Pure Wellness Centers

Vitality through the science of detoxification and rejuvenation

Welcome to *Pure Wellness Centers*;
Thank you for making a commitment to your health – a giant step toward a new, healthier you.

Why do I care about your health? Because I believe healthy people create a healthy world. I developed ***Pure Wellness Centers*** (***PWC***) after over 40 years of involvement with ecology, organic farming, and natural medicine. I was an emergency room nurse for 10 years and know strengths and weaknesses of drug-centered medicine. My preference is for Green Medicine – an organic and sustainable approach to health that identifies the underlying problems and provides natural solutions. Since 1982 I've been a naturopathic physician, helping people overcome illness and live more vigorous lives.

Pure Wellness Centers were created because of what science is revealing to us:

1. Everyone on the planet, no matter where they live, has some level of environmental toxins. These include plastic compounds, toxic metals, solvents and other chemicals.
2. Over 80% of Americans consume less than the recommended dietary allowance of nutrients.
3. Excessive toxins and deficiencies of nutrients are linked to chronic health problems including obesity, fatigue, heart disease, memory loss, diabetes, hormone imbalances, chronic pain, and cancer.
4. Many detox programs found in health-food stores and the internet are ineffective, often harmful.

Here's the good news:

A. Laboratory testing for environmental toxins and nutrient deficiencies is becoming reliable and affordable.
B. Detoxification treatments based on our advanced understanding of cellular metabolism and liver function are now available, effective and pleasant. (Yes, you'll feel better very quickly)
C. Targeted nutrition – "rejuvenation" – with vitamins, minerals, amino acids, and other nutrients, can be tailored to your needs.

People like you realize that just stopping symptoms does not promote long term health. Symptoms – fatigue, weight gain, pain, etc – are our fire alarms, they warn us of deeper problems. Shutting off the fire alarm is not the answer. Detoxification and optimal nutrition address core health issues; they remove the fires burning inside.

The truth is clear: the world is polluted and all creatures, including humans, are suffering because of it.
The question is: What are we going to do about it? By committing yourself and your family to cleaning up the planet and yourself you're taking a giant step toward creating a healthier world.

Please fill out the forms in this packet and bring them to your first appointment. It will take time and effort, but they provide your ***PWC*** doctor with valuable information on how to help you.

All the best of health,

Tom Ballard, RN, ND

Learn more: www.PureWellnessCenters.com
Appointments: Renton (425)255-8100 Ext. 6. Seattle: (206)324-2225

Pure Wellness Centers Registration

Last Name: _____ First Name: _____ MI: _____

Other names/Maiden Name: _____ Date of Birth: _____ Sex:_____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ SS#: _____

Employer/School: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ E-Mail:_____

May we leave confidential messages for you? □ No □ Yes (specify): □ **Home** □ **Work** □ **Cell** □ **Email**

Mother's Name (minors only): _____

Father's Name (minors only): _____

Emergency Contact: _____ Contact's Phone #: _____

Emergency Contact is my: (specify relationship) _____

Do you have special needs? _____

Are you visually impaired? _**Yes** **No** Are you hearing impaired? **Yes** **No**

How did you hear about us? (Circle) Newspaper Ad News Story Mailer/Flyer Website Workshop/Event Medical Referral Yellow Pages T.V. Ad Insurance Co. Friend/Family/Other: _____

Insurance Carrier: _____ID# _____ Group # _____

Name of Primary Insured (if not you) _____ Relationship: _____ DOB: _____

Pure Wellness Centers* are** required to provide you with a copy of their Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please contact ***Pure Wellness Centers.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

Pure Wellness Centers

CONSENT FOR TREATMENT

I hereby authorize ***Pure Wellness Centers*** to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, radiography, and blood and urine laboratory work, general physical exams, neurological and musculoskeletal assessments)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction, mechanical massage, and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point, and hydrotherapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by ***Pure Wellness Centers***. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

I understand that Thomas Ballard, ND, and any other Pure Wellness Center practitioners and employees are not employees or agents of the Euro Institute but are providing services at the Euro Institute facility as independent contractors. Euro Institute assumes no liability for any services they render.

Furthermore, I understand that the role of Pure Wellness Centers is to address my general well being and that I should consult with my primary-care physician regarding any specific health conditions that I have and about any medications that I am taking.

_____ _____ City: _____Zip: _____

Patient's Name (PRINT) Address:

_____ _____

Patient's Signature Phone:

_____ _____

Date E-Mail

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www.purewellnesscenters.com

Financial/Insurance Agreement

I, _____, being a patient of the ***Pure Wellness Centers***, do herby acknowledge that my health insurance policy is an arrangement between my health plan and myself.

I understand it is my responsibility to know and understand my insurance policy and its benefits. I agree to pay all co-pays, deductibles and portions not covered by my policy. If I choose to personally pay for my medical services, I will pay at the time of services.

I understand that ***Pure Wellness***, in helping me reach my optimum health, may provide certain services, laboratory tests, and supplements that may not be covered by my insurance policy. I understand that if I accept these, I am responsible for all bills incurred through this office.

Dated at (city) _____, Washington, this day _____/20__.

_____
(Patient's printed name)

_____
(Patient's signature)

Name_____**Date:**_____

Pure Wellness Centers
Problem List

Patient: _____DOB: _____ Date: _____

Order of importance of your health problems.

Problem: (Disease or symptom)	**Duration** (when you first became aware of the problem)	**Intensity & Frequency**: Intensity: 0-10 scale (10 = severe) Frequency: Times per day/week/month)	**Diagnosis/Treatments** Date of medical diagnosis, testing and treatments.
Example: Asthma	Since 10 years old	Severe as child. Now only with exercise.	1999, Lung testing. Prednisone Inhaler
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

Pure Wellness Centers

HEALTH INTAKE QUESTIONNAIRE

Full Name: _____ DOB: _____ DATE: _____

Have you ever consulted a Naturopathic physician, an Acupuncturist, a Nutritionist or a Counselor? Yes No

Date of last physical/annual exam: _____ Date of last blood tests: _____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Drug allergies: _____

Other allergies: _____

Personal Habits:

Tobacco: Current number of cigarettes/cigars/chew daily ____ Past use? Yes No Number of years? ____

Alcohol: Ever a "problem" with alcohol? Yes No Recreational drugs used now or in past? Yes No

Do you exercise regularly? θ Yes θ No What type: _____ How Often: _____

Social History:

Please circle those that apply: Single Married Divorced Number of children: __ Ages: _____

Family History:

Please check the "yes" box next to each condition that applies **to your family members (not you)**.

Please note whether condition applied to family member in the past "P" or currently "C"

	YES	RELATION	DATES RESOLVED Past(P)/Current(C)		YES	RELATION	DATES RESOLVED Past(P)/Current(C)
Alcoholism/ Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Pure Wellness Centers

Full Name: _____ DOB: _____ DATE: _____

DIET: Are you now or have you ever been a vegetarian or vegan? Y N When/how long? _____
List number of servings of each item per day, week, or month (example: water 6/d, eggs 4/m)

Water Tap Filter Bottle	Meat	Veggies: (1/2 cup=serving)	Fast food
Coffee	Poultry	Raw	Fried foods
Black tea	Fish	Steamed	Chips
Herbal tea	Beans	Cooked	Sweets
Milk	Soy	Canned	Chocolate
Soda	Nuts/Seeds:	Frozen	Ice cream
Fruit juice		Pasta	Cheese
Veg. juice	Beer	Rice	Yogurt
Eggs	Wine	Other Grains	Cottage cheese
Tofu	Liquor	Bread	Fruit

Do you eat organic foods? Never Sometimes Often Always Do you use a microwave? Never Sometimes Often
List typical foods you eat for:
Breakfast

Lunch:

Dinner:

Snacks: Food cravings?

Foods you exclude from your diet? How do you feel if you miss a meal?

LIFESTYLE FACTORS:

-Current **weight**_____ Lowest adult weight____ Highest adult (non-pregnant) weight____ Goal weight____ Height____
-How many **colds** or flus do you have in an average year?___ Work days missed/year due to illness? ___
What is the most common type of illness you have? (bronchitis, sinusitis, sore throat, etc)_____
-Average **energy** on a scale of 0-10 (10 highest) __/10 What time is it highest?_____ When lowest? _____
-Do you get **headrushes**/dizzy when you stand? Do you **sweat** too much? Too little?
-Do you feel you have **colder hands and feet** than other people? Y N Do you often wear socks to bed? Y N
-Go to **sleep** similar time ea. night? ____ Wake during the night? Y N What time? _____
Average number of hours of sleep: _____ Trouble falling asleep? Y N
Energy slumps/nap after lunch? Y N I wake feeling rested _____% of the time.
Do you snore? Y N Do you have sleep apnea? Y N C-PAP? Y N How long? _____
-Ever had **counseling**/therapy? When/how long? _____
-Frequency of **bowel movement**? ____/Day /Week Need to strain? Y N Gas? Y N Bloating? Y N Pain? Y N
Use laxatives? Y N Use Metamucil or other fiber? Y N _____ Blood, black, mucus in stools? Y N
What about your digestion is not perfect? _____
-Are you **sexually** active? _____ w/men___women___both___ Do you practice safe sex? _____
Have you ever been physically touched against your will? _____
-Do you wear **seat belts**? Always Sometimes Never
-**Sensitive** to: mold animals soaps perfumes other _____ Home has: Gas heat Mold
Toxic life exposures: lead mercury pesticides city air pottery swimming other _____
Toxic occupation exposures: exterminator dry cleaning painter car mechanic other _____

Pure Wellness Centers

Mood/Hormone Questionnaire

Full Name: _____ DOB: _____ DATE: _____

Please circle the number next to each symptom that you most identify with and add your score. If you answered these questions during a previous appointment, base your new answers on the time since then.

Scoring:
0 = never/rarely 1 = 1 to 2 days per week 2 = 3 to 5 days per week 3 = Most days

Part 1: Moods

0 1 2 3	Do you have a tendency to be negative, to see the glass as half-empty rather than half-full?
	Do you have dark, pessimistic thoughts?
0 1 2 3	Are you often worried and anxious?
0 1 2 3	Do you have feelings of low self-esteem and lack confidence?
0 1 2 3	Do you have obsessive, repetitive, angry, or useless thoughts that you just can't turn off – for instance, when you're trying to get to sleep?
0 1 2 3	Does your behavior often get a bit, or a lot, obsessive? Is it hard for you to make transitions, to be flexible? Are you a perfectionist, a 'neatnik', or a control freak? A computer, TV, or work addict?
0 1 2 3	Do you really dislike the dark weather or have a clear-cut fall/winter depression (SAD)?
0 1 2 3	Are you apt to be irritable, impatient, edgy, or angry?
0 1 2 3	Do you tend to be shy or fearful? Do you get nervous or panicky about heights, flying, enclosed spaces, public performance, spiders, snakes, bridges, crowds, leaving the house, or anything else?
0 1 2 3	Have you had anxiety attacks or panic attack (your heart races, it's hard to breathe)?
0 1 2 3	Do you get PMS or menopausal moodiness (tears, anger, depression)?
0 1 2 3	Do you hate hot weather?
0 1 2 3	Are you a night owl, or do you often find it hard to get to sleep?
0 1 2 3	Do you wake up in the night, have restless or light sleep, or wake up too early?
0 1 2 3	Do you routinely like to have sweet or starchy snacks, wine, or marijuana in the afternoons, evenings, or in the middle of the night (but not earlier in the day)?
0 1 2 3	Do you find relief from any of the above symptoms through exercise?
0 1 2 3	Have you had fibromyalgia (unexplained muscle pain) or TMJ (pain, tension, and grinding associated with your jaw)?
0 1 2 3	Have you had suicidal thoughts or plans?

Total_____ (12, Ser, 5-H, Hyp, 25)

(over)

Full Name: _____ DOB: _____ DATE: _____

Part 2 Energy

0 1 2 3 Do you often feel depressed – the flat, bored, apathetic kind?
0 1 2 3 Are you low on physical or mental energy? Do you feel tired a lot; have to push yourself to exercise?
0 1 2 3 Is your drive, enthusiasm, and motivation quota on the low side?
0 1 2 3 Do you have difficulty focusing or concentrating?
0 1 2 3 Do you need a lot of sleep? Are you slow to wake up in the morning?
0 1 2 3 Are you easily chilled? Do you have cold hands or feet?
0 1 2 3 Do you tend to put on weight too easily?
0 1 2 3 Do you feel the need to get more alert and motivated by consuming coffee or other "uppers" like sugar, diet soda, ephedra, or cocaine?

Total____ (6, cats, tyro, thyro,53)

Part 3: Stress

0 1 2 3 Do you often feel overworked or pressured with deadlines?
0 1 2 3 Do you have trouble relaxing or loosening up?
0 1 2 3 Does your body tend to be stiff, uptight, and/or tense?
0 1 2 3 Are you easily upset, frustrated, or snappy under stress?
0 1 2 3 Do you often feel overwhelmed or as though you just can't get it all done?
0 1 2 3 Do you feel weak or shaky at times?
0 1 2 3 Are you sensitive to bright light, noise, or chemical fumes? Do you need to wear dark glasses a lot?
0 1 2 3 Do you feel significantly worse if you skip meals or go too long without eating?
0 1 2 3 Do you use tobacco, alcohol, food, or drugs to relax and calm down?

Total____ (8, Adr, gab, tau, gly, 77)

Part 4: Pain

0 1 2 3 Do you consider yourself or do others consider you to be very sensitive? Does emotional pain or perhaps physical pain really get to you?
0 1 2 3 Do you tear up cry easily – for instance, even during TV commercials?
0 1 2 3 Do you tend to avoid dealing with painful issues?
0 1 2 3 Do you find it hard to get over losses or get through grieving?
0 1 2 3 Have you been through a great deal of physical or emotional pain?
0 1 2 3 Do you crave pleasure, comfort, reward, enjoyment, or numbing from treats like chocolate, bread, wine, romance novels, marijuana, tobacco, or lattes?

Total___ (6, End, dlpa, 100)

Review of Body Systems

Write a **C** if symptoms are current,
a **Y** if they occurred in the past year.
Severity of symptoms: Low, Medium, High

GENERAL:	**Lo**	**Med**	**Hi**
Cold hands & feet			
Trouble sleeping			
Fatigue			
Fever			
Dizziness/Head rushes			
Heat intolerance			
Cold intolerance			
Sudden weight change			
Sleepy after lunch			
Dry skin			
Irregular Sweating			
HEAD, EYES & EARS:	**Lo**	**Med**	**Hi**
Headaches			
Migraine			
(sens to light, nausea)			
TMJ/Jaw problems			
Eye infections			
Eye pain			
Vision problems			
Ear fullness			
Ear pain			
Ear ringing/buzzing			
Hearing problems			
Distorted sense of smell			
Distorted taste			

MUSCULOSKELETAL:	**Lo**	**Med**	**Hi**
Muscle spasm/cramps:			
-Back			
-Calf			
-Foot			
-Neck			
-Other:			
Muscle pain/aches			
Muscle stiffness			
Muscle twitches:			
-Around eyes			
-Arms or legs			
Muscle weakness			
Tendonitis			
-Where:			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
MOOD/NERVES:	**Lo**	**Med**	**Hi**
Irritability			
Anxiety			
Panic Attacks			
Depression			
Balance Probs			
Speech Probs			
Concentration Probs			
Memory Probs			
Dizziness (spinning)			
Fainting			
Light-headedness			
Numbness			
Tingling			
Seizures			
Suicidal thoughts			
Tremor/trembling			
Visual hallucinations			
EATING:	**Lo**	**Med**	**Hi**
Poor appetite			
Salt craving			
Sugar craving			
Can't gain weight			
Can't lose weight			
Carb intolerance			
Bulimia / Binge eating			
Anorexia/No appetite			
Intolerance to: Lactose			
All milk products			
Gluten (wheat)			

Corn			
Eggs			
Fatty foods			
Yeast			
DIGESTION:	**Lo**	**Med**	**Hi**
Bleeding gums			
Bad breath			
Cracking corner of lips			
Canker sores			
Cold sores			
Extreme thirst			
Sore tongue			
Dentures			
Foods "repeat" (reflux)			
Heartburn			
Difficulty swallowing			
Burping (frequent)			
Nausea (frequent)			
Vomiting (frequent)			
Upper abdominal pain			
Lower abdominal pain			
Bloating			
Gas (frequent)			
Constipation			
Diarrhea			
Stools:			
-Blood			
-Mucus			
-Undigested food			
Strong stool odor			
Hemorrhoids			
Liver disease/jaundice (yellow eyes or skin)			
SKIN:	**Lo**	**Med**	**Hi**
Dark circles under eyes			
Red face			
Acne			
-Where:			
Easy bruising			
Dry/dull skin			

Cellulite			
Wounds won't heal			

Current, **P**ast; Severity (Lo, Med, Hi)

Moles (color/size change)			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Eczema			
Hives			
Rash			
Bumps on back of upper arms			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Vitiligo (pale skin spots)			
Athlete's foot			
Itching:			
-Where:			
Dryness			
-Where:			
Hands crack /bleed			
Feet crack / bleed			
Hair falling out			
Scalp itchy, flaky			

Current, **P**ast; Severity (Lo, Med, Hi)

NAILS:	**Lo**	**Med**	**Hi**
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			

Soft			
Thickening of: -Fingernails			
-Toenails			
White spots/lines			
LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			

Current, **P**ast; Severity (Lo, Med, Hi)

Notes:

RESPIRATORY:	**Lo**	**Med**	**Hi**
Frequent colds			
Cough - dry			
Cough - productive			
-Cough up blood			
Hay fever : Spring			
Summer			
Fall			
Season change			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness / pain			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
Deviated septum			
CARDIOVASCULAR:			
Chest pain			
Chest tightness			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Swollen ankles/feet			
Varicose veins			

Notes:

URINARY:	**Lo**	**Med**	**Hi**
Frequent urination			
Infection (frequent)			
Urine stops and starts			
Urgency			
Leaking/incontinence			
Pain/burning			
Blood in urine			
Kidney disease			
Kidney stones			
Bed wetting			
MALE REPRODUCTIVE:			
Prostate enlargement			
Prostate infection			
Ejaculation problem			
Discharge from penis			
Genital pain			
Erectile dysfunction			
Infection			
Lumps in testicles			
Swelling of testicles			
Poor libido (sex drive)			
Jock itch			
STD's:			
Sores			
FEMALE REPRODUCTIVE:			
Breast discharge			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Pain during intercourse			
Endometriosis			

Fibroids			
Infertility			
Vaginal infections (frequent)			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal sores			
Low sex drive			
Premenstrual: Bloating			
Breast tenderness			
Carb craving			
Water retention			

Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability / Depression			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Age at first period _____ Date of last Pap Smear _____ Normal _____ Abnormal

Ever had abnormal Pap? _____ When? _____

Do you currently use contraception? Yes No What type? _____

Have you ever used birth control pills? Yes No If yes, when/how long _____

Any problems w/ pill/patch/Depo/ring/contraception? _____
_____

Have you ever been pregnant? Yes____ No____

Number of miscarriages _____ abortions _____ preemies _____ term births _____
Birth weight of largest baby _____ Smallest baby _____

Any problems with pregnancy? (toxemia (high blood pressure), high blood sugar, others?)

_____
_____

Date of last Mammogram_____ Normal Abnormal Never Had

Are you in menopause? No Yes If yes, age at last period _____

HRT: Do you take: Estrogen?___ Ogen?___ Estrace?___ Premarin?___ Other (specify)_____
Progesterone?___ Provera? ___ Other (specify) _____

How long have you been on hormone replacement therapy (if applicable)? _____

Past Medical and Surgical History Name: **Date:**

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Appendicitis		
c.	Bleeding disorder		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Fibromyalgia		
l.	Gallstones		
m.	Gout		
n.	Heart attack/Chest Pain		
o.	Heart failure		
p.	Hepatitis		
q.	High blood fats (cholesterol, triglycerides, LDL)		
r.	High blood pressure (hypertension)		
s.	Irritable bowel		
t.	Kidney stones		
u.	Mononucleosis		
v.	Pneumonia		
w.	Rheumatic fever		
x.	Sinusitis		
y.	Sleep apnea		
z.	Stroke		
aa.	Thyroid disease		
	Sexually Transmitted Diseases		
	Ulcers		
	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
a.	Back injury		
b.	Broken (describe)		
c.	Head injury		
d.	Neck injury		
e.	Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Ultrasound		
Bone Scan		
CAT Scan of _____		
X-rays of _____		
Colonoscopy		
EKG		
Liver scan		
MRI		
Sigmoidoscopy		
Upper GI Series		
Other (describe)		
Other (describe)		

	OPERATIONS	WHEN	COMMENTS
a.	Appendectomy		
b.	Bladder repair		
c.	Dental Surgery		
d.	Gall Bladder		
e.	Hernia		
f.	Hysterectomy, (Ovary left?)		
g.	Pacemaker		
h.	Tonsillectomy		
i.	Tubal Ligation		
j.	Other (describe)		
k.	Other (describe)		

Better health comes through partnership!
We will guide you and hope that you will take an active role.
Completing this form is a great indication you are ready to do so.
We look forward to working together to achieve your best health!