Illuminate
NATURAL HEALTH

New Patient Paperwork- Adult

NAME: _____ **DOB:** _____

Phone: _____ **Email:** _____

Address: _____

Emergency contact: _____

How did you hear about our clinic? _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____

IF NOT, WHEN DID YOU LAST RECEIVE HEALTH CARE?_____

WHAT WAS THE REASON?_____

Height: _____ **Weight:** _____ **Maximum Weight ever:** _____
Blood Type: _____ ❑ **Unknown**

Sexual Orientation: _____

ALLERGIES: _____

HEALTH HISTORY /PREVIOUS DIAGNOSES/ HOSPITALIZATIONS/SURGERY:

_____

_____

_____

_____

FAMILY HISTORY:_____

❑ Cancer ❑ Kidney Disease ❑ Tuberculosis ❑ Asthma ❑ Diabetes

❑ Epilepsy ❑ Stroke ❑ Heart Disease ❑ High Blood Pressure ❑ Hay Fever

❑ Arthritis ❑ Anemia ❑ Hives ❑ Glaucoma ❑ Mental Health Illness

❑ Autoimmune disease

OCCUPATION: _____

PREVIOUS OCCUPATIONS: _____

MEDICATIONS:

SUPPLEMENTS:

LIFESTYLE

3 DAY DIET RECALL:

	Breakfast	Lunch	Dinner	Snacks	Beverages
Day 1					
Day 2					
Day 3					

Do you avoid any particular foods? _____

Do any particular foods cause you distress? _____

Main interests or hobbies: _____

Exercise? _____ What kind? _____ How often? _____

Sleep

How many hours?_____Wake during night? _____ Hard to fall asleep?_____Awake rested?_____

Do you enjoy your work? _____ Take vacations? _____

Do you work night shift? _____

If so, describe you sleeping schedule through week: _____

_____

How many hours of TV per week?_____

Do you have a spiritual practice?_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support health?

_____

_____

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive? _____

_____

_____

Substance	Current Use	Amount	Frequency	Past Use	Length of Use
Caffeine					
Alcohol					
Tobacco					
Marijuana					
Pain Killers					
Tranquilizers					
Inhalants					
Sleeping Pills					
Diet Pills					
Laxatives					
Steroids					
Methamphetamines					
PCP/LSD/Mushrooms					
Ecstasy					
Cocaine/Crack					
Heroin					

Current= Last 6 Months

REVIEW OF SYSTEMS:

Circle/highlight if the condition or symptoms are a present concern.
*Mark **P** for those you have experienced in the past.*

IMMUNE
Chronic Fatigue
Chronic Swollen Glands
Lyme disease
Autoimmune
Chronic infections
Slow Healing
Frequent colds
Hay fever

ENDOCRINE
Hypothyroid
Hypoglycemia
Excessive thirst/hunger
Fatigue
Heat or Cold Intolerance
Diabetes

MENTAL/EMOTIONAL
Seasonal depression
Depression
Anxiety
Stress level 0-10
Easily stressed
Mental illness diagnosis
Counseling/therapy
Have you ever attempted suicide?
Are you currently contemplating suicide?

NEUROLOGICAL
Seizures
Muscle Weakness
Loss of Memory
Vertigo/ Dizziness
Loss of balance
Paralysis
Numb/Tingling
Headaches/ Migraines
Head injury / TBI
Loose consciousness?
Age? #?

SKIN
Rashes
Acne
Lumps
Skin color change
Eczema
Hives
Itching
Hair loss
Night sweats

EYES
Spot in eyes
Impaired vision
Color blindness
Double vision
Cataracts
Glasses/Contacts
Eye pain
Tearing/ dryness
Glaucoma

NOSE/SINUSES
Stuffiness
Nose bleeds
Loss of smell

MOUTH/ THROAT
Frequent sore throat
Teeth grinding
Gum problems
Cavities
Sores in mouth
Hoarseness
TMJ pain/ clicks
Dry mouth
Excess saliva

NECK
Lump
Goiter
Pain/Stiffness
Swollen glands

RESPIRATORY
Cough
Sputum/Phlegm
Cough up blood
Asthma
Pneumonia
Pain with breathing
Shortness of breath (SOB)
SOB with lying
SOB with bending over
Lung Cancer

GASTROINTESTINAL
Belching/ passing gas
Trouble swallowing
Nausea/vomiting
Ulcers
Jaundice
Gall Bladder disease
Liver disease
Hemorrhoids
Heartburn
Abdominal pain
How often are you having bowel movements?
_____
Constipation
Diarrhea
Black/Bloody stools
Undigested food in stools

FEMALE REPRODUCTIVE
Age of first menses
Age of last menses (menopausal)
Length of cycle
Duration of menses
Day of last menses
Painful menses/Clotting/ Heavy flow/PMS
Breast pain or tenderness/ Lumps
Nipple discharge
Endometriosis
Ovarian cysts
Cervical dysplasia
Difficulty conceiving
Number of pregnancies
Number of live births ____ miscarriages____
Pain with intercourse
Birth control: how long? _____ What Type? _____

CARDIOVASCULAR
Heart disease
Ankle swelling
High/Low blood pressure
Blood clots/ Deep vein thrombosis
Phlebitis
Angina
Murmurs
Irregular heartbeat/ flutter/palpitations
Chest pain
Easy bleeding/bruising
Varicose veins
Dizzy when standing

URINARY
Pain with Urination
Urinate at night
Frequent urination
Frequent infections
Incontinence
Kidney stones

MUSCULOSKELETAL
Pain or stiffness
Broken bones
Muscle spasm or cramps
Arthritis
Weakness
Sciatica

MALE REPRODUCTIVE
Hernias
Testicular pain
Discharge/ sores
Premature ejaculation
Testicular mass
Prostate disease
Impotence

Some of these are repeat questions/symptoms, but I want to know how frequently you are experiencing them. This also will show you the categories your symptoms re lumped in.

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**

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 proteins and meats; 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				
Difficulty digesting roughage and fiber	**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**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	**0**	**1**	**2**	**3**
Frequent loss of appetite	**0**	**1**	**2**	**3**

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	**0**	**1**	**2**	**3**
Abdominal distention after certain probiotic or natural supplements	**0**	**1**	**2**	**3**
Decreased gastrointestinal motility, constipation	**0**	**1**	**2**	**3**
Increased gastrointestinal motility, diarrhea	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Suspicion of nutritional malabsorption	**0**	**1**	**2**	**3**
Frequent use of antacid medication	**0**	**1**	**2**	**3**
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	**Yes**		**No**	

Category VIII				
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**
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 IX				
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 X				
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 between meals	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**

Category XI				
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**

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

Category XII

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 XIII

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 XIV

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 XV

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 XVI

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 XVI *(Cont.)*

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

Category XVII *(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 XVIII *(Males Only)*

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

Category XIX *(Menstruating Females Only)*

Perimenopausal	**Yes**	**No**		
Alternating menstrual cycle lengths	**Yes**	**No**		
Extended menstrual cycle (greater than 32 days)	**Yes**	**No**		
Shortened menstrual cycle (less than 24 days)	**Yes**	**No**		
Pain and cramping during periods	**0**	**1**	**2**	**3**
Scanty blood flow	**0**	**1**	**2**	**3**
Heavy blood flow	**0**	**1**	**2**	**3**
Breast pain and swelling during menses	**0**	**1**	**2**	**3**
Pelvic pain during menses	**0**	**1**	**2**	**3**
Irritable and depressed during menses	**0**	**1**	**2**	**3**
Acne	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Hair loss/thinning	**0**	**1**	**2**	**3**

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ **years**			
Since menopause, do you ever have uterine bleeding?	**Yes**	**No**		
Hot flashes	**0**	**1**	**2**	**3**
Mental fogginess	**0**	**1**	**2**	**3**
Disinterest in sex	**0**	**1**	**2**	**3**
Mood swings	**0**	**1**	**2**	**3**
Depression	**0**	**1**	**2**	**3**
Painful intercourse	**0**	**1**	**2**	**3**
Shrinking breasts	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Acne	**0**	**1**	**2**	**3**
Increased vaginal pain, dryness, or itching	**0**	**1**	**2**	**3**

For Chronic Disease

Timeline

Events: include any psychological events (moving, parents divorcing) or physical events (broken arm, concussion). Include anything like tick bites, moving to new locations (home/job), medications taken and for what condition, vaccines, new symptoms that showed up (this type of review is used in functional medicine and will most likely help in deciding what functional labs to order, causes of illness that may have gone missed, triggers for symptoms, weakest organ systems). Start from you mother's pregnancy, go through childhood and adulthood, until present condition is addressed.

List your (official) Diagnoses in Chronological order, and your thoughts about each of them. (Do you think they were accurately diagnosed or did you feel unheard or misdiagnosed.)

List your Current Concerns in order of importance:
(These are the symptoms that you are wanting to address first, not the disease/root cause)

Chief Concern 1: _____
(complete for up to 3 concerns)

Onset of illness: _____

Description: (location, radiation, severity)

_____
_____
_____

Timeline of illness (how have things changed with time):

_____
_____
_____
_____
_____
_____
_____

Treatments you have tried (conventional and Natural):

_____
_____
_____
_____
_____
_____

Treatments that have worked:

_____
_____
_____
_____
_____
_____

Chief Concern 2: _____

(complete for up to 3 concerns)

Onset of illness: _____

Description: (location, radiation, severity)

Timeline of illness (how have things changed with time):

Treatments you have tried (conventional and Natural):

Treatments that have worked:

Chief Concern 3: _____

(complete for up to 3 concerns)

Onset of illness: _____

Description: (location, radiation, severity)

Timeline of illness (how have things changed with time):

Treatments you have tried (conventional and Natural):

Treatments that have worked: