NEW PATIENT INSTRUCTIONS – ALL NEW PATIENTS

If you are interested in making an appointment, please be sure you have reviewed all information on our website www.carolinacenter.com under "**NEW PATIENTS**", then "**HOW TO BECOME A PATIENT**" before completing these forms.

Please review "**Type of New Patients**" and then indicate which type office visit you prefer:

____ **Individual New Patient Visit - CANCER $1007**

____ **Individual New Patient Visit - $974**

____ **Combined Individual New Patient Visit - $899 per person**

(Both individuals will need to complete separate Medical History forms and submit together)

____ **Expedited Colon Therapy - $367**

____ **Urgent Lyme-Tick Borne Illness - $475**

- Please complete the **Medical History Form**.
- Complete and sign the **Patient Registration/Insurance Authorization Form**
- Provide us a **copy of your Insurance card, both front and back and a copy of your Driver's License** or other official identification which is required by the US Patriot Act. Failure to provide these documents will delay scheduling your appointment.
- Fill out the **Request for Medical Records** and give these to your primary care and/or specialty physicians to have them send us copies of any pertinent medical records and recent laboratory results. Do not have copies of x-rays sent as we only need the reports. Please make copies of any records you have and include in your materials prior to your initial office visit. Please be aware that any records provided will not be returned and we will not make copies of your records. Do not return this form to us.
- We require a **non-refundable $250 deposit** to process your initial paperwork. **The balance of $724 for the Individual Office Visit, $757 for Cancer Visit, $649 per person for Combined, $225 for Urgent Lyme, will be due at the time your initial office visit is scheduled.** This balance can be refunded up to 2 weeks prior to your actual office visit. The $250 deposit is not refundable. Send a check payable to: The Carolina Center or complete the following if you wish to make a credit / debit card payment.

____Visa ____MasterCard ____American Express ____Care Credit

Account #:_____Expiration: ____/____

Cardholder Name:_____

Cardholder Signature:_____

Please be aware of our **No Perfume-Scented Toiletries** policy and refrain from wearing any perfume or scented toiletries while at the clinic.

I have read all the information on the Carolina Center website under "New Patients" and "How to become a patient" and understand these procedures. I am requesting to become a patient of the Carolina Center and that it is highly recommended that I attend the "Introduction to the Carolina Center" Group Orientation. I understand that I will not be undergoing an evaluation at this Orientation. I understand that the **$250 deposit is nonrefundable** and I have reviewed the "**New Patient Cancellation Policy**".

_____ _____

Signature **Date**

Please check to be sure you have **ALL** the above items completed and return this form back to us.

Send all of this information to our office:

The Carolina Center for Integrative Medicine, P.A., New Patient Coordinator
4505 Fair Meadow Lane #111, Raleigh, NC 27607, Fax to: 919-571-8968 or E-mail: angel@carolinacenter.com

The Carolina Center for Integrative Medicine

New Patient Cancellation Policy

A non-refundable deposit of $250 is due upon receipt of the New Patient registration form and Medical History. The actual new patient appointment will then be scheduled following the initial “Orientation”. At that time, the balance is due for payment for the initial office visit, Individual, Group or Expedited Colon Therapy.

This balance is fully refundable up to two weeks prior to the scheduled office visit. No refunds will be made if a cancellation request is received after this time period however patients will be allowed one opportunity to reschedule. If this rescheduled appointment is then cancelled again or the patient is a no-show, the patient will not be allowed to reschedule any appointments and will forfeit all payments. Under these circumstances, the individual must reapply to be a new patient after a 3 month waiting period, submitting a new Patient Registration Form along with another $250 deposit. No credit will be given for any previous payments made. There will be no waivers of these fees for New Patients.

Date form filled out: _____

Patient Contact Sheet

Legal Name _____

What would you like us to call you? _____

Date of Birth: _____

Address/City/State/ZIP: _____

Insurance Carrier: _____

Policy Number: _____

Home Phone: _____ Work Phone: _____

Cell Number: _____ E-mail: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Fax Number _____

Best Phone Number to Reach You and/or Leave a Message concerning Appointments:

Best Phone Number to Reach You and/or Leave a Message concerning Prescriptions & other Medical Questions or Information at:

Emergency Contact: Name: _____ Phone Number: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

THE CAROLINA CENTER FOR INTEGRATIVE MEDICINE, P.A. - PATIENT REGISTRATION / INSURANCE FORM

Patient's Legal Name: (First, Middle Initial, Last):_____Social Security #: _____

Patient Address:_____County: _____

Home #:_____Cell #: _____

Sex M or F Birth date:_____Email address: _____

Marital Status: ____Single ____Married ____Divorced _____Widowed ____Domestic Partnership

Spouse's Name (if applicable):_____# of household members:_____Ethnicity: _____

Person responsible for payment: _____

Patient's Employer and Occupation: _____

Employer Address:_____Work #:_____Ext: _____

Primary Care Physician Name:_____Phone #: _____

DO YOU HAVE HEALTH INSURANCE? YES NO (Circle one) - If you answered YES, please provide a copy of your insurance card and complete the following:

Primary Insurance:_____Subscriber's Name: _____

Sex of Subscriber: M F Birth date of Subscriber:_____Social Security #: _____

Relationship to Patient:_____Policy #:_____Group #: _____

Secondary Insurance:_____Subscriber's Name: _____

Sex of Subscriber: M F Birth date of Subscriber:_____Social Security #: _____

Relationship to Patient:_____Policy #:_____Group #: _____

Emergency Contact: Name:_____Phone #:_____

Please tell us how you heard about our practice (circle one or more): Yellow Pages Newspaper Website Internet Family/Friend

Other: _____

Who can we thank for referring you to our practice? _____

Financial Obligation Statement

The services you are electing to receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of any and all charges incurred. As a courtesy, we will verify any insurance coverage and bill your insurance carrier on your behalf with the exception of Medicare, Medicaid, and Blue Cross Blue Shield; however, you are ultimately responsible for the payment of your bill. Payment for all office visits, procedures and other services is expected at the time the service is provided. Payment is also due immediately upon receipt of any bill presented to cover any deductible or coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim you will obligated for your account balance in full. I authorize my insurer to pay any benefits directly to Carolina Center for Integrative Medicine. I also agree to pay the Carolina Center the full and entire amount of all bills incurred by me within 30 days of treatment or upon receipt of any amount due after payment has been made by my insurance carrier. I understand that I will be assessed interest of 15% on any unpaid balance after 30 days and this interest will continue to accrue until payment is made in full. I have read the above policy regarding my financial responsibility to the Carolina Center for providing services to me. I certify that the information provided is, to the best of my knowledge, true and accurate.

Patient / Guardian Signature: _____ **Date:** _____

The Carolina Center for Integrative Medicine, P.A

John C. Pittman, M.D.
4505 Fair Meadow Lane, Suite 111
Raleigh, NC 27607
(919) 571-4391 Fax: (919) 571-8968

REQUEST FOR MEDICAL RECORDS

Authorization to Use/Release/Disclose Medical Information

Please give this form to your primary care doctor or any other physicians you have seen within the last several years so they are able to send copies of your medical records to us.

DO NOT RETURN THIS FORM TO THE CAROLINA CENTER

THIS IS FOR YOU TO TAKE TO YOUR REGULAR DOCTOR TO GET RECORDS SENT TO US

Patient Name (please print) _____

Date of Birth_____/_____/_____Social Security Number_____

Street Address_____

City_____State_____Zip_____

Home Telephone_____Work Telephone_____Ext._____

I request that copies of my complete medical records for the past six months along with any other pertinent labs or radiology reports related to my condition be sent to the Carolina Center for Integrative Medicine, P.A. at the above address

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

DO NOT RETURN THIS FORM TO THE CAROLINA CENTER – TAKE THIS TO YOUR REGULAR DOCTOR.

_____ _____

Signature of Patient or Guardian **Date**

NEW PATIENT HEALTH HISTORY

Our primary goal in your initial office visit is to review your health history since childhood, understanding the sequence of health care events of your life and how they may be linked leading us to your current state of health. It is enormously helpful for patients to provide this chronologic history for us in advance as this will expedite the visit, allow us to gain better information about the most important events in your life, and give more time to answer questions and discuss treatment considerations.

Please provide us the highlights of your health history being sure to incorporate the major topics noted below by either filling out this form or writing a narrative that allows you to expand on important issues. Please be concise, but elaborate on important details.

Major components of the health history:

- Chronologic history of health events and symptoms grouped by decades
- Details about major illnesses, hospitalizations, surgeries, trauma, pregnancies, symptoms, etc.
- Details about frequency of infections and use of antibiotics
- Any dental work other than routine cleanings, especially placement or removal of amalgam fillings
- Exposures to toxins, chemicals; history of work in potentially dangerous environments

Childhood:

Teens:

Twenties:

Thirties:

Forties:

Fifties:

Sixties:

Seventies and older:

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

Reason for your visit today _____

Recent and preventive medical care:

	Never	Mon/Yr	Results
Last physical examination:	[ ]	____/_____	
Last blood work/urinalysis:	[ ]	____/_____	
Last blood pressure check:	[ ]	____/_____	
Last EKG (electrocardiogram):	[ ]	____/_____	
Last chest x-ray:	[ ]	____/_____	
Other x-rays:	[ ]	____/_____	
Last vision check:	[ ]	____/_____	
Last hearing check:	[ ]	____/_____	
Last dental check/cleaning:	[ ]	____/_____	
Last stool test for bleeding:	[ ]	____/_____	
Last Sigmoidoscopic examination:	[ ]	____/_____	

Present Health Status:

Rate your present health status? [ ]Excellent [ ]Good [ ] Fair [ ] Poor

How much do you currently weigh?_____lbs How tall are you?_____ft_____in

How would you describe your body shape? [ ] Heavy [ ] Medium [ ] Small

Do you consider yourself: [ ] Lean [ ] Pudgy [ ] Obese [ ] Muscular [ ] Out-of-shape

Are you able to walk without assistance? [ ] Yes [ ] No
Without special agreement and arrangements, we are unable to accommodate patients who are not ambulatory due to the extra staff necessary for assistance. If you are in a wheelchair and wish to be a patient, you will need someone to come to all sessions with you as an assistant.

Have you ever had trouble getting IVs started in your arm? [ ] Yes [ ] No [ ] ???

What condition do you hope to improve here? _____

_____

Are you currently undergoing any treatment for this condition? [ ] Yes [ ] No

Brief history of this condition: _____

_____

_____

Please note any other major health or medical problems of which you are aware: _____

_____

Have you had any lab tests within last 6 months? [ ] No [ ] Yes - (Please include a copy with this form.)

MEDICAL HISTORY FORM

Patient Name_____ DOB_____ MR# _____

Present Medications:

Medication	Dosage	Frequency	Since
			___/___
			___/___
			___/___
			___/___
			___/___

Present Vitamins and Nutritional Supplements:

Name	Dosage	Frequency	Since
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___
			___/___

Allergies/Adverse Reactions To: Side-effects:

Medications: _____ _____

_____ _____

_____ _____

Chemicals: _____ _____

_____ _____

Foods: _____ _____

_____ _____

_____ _____

Past Medical History:

Have you ever had (or do you now have) problems with:

VISION/EYES [ ] Glaucoma [ ] Near or far-sighted [ ] Need glasses [ ] Cataracts

[ ] Other:_____ Details: _____

HEARING/EARS [ ] Hearing loss [ ] Tinnitus (Ringing in ears) [ ] Frequent ear infections
[ ] Previous injury to the ears [ ] Recurrent Vertigo (Dizziness)

[ ] Other:_____ Details: _____

RESPIRATORY/ BREATHING [ ] Sinus infection [ ] Hay Fever [ ] Pneumonia [ ] Emphysema
[ ] Asthma [ ] Chronic Cough [ ] Tuberculosis [ ] Allergies

[ ] Other:_____ Details: _____

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

HEART/ CIRCULATION
[ ] Rheumatic Fever, Rheumatic Heart Disease [ ] High Blood Pressure
[ ] Other Heart Disease [ ] Previous Heart Attack [ ] Angina, Heart Pains
[ ] Heart Murmur [ ] Stroke [ ] Aneurysm [ ] Abnormal EKG
[ ] Peripheral Vascular Disease (Poor Circulation) [ ] High Cholesterol Level

DIGESTIVE SYSTEM [ ] Gall bladder problems [ ] Indigestion/Heartburn [ ] Hemorrhoids [ ] Pancreatitis
[ ] Colon polyps [ ] Liver Disease [ ] Abnormal Liver Function Tests

[ ] Ulcer - type:_____

[ ] Hernias - type: _____

[ ] Colitis - type: _____

[ ] Other:_____Details: _____

KIDNEY/BLADDER [ ] Kidney Stones [ ] Glomerulonephritis [ ] Urethritis
[ ] Frequent Bladder Infections [ ] Kidney infection/pyelonephritis

[ ] Other:_____Details: _____

ORTHOPÆDIC/BONES [ ] Neck Pain or Surgery [ ] Low Back Pain or Surgery [ ] Loss of an Extremity

[ ] Arthritis [ ] Other joint problem or surgery:_____

[ ] Other:_____Details: _____

ENDOCRINE/GLANDS [ ] Hypothyroid (Low thyroid) [ ] Hyperthyroid (High thyroid) [ ] Diabetes

[ ] Hypoglycemia (Low blood sugar)

[ ] Other:_____Details: _____

BLOOD SYSTEM [ ] Anemia [ ] Bleeding disorder [ ] Abnormal Hemoglobin

[ ] Other:_____Details: _____

NEUROLOGICAL/ NERVES
[ ] Seizure disorder/Epilepsy [ ] Recurrent Vertigo [ ] Bell's Palsy
[ ] Neuritis/Inflammation of a Nerve [ ] Pinched Nerve [ ] Fainting or concussion

[ ] Other:_____Details: _____

PSYCHOLOGICAL [ ] Depression [ ] Anxiety [ ] Alcoholism [ ] Substance Abuse

[ ] Other:_____Details: _____

CANCER If "yes", type of cancer:_____

Date discovered/diagnosed (mo/yr):_____/_____Treatment:_____

_____

PREVIOUS SURGERY [ ] Tonsillectomy [ ] Appendectomy

[ ] Other: _____ Details: _____

OTHER HOSPITALIZATION OR SERIOUS ILLNESSES

Year/Reason:_____

Year/Reason:_____

Year/Reason:_____

What types of therapies have you previously used in the treatment of your condition? _____

_____

_____

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

Have you been to other health facilities or seen other practitioners for this problem? [ ] Yes [ ] No

If so, what did the treatment include? _____

_____

Was it effective? [ ] No [ ] Yes If "yes", what did the treatment accomplish? _____

_____

Major Family Illnesses: Has any relative had one or more of the following? (Please check all that apply.)
PGF: Paternal Grandfather * PGM: Paternal Grandmother * MGF: Maternal Grandfather * MGM: Maternal Grandmother

Disease	Relative
Cancer and type	[ ] PGF [ ] PGM_____[ ] MGF_____ [ ] MGM _____ [ ] Father ____ [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse _____ [ ] Mother_____ [ ] Children_____ [ ] Grandchildren _____ [ ] Other_____
Diabetes	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren Insulin Dependent? [ ] Yes If "yes", from what age?_____ [ ] No
Heart Disease	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren Age at onset: _____
High Blood Pressure	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren
Stroke	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren
High Cholesterol	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren
Bowel/Colon Disorders (Including polyps)	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren
Alcoholism	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren
Lung Disease	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren
Glaucoma	[ ] PGF [ ] PGM [ ] MGF [ ] MGM [ ] Father [ ] Mother [ ] Aunt [ ] Uncle [ ] Sister [ ] Brother [ ] Spouse [ ] Children [ ] Grandchildren

Family History

Relationship	Present age or age at death (indicate with a D)	State of Health	Major Illnesses (Cause of death if deceased)
Paternal Grandfather (PGF)	_____	[ ] E x [ ] Good [ ] Fair [ ] Poor	
_____ Paternal Grandmother (PGM)	_____	[ ] E x [ ] Good [ ] Fair [ ] Poor	_____
Maternal Grandfather (MGF)	_____	[ ] E x [ ] Good [ ] Fair [ ] Poor	_____
Maternal Grandmother (MGM)	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
Father	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
Mother	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
Brothers	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

Sisters	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
Children	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____
	_____	[ ] Ex [ ] Good [ ] Fair [ ] Poor	_____

Recent Symptoms:

Do you now have or have you had any of the following symptoms within the past 12 months:

VISION/EYES
[ ] Blurred vision
[ ] Double vision
[ ] Eye infection
[ ] Eye pain
[ ] Change in vision
[ ] Do you wear glasses?

HEARING/EARS
[ ] Earaches
[ ] Discharge from your ears
[ ] Ringing or noise in your ears
[ ] Hearing loss
[ ] Family or friends noting that you have a hearing problem

RESPIRATORY/BREATHING
[ ] Nose bleeds
[ ] Head colds
[ ] Sinus problems
[ ] Hay fever
[ ] Loss or change of smell or taste
[ ] Hoarseness
[ ] Sore throat
[ ] Sores on your mouth or throat
[ ] Chronic cough
[ ] Coughing up blood
[ ] Waking up at night short of breath

HEART & BLOOD VESSELS
[ ] Chest pain
[ ] Angina
[ ] Pain radiating into your arms, neck, jaw, or shoulders
[ ] Are you able to lie flat on your back in bed? _____
[ ] High blood pressure
[ ] Varicose veins
[ ] Palpitations or heart fluttering
[ ] Swelling of hands, feet, ankles _____
[ ] Leg cramps while walking
[ ] Leg cramps at night
[ ] Shortness of breath after walking

DIGESTIVE SYSTEM
[ ] Repeated stomach pain
[ ] Heartburn
[ ] Indigestion
[ ] Gum problems
[ ] Belching
[ ] Change in appetite
[ ] Nausea or vomiting
[ ] Difficulty swallowing
[ ] Vomiting up blood
[ ] Constipation
[ ] Black bowel movements
[ ] Blood in stools
[ ] Diarrhea (longer than 2-3 days)

ORTHOPÆDIC/BONES/JOINTS
[ ] Recurrent back pain
[ ] Joint aches
[ ] Joint swelling
[ ] Tingling or weakness
[ ] Muscle spasms
[ ] Numbness of hands or feet
[ ] Trembling of hands or feet
[ ] Recent fracture – Which bone? _____
[ ] Problems walking or running
[ ] Repeated injuries to the same area

KIDNEY/BLADDER
[ ] Pain on urinating
[ ] Difficulty starting urination
[ ] Frequency or urgency of urination
[ ] Blood in urine
[ ] Incontinence (losing urine involuntarily)

SKIN
[ ] Skin rash
[ ] Easy bruising
[ ] Moles that look unusual or changing
[ ] Swollen glands or lymph nodes
[ ] Chronic acne and eruptions

MEDICAL HISTORY FORM

Patient Name_____ DOB_____ MR# _____

ENDOCRINE/GLANDS
[ ] Lump in throat
[ ] Increased thirst
[ ] Increased urination
[ ] Unintentional weight gain
[ ] Unintentional weight loss
[ ] Excessive fatigue
[ ] Discharge from nipples
[ ] Decreased tolerance of heat
[ ] Decreased tolerance of cold
[ ] Change in texture of hair

NEUROLOGICAL/PSYCHOLOGICAL
[ ] Frequent or severe headaches
[ ] Fainting spells
[ ] Dizziness
[ ] Unconscious spells
[ ] Numbness
Where:_____
[ ] Nervousness or depression
[ ] Difficulty concentrating
[ ] Insomnia, difficulty sleeping
[ ] Nervous "tics"

FOR WOMEN ONLY

[ ] Yes	[ ] No	Change in vaginal discharge	[ ] Yes	[ ] No	Skipped or absent periods
[ ] Yes	[ ] No	Menstrual pain/dysmenorrhea	[ ] Yes	[ ] No	Pain or bleeding with intercourse
[ ] Yes	[ ] No	Increased menstrual bleeding	[ ] Yes	[ ] No	Is sex entirely satisfactory?
[ ] Yes	[ ] No	Breast lump or discharge	[ ] Yes	[ ] No	Pelvic Inflammatory Disease
[ ] Yes	[ ] No	Previous abnormal PAP smear	[ ] Yes	[ ] No	Venereal Disease

Results of last PAP smear:_____ Date:_/____/_____

Number of pregnancies:_____ Number of Live Births: _____

FOR MEN ONLY

[ ] Yes	[ ] No	Discharge from penis	[ ] Yes	[ ] No	Is sex entirely satisfactory?
[ ] Yes	[ ] No	Lump in testicles	[ ] Yes	[ ] No	Prostatitis
[ ] Yes	[ ] No	Enlarged Prostate	[ ] Yes	[ ] No	Impotence
[ ] Yes	[ ] No	Testicular tumor/problem	[ ] Yes	[ ] No	Venereal Disease

Lifestyle & Nutrition

Do you engage in any Cardiovascular or Aerobic exercise? [ ] Yes [ ] No

What type?_____ How often? _____

Do you engage in any Muscle Strength or Endurance exercise? [ ] Yes [ ] No

What type?_____How often? _____

Do you engage in any Flexibility and Stretching exercise? [ ] Yes [ ] No

What type?_____ How often? _____

Diet: Do you have any special diet or food needs? [ ] Yes [ ] No

If "yes", please list considerations: _____

_____

Do you consume caffeinated beverages? [ ] Yes [ ] No How many do you consume per day? _____

Do you consume fish? [ ] Yes [ ] No How often?_____Favorite type? _____

Do you consume dairy products? [ ] Yes [ ] No How often?_____Favorite type? _____

Do you consume fried foods? [ ] Yes [ ] No How often?_____Favorite type? _____

Describe the following typical meals:

Breakfast:_____

_____

Lunch:_____

_____

MEDICAL HISTORY FORM

Patient Name_____DOB_____MR# _____

Dinner:_____

_____

What percentage of your diet is raw & uncooked? [ ] 0 - 25 [ ] 25 - 50 [ ] 50 - 75 [ ] 75 - 100

Do you know the amount of fiber in your food daily? [ ] Yes - Amount: _____ [ ] No

Have you changed your diet since the development of your condition? [ ] Yes [ ] No

If "yes", how? _____

_____

Do you feel this change has improved your health? [ ] No [ ] Yes - _____

Drug and Alcohol Usage

Use of recreational drugs: [ ] Never [ ] 1 - 3 times per week [ ] 4 - 7 times per week [ ] > 7 times per week

How often do you drink beer?_____Wine?_____Hard Liquor?_____

Weight Control

Is weight control a problem for you? [ ] No [ ] Yes - [ ] Overweight [ ] Underweight

Current height?_____Current weight:_____Ideal weight: _____

Weight 1 year ago:_____Highest previous weight:___

_____ Are you doing (have you done) anything to control your weight? [ ] No [ ] Yes - _____

Can you easily see the veins on your arms and legs? [ ] Yes [ ] No

Tobacco Usage

Do you currently use any form of tobacco? [ ] Yes [ ] No What type and how much do you use? _____

If you once used tobacco, what year did you quit? _____ What did you use? _____

Stress Management

Do you meditate? [ ] Yes [ ] No How often/for how long?_____

Do you practice other relaxation exercise? [ ] Yes [ ] No How often? _____

Do you have any regular or leisure time activities? [ ] Yes [ ] No Type? _____

How many weeks of vacation do you take each year? _____

How stressful do you consider your life to be? [ ] High [ ] Moderate [ ] Slight [ ] Very Relaxed

Sleep Habits

Do you sleep well? [ ] Yes [ ] No How many hours of sleep do you actually get each night? _____

I certify that the above information is true and correct to the best of my knowledge. It is my responsibility to inform my physician if there are any changes in any of the information contained in this form.

_____ _____

Patient/Guarantor Signature Date