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 $ 375.00

Date ____________________ **Patient No** ____________________

Patient Name ______________________________ **Birth Date** ______________________________

Home Phone ____________________ **Work or Cell Phone** ____________________ **Email** ____________________

Address ______________________________ **City** ______________ **State** ________ **Zip Code** __________

Describe your main complaint ____

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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 ______________________________

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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

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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

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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
- ☐ Sensitivity to certain foods
- ☐ Craving for sugar
- ☐ Alcohol intolerance

From Dr. Nasha 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?		

FATIGUE QUESTIONNAIRE

Answer the questions below by checking each applicable box if you have ever experience any of the following:

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 ________________