Environmental Illness and Detoxification
Initial Patient Intake Questionnaire

This form will become part of your medical record and the contents are confidential. It is very important to answer all questions as this will be most helpful in evaluating your condition.

Date_____
Name_____Birthdate_____Birthplace_____
Occupation_____Hobbies_____
List all locations in which you have lived: _____
_____

Exposure History: *Answer yes/no and when/where/ how long**

Community

- Heavy traffic(excessive)
- Vehicle idling area
- Dump site
- Farm(s)
- Industrial plants
- Radiation source
- Polluted lake/stream
- Other potential hazards

Home & Hobby

How long have you lived in your present residence?_____ How old is it?_____
If more than 40 yrs old, do you have
- Asbestos insulation or vinyl tile
- Flaking paint

What type of dwelling is your residence?
House Mobile home Apartment Basement
Above store Highrise⇒ what floor___

Does your residence have an attached or underground garage: no / yes
Have you done any painting / renovating / bought new large furniture? no / yes
⇒ If so, When? _____ What? _____
_____

(Home and Hobby continued)
Who smokes in your home? _____ Car? _____
Do or did you use pesticides or herbicides (bug or weed killers, flea / tick sprays, collars, powders, etc.) in your home, lawn, garden, or on your pets? • no • yes (specify)
_____

What is your water source for bathing? • City • Well • Other_____

Occupation

1. Please list the significant chemicals, solvents, heavy metals, paints, dusts, fibers, fumes, radiation, biologic agents (bacteria, molds, viruses) and physical agents (extreme heat, cold, vibration, noise) that you have been exposed to;
Please list any protective measures taken (e.g. showering at work, laundering clothes at work, etc.) or protective equipment used (e.g. gloves, apron, mask, respirator, hearing protectors, etc.)

Past/Present Jobs and Hobbies	For how long did you do this?	Exposures	Protective measures and equipment
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

2. The following questions are about your present or most recent work environment:
Age of building: _____ Number of floors: ___ Approximate # of occupants: ____

Which of the following does / did your present or most recent work environment have?

- laboratory
- cafeteria
- windows that open
- banks of computers
- manufacturing area
- central air conditioning
- unvented smoking areas
- partitions or room dividers
- unvented copy machines
- nearby parking garage
- carpets – *How old?* _____

3. Have any of the following occurred in your work environment over the past 12 months or the last 12 months you worked in your most recent job?
• use of pesticides ⇒ • indoors • outdoors • fire, smoke • flood, water leaks • carpet cleaning
• new flooring, furniture, etc. *(specify):* _____ • construction • renovation
• painting • chemical spill, leak *(specify):* _____ • accidents • stress

Home

1. For each of the items listed below:

	Do you have in your home?	If you ever had, please write the years:
Damp, musty basement or crawl space	• no • yes	_____
Wet windows or outside closet walls (condensation)	• no • yes	_____
Water leaks	• no • yes	_____
Visible mold	• no • yes	where? _____
Stagnant stuffy air	• no • yes	_____
Gas or propane stove	• no • yes	_____
Air filter(s)	• no • yes	(specify)_____
Carpets	• no • yes	*Where?* _____
		How Old? _____
Pets	• no • yes	*(specify)*_____
Do you use flea collars?	• no • yes	
Do you use an electric blanket?	• no • yes	

3. What cleaning product(s) do you usually use:

Bathroom _____ floor / wall _____ window / mirror _____
Deodorizer_____ laundry detergent_____ fabric softener_____

4. What hobbies do members of your household have? _____

5. Have you personally done any of the following:

- furniture stripping / refinishing
- home renovating
- art work Years:_____ (specify)_____
- other non-occupational activities with exposure to chemicals Years:_____

Specify:_____

6. Do you:

Use mothballs? no / yes
Use potpourri or air fresheners no / yes
Have regular manicures? no / yes
Do you: have acrylic fingernails? no / yes
Remove your shoes when entering your home? no / yes
Burn candles? no / yes
Use fabric softener: no / yes
Use nail polish no / yes
Have your clothes dry cleaned? no / yes

Personal

1) Synthetic Chemicals

How often do you use ***scented*** personal products (please check)

Scented Product:	Soap	Lotion	Cosmetics	Hair permanent / Hair tint	Perfume/ Aftershave	Others?
Never						
Occasionally						
Daily						

Have you ever had symptoms you linked with exposure to any synthetic (person-made) chemical at a level that did not seem to bother most people (e.g. paints, perfumes, cosmetics, engine exhaust, tar, new cars interiors, etc.?) • no • yes

If YES, please specify chemical(s) and symptoms (s):

("Linked" means that the symptom started or worsened within 48 hours after you were exposed to something, or the symptom improved or disappeared after you were no longer exposed to it.

"Exposure" means being near, touching, smelling, breathing, eating, drinking, swallowing or injecting something.)

Person-Made Chemical	Symptoms Linked with Low-level Exposure	Presently Affected? 1 = a little 2 = somewhat 3 = a lot	In the Past 1 = a little 2 = somewhat 3 = a lot

2) Dental Amalgams / Implants

How many silver / mercury fillings do you currently have? _____

Have you had silver / mercury fillings removed? • no • yes ⇒ When? _____

How many gold fillings / caps do you currently have ? _____

Do you have implants of silicone, teflon, etc. • no • yes⇒ How long _____

3) Smoking history

Current

- If YES, number of years: ____ Average number of cigarettes per day: ____

Past

- If YES, number of years you smoked: ____ Average number of cigarettes per day: ____
- When did you last smoked regularly? _____

Never

Have you ever regularly used other tobacco products? • no • yes

- If YES, what / how much / and when? _____

Diet and Drug History

1. Where do you grocery shop? • chain grocery store • health food store • market • other _____
2. Who cooks for you? _____
3. Please indicate foods and beverages most typically consumed for each of the following meals and the times at which they are most typically eaten.

Foods / Snacks	Please specify typical meals or foods	Time	Beverages	Please Specify	Time
Breakfast			Breakfast		
Mid-morning			Mid-morning		
Lunch			Lunch		
Mid-afternoon			Mid-afternoon		
Dinner			Dinner		
Evening			Evening		

4. **How much of the following beverages do you consume regularly and have you linked any symptoms with drinking them?**
   - Water ⇒ Number of 8 oz glasses per 24 hours ____ • tap water • filtered • distilled • bottled (glass) • bottled (plastic) Any symptoms: _____
   - Beer, ale ⇒ Number of 12 oz containers per week ____ Any symptoms: _____
   - Wine ⇒ Number of 6 oz glasses per week ____ Any symptoms: _____
   - Spirits (e.g. whisky, rum) ⇒ Number of 1 ½ oz drinks per week ____ Any symptoms: _____
   - Coffee ⇒ Number of 8 oz cups or espresso shots per 24 hours ____ Any symptoms: _____
   - Tea ⇒ Number of 8 oz cups per 24 hours ____ Any symptoms: _____
   - Cola ⇒ Number of 12 oz drinks per 24 h ours Regular ____ Diet Any symptoms: _____
   - Other(s) (please specify) _____ Any symptoms: _____

5. **Do you eat fish?** • no • yes ⇒ On average how many servings (3-4 oz) per week? _____
   What are the types of fish that you eat, in order of frequency: _____

6. **Please list foods / beverages that do not agree with you (e.g. stuffy nose, heartburn, bloating, diarrhea, sleepiness, difficulty concentrating, etc.) or cause allergic reactions (e.g. hives, rashes, shortness of breath, wheezing, anaphylaxis, etc.):**

List foods / beverages that are a problem	What problem(s) do they give you?	Approximately how often do you eat / drink these problem foods?			
		Never	Occasionally	Daily	More than daily

7. Please list any foods / beverages that you crave or that help you to feel better:

List foods that you crave or that help you to feel better	What problem(s), if any, do they give you?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More than once daily