
corn meal										
popcorn										
peanut butter										
soy products										
garlic										
onion										
potatos										
tomatoes										
beef										
chicken										
eggs										
fish										
bacon										
sausage										
hot dogs										
sandwich meat										
bread, rolls										

Mark all items:	DAILY	3 X WEEK	1-2 X WEEK	SELDOM	NEVER	CRAVE/LOVE	LIKE	NEUTRAL	MAKES ILL	CHILL
cereal										
oatmeal										
rice										
rye										
wheat										
cake, cookies										
crackers										
pizza										
pasta										
sugar										
chocolate										
coffee										
coffee (decaf)										
tea										
tea (decaf)										
honey										
mushrooms										
diet soft drinks										
soft drinks										
other										

Adult History Form
Mary Ann Block, DO, PA
1750 Norwood Drive, Hurst, TX 76054
817-280-9933

Today's Date_____

This questionnaire is to help me evaluate your symptoms. This history is the single most important source of information about you. It is estimated that 70% of health problems can be solved from the history, 20% from the physical exam and 10% from lab and X-rays.

General Information

Name _____Date of birth_____

Address_____(City)_____(State)_____(Zip)_____

Phone(_____)_____ Age_____

Marital Status ____Single ____Married _____ Divorced _____Separated _____Widow/Widower

Occupation_____ Hobbies_____

Work History and Dates _____

Education: Years of High School _____ Years of College _____ Years of Post-graduate_____

List other countries where you have lived_____

List out of country travel_____

1. How did you hear about The Block Center?_____
2. Name of primary care physician_____
3. Describer problems which prompted you to call The Block Center:

_____ _____

_____ _____

_____ _____

4. Have you tried other professionals for this complaint?_____If Yes, explain_____

_____

5.Has child had any treatment for this problem?_____If Yes, explain_____

_____

6. What do you wish to accomplish?_____

_____

General Health Information

When and where was last physical exam? _____

List all prescription medications, over-the-counter medications and supplements currently taking:

Name	Dose	Frequency	How Long Taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Have you taken antibiotics or steroids in the past year? ____Yes ____No

Do you take herbs? ____Yes ____No Do you now or ever, used tobacco in any form? ____Yes ____No

Do you currently use tobacco? ____Yes ____No What kind?_____How much?_____

Do you currently drink alcohol? ____Yes ____No, If yes, how often?_____How much?_____

Do you currently use street drugs? ____Yes ____No If yes, how often?_____How much?_____

List any allergy to drugs with symptoms:

Drug	Symptom	Drug	Symptom

Check which applied to you when you were a child:

____Bothered by foods	____Poor Appetite	____Bottle Fed	____Behavior Problems
____Eczema	____Constipation	____Stomachaches	____Feeding Problems
____Headaches	____Hyperactivity	____Night Sweats	____Failure to Thrive
____Learning Problems	____Dyslexia	____Bedwetting	____Picky Eater
____Colic	____Hives	____Diarrhea	____Celiac Disease
____Constipation	____Skin Rashes	____Vomiting	____Leg Aches
____Gas	____Fussiness	____Food Allergies	_____Other_____
____Other_____		____Other_____	

Do you have a history of allergies or food intolerance? ____Yes ____No

Most meals eaten? ____at home ____at restaurants Do you feel better if you skip a meal? ____Yes ____No

Are there foods that make symptoms worse? ____Yes ____No List:_____

Are there foods that make symptoms better? ____Yes ____No List:_____

Do you often wake up at night? If Yes, do you eat or drink? What? _____

Have you ever fasted? If Yes, did you feel _____Better ____Worse ____Same

Are there foods you crave? If yes, list_____

Are there any foods you binge on? If Yes, list_____

Do you have hypoglycemia? ____Yes ____No When you go on vacation do you feel ____Better ____Worse

Do family members have allergies or food intolerances? ____Yes ____No

Which foods would you miss most if you could not eat them for several days?_____

Surgical History:

In the last two years have you had any of the following?

____Sinus X-rays ____Chest X-rays ____Teeth X-rays ____Abdominal X-rays

____Brain Scan ____Bone Scan ____Body Scan ____Hearing Tests

____EKG ____Blood Tests ____Urine Tests ____TB Test

____Mammogram, If Yes, was it normal? ____Yes ____No Pap Smear, If Yes, was it normal? ____Yes ____No

What kind of doctors or specialists have you seen for your problems?

____Osteopath ____MD ____Psychologist ____Chiropractor

____Biofeedback ____Hypnosis ____Nutritionist ____Acupuncturist

Living Situation

Are you under stress? ____Yes ____No

Are you 15 pounds or more overweight? ____Yes ____No

Are you usually happy? ____Yes ____No

Do you like your job? ____Yes ____No

Are you usually satisfied with medical advice? ____Yes ____No

Is your hostility easily aroused? ____Yes ____No

Do you have crying spells? ____Yes ____No

Is anyone at home sick? ____Yes ____No

Do you have nightmares? ____Yes ____No

Are you sad? ____Yes ____No

Do you exercise regularly? ____Yes ____No, If Yes, how often? _____

Do you use strong smelling cleaning chemicals? ____Yes ____No

Do you use pesticides in your home? ____Yes ____No

Is your home treated regularly ____Yes ____No

Do you use a lawn chemical company? ____Yes ____No

Do you have pets/animals? ____Yes ____No, If Yes, ____Dog ____Cat ____Bird ____Hamster ____Rat

____Horse ____Rabbit ____Guinea Pig ____Other _____

Animals in the house? ____Yes ____No

Animals in the bedroom? ____Yes ____No

Is your pillow? ____Feather ____Down ____Foam ____Other_____

Is your mattress? ____Foam ____Box Spring ____Futon ____Waterbed ____Plastic Covered _____Other

Are your sheets and blankets? ____100% Cotton ____Wool ____Synthetic ____Other

Have you had any allergy testing? ____Yes ____No, If Yes, what type? ____Skin ____Blood

Are you taking any type of allergy treatment currently? ____Yes ____No, If yes, what? ____Prescription

____Over-the-counter ____Allergy Injections ____Avoidance

Have you been to emergency room for allergies or asthma? ____Yes ____No How often?_____

Do symptoms flare when starting heating in the winter? ____Yes ____No Worse ? ____Indoors ____Outdoors

Symptoms flare when going to bed? ____Yes ____No

Do you have nasal symptoms? ____Yes ____No

Environment

Do you live in ____House ____Apartment ____Other How long in this residence?_____

Is garage attached ____Yes ____No Is there much vegetation(trees, weeds, etc.)? ____Yes ____No

Is there a lot of dust in the home? ____Yes ____No Does home have basement? ____Yes ____No

Is there mold/mildew in home? ____Yes ____No Is HVAC System? ____Gas ____Electric

Are your symptoms worse:

____Outdoors ____Indoors ____Rainy Days ____Windy Days

____Fall ____Summer ____Spring ____Winter

____At Night ____Weather Changes

Do you live near a power generating station/high voltage tower/transmitter? ____Yes ____No

Do you use electric blankets? ____Yes ____No Do you have indoor plants? ____Yes ____No

What kind of water do you drink? ____Tap ____Filtered ____Plastic Bottled ____Glass Bottled

Your Flooring Is: (Check all that apply) ____Carpet/rugs ____Wood ____Tile ____Vinyl ____Cork

Review of Symptoms: Check those that apply:

Skin:

____Eczema ____Dry Skin ____Oily Skin ____Acne ____Hives

____Boils ____Herpes ____Split Nails ____Easy Bruising ____Face Swelling

Ear/Eyes/Nose/Throat:

____Ears Ring ____Dizziness ____Hay Fever ____Nasal Polyps ____Ear Infections

____Tubes in Ears ____Mouth Sores ____Sinus Infections ____Post Nasal Drip ____Hoarseness

____Gums Bleed ____Decayed Teeth ____Glasses ____Contacts ____Cataracts

____Glaucoma ____Floaters ____Night Blindness ____Light Sensitive ____Headaches

Headache Types: ____Migraine ____Sinus ____Tension

Headache Symptoms: ____Flushing ____Nausea ____Loss of Sight ____Dazzling Lights

____Neck Pain ____Abdominal Pain ____Vomiting _____Visual Disturbance

Endocrine:

____Fatigue ____Hypothyroid ____Hyperthyroid ____ Diabetes: ____ Type II ____Type I

____Hypoglycemia ____Adrenal Fatigue

Heart/Lungs:

____Asthma ____Emphysema ____Bronchitis ____Cough ____Short of Breath

____Chest Pain ____Heart Attack ____Heart Murmur ____Abnormal EKG ____Heart Races

____Heart Skips ____Ankles Swell

Gastrointestinal:

____Abdominal Pain ____Nausea ____Vomiting ____Gall Stones ____Vomited Blood

____Ulcer ____Heartburn ____Bloating ____Cramps ____Laxative Use

____Diarrhea ____Constipation ____Anal Itching ____Hepatitis ____Blood in Stool

____Belching ____Gas ____Regular Antacid Use ____Black Bowel Movements

Urinary Tract:

____Burning ____Urgency ____Blood in Urine ____Kidney Stones ____Kidney Disease

____Lose Urine When Coughs/Sneezes ____Bladder/Kidney Infections ____Hard to Start Urine

____Kidney Disease ____Void Small Amounts Urine Each Time You Go

Gynecology: (Females Only) At the time of your period, check all that apply:

____Fluid Retention ____Cramps ____PMS ____Depressed ____Irritable

____Heavy Bleeding ____Appetite Change ____Irregular Flow ____Irregular Period ____Vaginal itching

____Yeast Infection ____Vaginal Itching ____Vaginal Discharge ____Bleeding Between Periods

____Menopause, If yes, What Age?_____ ____Vaginal Bleeding Since Menopause ____Pregnant

____Birth Control, If Yes, What Kind? _____

Date of last PAP Smear_____ ____Cervical Cancer Vaccine

Date of last period _____

____Breast Implants ____Any Miscarriages ____Lumps in Breasts ____Breast Pain

____Breast Discharge How many pregnancies? _____ ____Pregnancy Complications

Men Only: Check all that apply:

____Lump in Testicle ____Discharge from Penis ____Sores on Penis/Scrotum

____Painful Erection ____Inability to Sustain Erection ____You do not examine testicles monthly

Blood:

____Low White Count ____Anemia (Low Red Blood Count) ____Easy Bruising ____Takes Iron

____Easy Bleeding ____Lymph Gland Swelling

Musculo-skeletal:

____Rheumatoid Arthritis	____Osteoarthritis	____Gout	____Muscle Spasms
____Joint Swelling	____Muscle Fatigue	____Restless Legs	____Painful Joints
____Swollen Joints	____Red Joints	____Neck Pain	____Other Pain

Neurology:

____Head Injury	____Blackout Spells	____Headaches	____Seizures
____Numbness	____Tingling	____Lost Ability to Speak	____Lost Ability to Move
____Dyslexia	____Trouble Thinking	____Learning Disabilities	____Trouble in School
____Memory Loss	____Trouble Explaining What You Mean		

IMMEDIATE FAMILY

Instructions: Please include all information you know related to the following areas.
You may need to ask your parents for a complete history.

					Maternal		Paternal	
	Father	Mother	Brother	Sister	Grandmother	Grandfather	Grandmother	Grandfather
Age if living								
Age at death								
Cause of death								
Type of work								

Mark an "X" for any positive answer

Asthma								
Allergy Hives								
Eczema								
Hayfever								
Weight Problem								
Smokers								
Alcohol Abuse								
Mental illness								
Cancer								
Diabetes								
Hypertension								
Heart problem								
High cholesterol								
Thyroid disease								
Blood disease								
Bowel problem								
Ulcers								
Arthritis								
Migraines								
Other								

Diet Diary: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Sunday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Monday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Tuesday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Wednesday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Thursday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Friday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Saturday:

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Favorite Foods: _____

Mark all items:	DAILY	3 X WEEK	1-2 X WEEK	SELDOM	NEVER	CRAVE	LIKE	NEUTRAL	MAKES ILL	CHILL
milk										
cheese										
orange juice										
apple juice										
grape juice										
corn syrup										
corn meal										
popcorn										
peanut butter										
soy products										
garlic										
onion										
potatos										
tomatoes										
beef										
chicken										
eggs										
fish										
bacon										
sausage										
hot dogs										
sandwich meat										
bread, rolls										

Mark all items:	DAILY	3 X WEEK	1-2 X WEEK	SELDOM	NEVER	CRAVE/LOVE	LIKE	NEUTRAL	MAKES ILL	CHILL
cereal										
oatmeal										
rice										
rye										
wheat										
cake, cookies										
crackers										
pizza										
pasta										
sugar										
chocolate										
coffee										
coffee (decaf)										
tea										
tea (decaf)										
honey										
mushrooms										
diet soft drinks										
soft drinks										
other										