NEW PATIENT HEALTH SURVEY

Welcome to our practice. As a new patient, please answer the questions below to the best of your ability. The Initial Consult Fee is $ 525.00

Date _____ **Patient No**_____

Patient Name _____ **Birth Date** _____

Home Phone _____ **Work or Cell Phone** _____ **Email** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Describe your main complaint _____

_____

If your complaint is due to pain, complete the following:

Location _____ **Severity on a scale of 1** _____**10**

Quality _____ **Duration** _____

Time _____ **What makes it better or worse?** _____

Do you have any other health concerns? _____

MEDICAL HISTORY: List any other doctors you've seen for this condition _____

Who is your current family physician? _____ **Specialist?** _____

Date of your last physical exam _____ **When did you have your last blood tests?** _____

List any diagnoses or treatments _____

List any surgeries or major illness with date of occurrence _____

Have you had any infectious diseases? _____

Have you been hospitalized for any condition? What?_____

Do you have any allergies? _____ **Have you ever reacted to medications?** _____

MEDICATIONS: List all prescription or over-the-counter drugs you are taking _____

_____

FAMILY HISTORY: Please indicate if your mother, father, or sibling has had any of the following conditions?

- ☐ Heart or coronary arterial disease (congestive heart failure, angina, etc.) _____
- ☐ Atherosclerosis (hardening of the arteries) _____
- ☐ High cholesterol or other form of abnormal lipids _____
- ☐ Heart attack or stroke _____
- ☐ Diabetes or any form of metabolic disease or obesity _____
- ☐ Cancer and list type(s) _____
- ☐ Osteoporosis or any form of bone disease _____
- ☐ Thyroid disease _____
- ☐ List any other diseases in your family _____

ADDITIONAL INFORMATION: Describe any other information you feel is important for your doctor to know

NUTRITION REVIEW

NUTRIONAL SUPPLEMENTS: List all vitamin, mineral, and other nutritional or herbal supplements

_____

_____

LIFE STYLE INFORMATION: Answer the following questions with YES or NO and explain if necessary

- ☐ **Do you exercise? How often? _____ What type? _____**
- ☐ **Do you use alcohol? How often? _____ What kind? _____**
- ☐ **Do you smoke? How much? _____ For how long? _____ When did you quite? _____**
- ☐ **Do you drink coffee? _____**
- ☐ **Do you drink caffeinated sodas? _____**
- ☐ **Do you follow a specific diet? _____**
- ☐ **Are you concerned about your weight? Are you following a specific diet? _____**
- ☐ **Do you overeat? How is your appetite? _____ Do you have any reactions to foods? _____**
- ☐ **Do you crave sweets? Do you have any other food cravings? _____Or aversions? _____**
- ☐ **Are you concerned about aging? Do you have a specific concern? _____**
- ☐ **Are you concerned about your appearance? Have you used any aesthetic therapies? _____**
- ☐ **Are you stressed or anxious? _____**
- ☐ **Do you or have you experienced depression? Is there any form of depression or dementia in your family? _____**
- ☐ **Do you suffer from insomnia or any other form of sleep abnormality? _____**
- ☐ **Are you concerned about memory loss? _____**
- ☐ **Do you practice any form of stress reduction such as meditation, tai chi, or yoga? _____**
- ☐ **Is your relationship fulfilling? _____ How is your children's health? _____**
- ☐ **Do you experience fatigue? _____**
- ☐ **Do you live on a golf course? How long?_____**
- ☐ **Have you had Covid 19 or the vaccination? If yes, provide dates ____ _____**
- ☐ **Have you ever had to lower your dose of a medication or supplement? Because you were too sensitive?_____**
- ☐ **Do you avoid caffeine in the afternoon because it keeps you up at night? _____ _____**
- ☐ **Do you smell odors when others can't_____**
- ☐ **Is there anything in your body you weren't born with? If yes, what, and when was it put there? _____**
- ☐ **_____ _____**
- ☐ **Do you currently or were you raised near any agriculture, toxic waste, factories, busy roadways, military bases, industries or airports golf courses, gas stations, landfill, mining? _____**
- ☐ **Are you sensitive to odors such as perfumes or gas? _____**
- ☐ **Please list all chemicals that you react badly to._____**

DIETARY INFORMATION: Describe your daily diet

_____

_____

BIOMARKER QUESTIONNAIRE

Age _____ Sex_____ Height _____ Weight _____ BMI _____

Have you experienced any of the following?

- ☐ Decreasing muscle mass
- ☐ Reduced strength
- ☐ Decreased joint mobility
- ☐ Increased stiffness
- ☐ Reduced capacity for work and exercise
- ☐ Decreased endurance
- ☐ Significant weight loss
- ☐ Increased body fat
- ☐ Increased waist to hip ratio (more fat deposits on the abdomen and waist)
- ☐ Reduced sexual drive and/or performance
- ☐ Muscle mass loss or flabbiness
- ☐ Changes in body temperature
- ☐ Sensitivity to cold or heat
- ☐ Hot flashes
- ☐ Dryer or thinning skin and hair
- ☐ Brown or red spots
- ☐ Spider veins on the skin
- ☐ Slow wound healing
- ☐ Frequent colds or flu
- ☐ Presence of viral infections: Herpes Zoster (shingles), Epstein Barr, HIV, HHV-6, Hepatitis
- ☐ Chronic pain or inflammation
- ☐ Poor sleep
- ☐ Waking up tired
- ☐ Fatigue
- ☐ Longer recovery time needed after exertion
- ☐ Forgetfulness
- ☐ Increasing difficulty concentrating
- ☐ Mood changes
- ☐ Unexplained depression
- ☐ Anxiety
- ☐ Increased anger or irritability
- ☐ Craving for sugar
- ☐ Alcohol intolerance

From Nash Winters Terrain 10	Yes/No	If yes, provide details
Do you use herbicides, pesticides, insecticides in, on or around your home and on your pets?		
Do you use commercial body care products and household cleaning products, fabric softeners, hair dyes, canned foods, and artificial sweeteners?		
Do you have your clothes dry-cleaned?		
Do you use Teflon/non-stick cookware? Do you drink RO filtered water? If not, what is, if any, your water filtration system?		
Do you have mercury fillings, eat fish more than 3 times per week, been exposed to heavy metals or any other industrial metals/toxins?		
Do you find it difficult to sweat?		
Do you use a microwave, cell phone, cell towers, Wi-Fi, laptop computer more than 3 hours/day and, or have a Smart Meter? Or had recent or past x-rays, scans, and mammography, DEXA or radiation treatment? **Microbiome and Digestive Function:**		
Were you born C-Section?		
Were you fed infant formula before the age of 1?		
Have you ever tested positive for a parasite, c.diff, or H.pylori infection?		
Have you ever or do you now use hand sanitizer and antimicrobial soap?		
Do you have any digestive symptoms including gas, bloating, diarrhea, constipation, SIBO, colitis, diverticulitis, reflux? And please describe the quality of your stools (soft, firm, pebbles, odor, color and how often?)		
Do you currently use Round Up near your home and eat nonorganic grains?		

	Yes/No	If yes, provide details
Do you eat non-organic meat and dairy products?		
Do you take NSAIDS (Tylenol, aspirin, ibuprofen) or antacids more than a few times per year?		
Do you eat less than 25g/d of fiber?		
Have you ever taken the recommended oral prep for colonoscopy?		

Please provide us with a timeline of your current illness or complaint. Start 1 year prior to your first experience of your current chief complaint.

Date	Significant Life Events	Significant Health Event

In case of emergency, notify _____ Phone No. _____Relationship _____

I understand that all fees for consultations, examinations, treatments, and supplies are to be paid for as they are received. My signature is consent for consultation and treatment.

PATIENT'S SIGNATURE: _____ Date _____