Tustin Chronic Condition Center
PATIENT CONFIDENTIAL FORM:

TODAY'S DATE: ___/____/_____

_____ ___MALE ___FEMALE DATE OF BIRTH ____/____/_____

LAST NAME FIRST MI AGE: ____

EMERGENCY CONTACT: _____ PHONE: (_____) _____

_____ HOME PHONE: ( ) _____
MAILING ADDRESS

WORK PHONE: ( ) _____

_____ _____ _____ MOBILE PHONE: ( ) _____
CITY STATE ZIP CODE

EMAIL ADDRESS: _____

HOW WERE YOU REFERRED TO THE CLINIC: _____

STATUS: ___ MINOR ___SINGLE ___MARRIED ___DIVORCED ___WIDOWED

DO YOU HAVE CHILDREN? ___YES ___NO
HOW MANY_____

SPOUSE'S NAME: _____

Please describe any problem you are currently experiencing or have experienced in the past to help us get a better understanding of your health history. For example, if you now, or as a child, you were frequently ill with ear infections please write that in the ears/nose/throat section below. **Again please be as detailed as possible as this form is VERY IMPORTANT to us. We need to know as much about you as possible in order to properly evaluate and manage your condition. If more space is needed, please type out the information.**

1. **WHOLE BODY**

HEAD: (concussions, stroke, headaches, dizziness, etc.)

EARS/NOSE/THROAT: (ear infections, inner ear problems, nose bleeds, frequent strep infections, difficulty swallowing, loss of hearing, smelling or taste etc.)

EYES: (corrective lenses, dryness, double/blurry vision, etc.)

THYROID: (hyper/hypothyroidism? Medication for this?)

ARMS/LEGS: (pain, skin disorders, abnormal weakness, loss of limbs/fingers/toes-briefly explain how loss occurred, etc.)

ABDOMINAL/REPRODUCTIVE AREA: (nausea, ulcers, kidney stones, ovarian cancer, prostate problems, diabetes, bladder control, any cancers, etc.)

LUNG/HEART: (difficulties breathing, asthma, heart attacks, angina, stroke, rapid/slow heart rate, pacemaker, etc.)

BLOOD: (anemia, etc.)

THE FOLLOWING QUESTIONS HAVE TO DO WITH BRAIN STEM FUNCTION:

Are you sensitive to light or have blurring vision?

Have you experienced an increase in sweating?

Do you have trouble sleeping, continuously waking up during the night or trouble getting to sleep?

Have you experienced an increase in pulse or heart rate, or experienced heart palpitations?

Do you have a history of urinary tract infections?

Have you experienced visual changes before migraine headaches?

Do you have, or have you had bedsores or lesions?

Do you fatigue easily?

Do you have cold hands or feet?

Do you experience frequent urination or are you unable to control urinary or bowel movements?

Do you have episodes of fainting or hypoxia?

For the next several questions please answer briefly and give the dates each began to the best of your knowledge and if you can think of what contributed to it.

1. Any history of fainting/loss of consciousness?

2. Noticeable changes in your handwriting?

3. Changes in sexual function?

4. Are you more irritable or angry?

5. Episodes of depression or anxiety?

6. Problems with equilibrium, loss of balance, tripping, dropping things, etc? **Details**:

7. Difficulty scanning pages while reading a book?

8. Difficulty adding or subtracting?

9. Difficulty expressing what you would like to say? Verbalizing? Recalling?

10. Any changes in speech?

11. Any changes in sensation?

12. Any changes in memory? Short-term? Long-term?

13. Any changes in hearing? Bilateral? Unilateral?

14. Excessive dryness or wetness of the eyes or nose?

2. <u>FULL DESCRIPTION (DETAILED) OF WORK ACTIVITIES</u>

What do you do? What are your duties? How many hours do you work?

3. LIFESTYLE

Hobbies/Activities/Exercise.

Diet (List briefly the types of foods you generally eat.)

Rate your salt/sugar/fat consumption. (Mark each: **L**ow/**M**oderate/**H**igh)

Salt	L	M	H
Sugar	L	M	H
Fat	L	M	H

History of diets? Any changes?

If you have had blood work performed, **you must send lab work with your intake forms,** as I will also be going over this as well. If your doctor has this they are free to fax it over to our office. You will have to give them permission to do so.

What have you been diagnosed with from your previous doctors?

_____
_____
_____
_____
_____
_____

Family Health History: Please list any health conditions your family members have suffered from.

_____
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Your Health Story

I would like for you to share with me your "health story". What this means is for you, in your own words, to tell me what you have been going through with your condition. Please, be **VERY SPECIFIC**, as this information is **CRUCIAL** for managing your condition correctly. If more space is needed or your hand writing is not neat, please type this out.

1. How long did it take for you to be diagnosed with your specific condition **AFTER** you started having symptoms?

2. What medications/treatments have you had in the past, are still doing/taking, and how did you feel with each one?

3. How often/frequent have you had to change or increase your medication?

4. Tell me your story (please include your **MAJOR** symptoms and how they affect **YOU**). Also, do you have a good support team to help your through a program that will change your life?

5. If you could paint a picture of how your body would look and feel if you didn't have your chronic condition, what would that picture look like?

6. What has been your past experience with the attempts at managing your condition?

7. What are you looking for in a doctor? What are you expecting of myself?

8. What is the first thing you would like to improve about your condition?

9. What do you expect from yourself if you are accepted into our natural program?

10. If your case is accepted, is there anything that would hold you back from beginning our natural program? If there is something, how do you foresee yourself overcoming that?