

ELAN VITAL MEDICAL CTR
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PATIENT INFORMATION

(Please print clearly)

WELCOME

The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide if we can assist you. If we do not believe that your condition will respond to our care, we will not accept you as a patient but will refer you to another health care provider.

Last Name _____

First _____ MI _____

Street _____

City _____ State _____ Zip _____

Phone () _____ - _____ Email Address _____

Birth Date _____ - _____ - _____ Sex: _____ Male _____ Female

Employer _____ Work Phone () _____ - _____

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

I understand and agree that the doctor has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. I further understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that, unless other arrangements are made with your office, all services are rendered to me are charged directly to me and that I am personally responsible for payment.

Signature _____ Date _____ - _____ - _____

PLEASE VISIT US ONLINE AT: WWW.EVMEDCENTER.COM

Name _____

What is the reason for your visit? _____

What do you think caused your problem? _____

When did this condition begin? _____ Has this condition occurred before? () Y () N

What type(s) of therapy have you tried for this condition?

() conventional drugs () chiropractic () acupuncture

() diet modification () vitamin/minerals () herbs

() homeopathy () other _____

Laboratory tests performed (e.g. blood, urine, stool, hair analysis) _____

Outcome of tests _____

What diagnosis were you given? _____

Is your health currently: () getting better () getting worse () staying same

How do you know? _____

Please list any other health concerns/conditions, even if you think they may not be important. _____

Primary care physician _____ Date of last physical exam _____

Please list all medications you have taken over the past 3 months (prescription or over the counter)

Drug Name	Start Date	Stop Date	Reason For It	Results

Please list all of your medication allergies

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Please list all hospitalizations or surgeries

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____

Have you EVER been on frequent or prolonged antibiotic therapy? ()Y ()N

Any medications devices/prosthetics/implants ()Y ()N describe: _____

WOMEN

Age of onset of menstruation _____ Are you pregnant? () Y () N
Age of onset of menopause _____ Hysterectomy ()Y ()N
Number of children _____ Number of miscarriages _____
Length of menstrual cycle _____ days Interval of time between cycles _____ days
Duration of flow _____ days Is your flow ()Light ()Medium () Heavy
Date last period began _____ Date of last PAP _____

Do you have:

- ()irregular periods ()cramps/pain with period
()tension/depression before period ()hot flashes at any time
()pain during intercourse ()any unusual bleeding or discharge

Do you smoke cigarettes? ()Y ()N _____ packs/day How many years _____
Do you smoke cigars? ()Y ()N _____ cigars/day How many years _____
Do you do illegal drugs? ()Y ()N amount/type _____
Do you drink alcohol? ()Y ()N _____ drinks/week
Do you drink caffeine ()Y ()N _____ cups/per day
How many cups of water do you drink each day? _____
Do you exercise regularly? ()Y ()N If yes, what kind and how often? _____

Are you on a special diet? ()Y ()N If yes, what kind? _____

Please list everything you eat and drink for 3 days.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

Please list all supplements/herbs/homeopathic you are currently taking.

Name/Type	Dosage	Reason For It

Please list your special interests and passions: _____

Please check the boxes next to all illnesses you have or have had.

- | | | |
|---|--|--|
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Cancer: Colon |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Cancer: Esophagus |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer: Stomach |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Cancer: Pancreas |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Cancer: Prostate |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Liver Cirrhosis | <input type="checkbox"/> Cancer: Breast |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Excessive Alcohol Use |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sprue | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Esophagitis | <input type="checkbox"/> Migraine Headache |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Arthritis |

Have you had the following immunizations:

- | | |
|---|---|
| <input type="checkbox"/> Polio | <input type="checkbox"/> tetanus booster (last 10 yr) |
| <input type="checkbox"/> DPT (diphtheria/pertussis/tetanus) | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Measles | <input type="checkbox"/> HPV (human papillo virus) |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Others_____ |
| <input type="checkbox"/> Small Pox | |

Please list any family members who have had any of the following problems.

Disease	Relation To You	Disease	Relation To You
Cancer: Colon		Colon Polyps	
Cancer: Breast		Colitis	
Cancer: Prostate		Bleeding Problems	
Cancer: Other		Alcohol Abuse	
Obesity		Hepatitis	
Diabetes		Osteoporosis	
Hypertension		Liver Disease	
Heart Disease		Other:	
High Cholesterol		Other:	

Please circle your answer:

Date of last colonoscopy (if over age 50)	Year:	Never – Don't know
Date of last mammogram (if female)	Year:	Never – Don't know
Date of last bone density test (for osteoporosis)	Year:	Never – Don't know

Symptoms		Physician Comment
Lack of energy	Yes No	Constitutional
Trouble sleeping	Yes No	
Weight loss (10 lbs. in 1 yr.)	Yes No	
Weight gain (10 lbs. in 1 yr.)	Yes No	
Fevers	Yes No	
Hard or infrequent bowel movements	Yes No	GI
Loose or frequent bowel movements	Yes No	
Blood in bowel movements	Yes No	
Vomit blood	Yes No	
Heartburn/indigestion	Yes No	
Food sticks when swallowing	Yes No	
Painful swallowing	Yes No	
Yellow jaundice	Yes No	
Chest pain	Yes No	Cardiovascular
Irregular heartbeat	Yes No	
Palpitations	Yes No	
Swollen legs	Yes No	
Fainting	Yes No	
Shortness of breath	Yes No	Respiratory
Wheezing	Yes No	
Coughing up blood	Yes No	
Asthma	Yes No	
Frequent urination	Yes No	GU
Blood in urine	Yes No	
Difficulty urinating	Yes No	
Could you be pregnant	Yes No	
Painful menses	Yes No	
Joint swelling	Yes No	Musculoskeletal
Joint redness	Yes No	
Gout	Yes No	
Muscle aches	Yes No	
Breast lump	Yes No	Breast/skin
Unusual or new rash	Yes No	
Paralysis	Yes No	Neuro
Stroke	Yes No	
Seizures	Yes No	
Loss of memory	Yes No	
Depression	Yes No	Psychological
Suicide attempts	Yes No	
Anxiety	Yes No	
Diabetes	Yes No	Endocrine
Excessive thirst	Yes No	
Bleeding	Yes No	Heme
Easy bruising	Yes No	
Allergy to shellfish	Yes No	Allergy
Allergy to X-ray dye	Yes No	

Patient Signature:

Date:

METABOLIC BIOTRANSFORMATION QUESTIONNAIRE

Patient Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile

Point Scale

0-Never or almost never have the symptoms

1-Occasionally have it, effect is not severe

2-Occasionally have it, effect is severe

3-Frequently have it, effect is not severe

4-Frequently have it, effect is severe

HEAD

___ Headaches

___ Faintness

___ Dizziness

___ Insomnia

___ Total

EYES

___ Watery or itchy eyes

___ Swollen, reddened or sticky eyelids

___ Bags or dark circles under eyes

___ Blurred or tunnel vision

___ Total

EARS

___ Itchy ears

___ Earaches, ear infections

___ Drainage from ear

___ Ringing in ears, hearing loss

___ Total

NOSE

___ Stuffy nose

___ Sinus problems

___ Hay fever

___ Sneezing attacks

___ Excessive mucus formation

___ Total

MOUTH/THROAT

___ Chronic coughing

___ Gagging, frequent need to clear throat

___ Sore throat, hoarseness, loss of voice

___ Swollen or discolored tongue, gums, lips

___ Canker sores

___ Total

SKIN

___ Acne

___ Hives, rashes, dry skin

___ Hair loss

___ Excessive sweating

___ Flushing, hot flashes

___ Total

HEART

___ Irregular or skipped heartbeat

___ Rapid or pounding heartbeat

___ Chest pain

___ Total

LUNGS

___ Chest congestion

___ Asthma, bronchitis

___ Shortness of breath

___ Difficulty breathing

___ Total

DIGESTIVE

___ Diarrhea

___ Constipation

___ Bloating feeling

___ Belching, passing gas

___ Heartburn

___ Intestinal/stomach pain

___ Total

JOINTS/MUSCLES

___ Pain or aches in joints

___ Arthritis

___ Stiffness or limitation of movement

___ Pain or aches in muscles

___ Feeling of weakness or tiredness

___ Total

WEIGHT

___ Binge eating/drinking

___ Craving certain foods

___ Excessive weight

___ Compulsive eating

___ Water retention

___ Underweight

___ Total

ENERGY/ACTIVITY

___ Fatigue, sluggishness

___ Apathy, lethargy

___ Hyperactivity

___ Restlessness

___ Total

MIND

___ Poor memory

___ Confusion, poor comprehension

___ Poor concentration

___ Poor physical coordination

___ Difficulty in making decisions

___ Stuttering or stammering

___ Slurred speech

___ Learning disabilities

___ Total

EMOTIONS

___ Mood Swings

___ Anxiety, fear, nervousness

___ Anger, irritability, aggressiveness

___ Depression

___ Total

OTHER

___ Frequent illness

___ Frequent or urgent urination

___ Genital itch or discharge

___ Total

CARBOHYDRATE TOLERANCE ASSESSMENT

NAME: _____ DATE: _____

For each of the questions, answer yes if it usually applies to you and no if it usually does not. Nevertheless, answer each question. Answer as if you were not on a diet or worrying about caloric consumption or about your weight.

PLEASE ANSWER YES OR NO TO EVERY QUESTION

- (5)_____I have high blood pressure.
- (3)_____I have high blood cholesterol.
- (5)_____I have high blood triglycerides
- (3)_____I get tired and or hungry in the mid-afternoon.
- (5)_____I gain weight easily, especially around my waist and have difficulty losing it.
- (5)_____An hour or two after eating a full meal that includes dessert, I want more sweets/snacks.
- (5)_____I often experience mental confusion or brain fog.
- (3)_____Once I start eating sweets, starches or snack food, I often have a difficult time stopping.
- (5)_____I often experience fatigue and generalized weakness.
- (3)_____I would rather have an ordinary meal that included dessert than a gourmet meal that did not include dessert.
- (10)_____I have diabetes/high blood sugar/my blood sugar is not stable.
- (5)_____I have a family history of high blood sugar/diabetes.
- (5)_____After finishing a full meal, I sometimes feel as if I could go back and eat the whole meal again.
- (3)_____I have a family history or obesity/overweight relatives.
- (3)_____A meal of only meat and vegetables leaves me feeling unsatisfied.
- (3)_____If I am feeling down, a snack of cake, cookies, or chocolate makes me feel better.
- (3)_____If potatoes, bread, pasta or dessert are on the table, I will often skip eating vegetables or salad.
- (4)_____I get sleepy, almost “drugged” feeling after eating a large meal containing bread or pasta or potatoes and dessert.
- (3)_____I have a hard time going to sleep at times without a bedtime snack.
- (3)_____At times I wake in the middle of the night and can’t go back to sleep unless I eat something.
- (4)_____I get irritable if I miss a meal of mealtime is delayed.
- (2)_____At a restaurant I almost always eat too much bread, even before the meal is served.

_____TOTAL SCORE

What your score indicates:

- | | |
|--------------|---|
| 10-15 | It is very unlikely that you are carbohydrate intolerant |
| 16-20 | There is a possibility that you are carbohydrate intolerant |
| 21-40 | Your symptomatology could be due to carbohydrate intolerance |
| 40 and Above | You are definitely carbohydrate intolerant and need to discuss further with your doctor |

AGREEMENT CONCERNING SCOPE OF CARE

Dear Patient,

You have come to us with the desire to improve your general health through Complementary and Alternative Medicine(CAM). You may or may not at the same time be under the care of another physician for primary care or for a specific ailment, it is important to understand clearly the scope and extent of CAM which we expect to render in your case. Since nutritional deficiency may or may not be associated with a specific disease, or may be the cause of that disease, or may **occur** as a result of that disease, our concern in your case **will** be with your nutritional program and your lifestyle and your ability to metabolize and utilize the nutrients you consume. If you have a specific disease and desire treatment for that specific disease entity, you should place yourself under the care of a specialist for such diagnosis and treatments as may be indicated or desired by you.

In our lifestyle changes, CAM and nutritional management of your case, we may prescribe vitamins, herbs, minerals, enzymes, and naturopathic and nutritional supplements. The purpose of these natural prescriptions is limited to:

- Improvement of your overall nutritional status
- Improvement of your metabolism
- Increasing your sense of well-being
- Normalizing your appetite
- Reducing your pain and discomfort
- Balance your mind body constitution

It is important to understand that you may not receive any of these benefits. Results do not occur predictably in every patient, and in some cases they do not occur at all.

Our viewpoint concerning Complementary and Alternative Medicine(CAM) and the diagnostic evaluation of disease is not necessarily shared by the American Medical Association, the Food and Drug Administration, the American Cancer Society, the Arthritis Foundation, the American Heart Association or similar agencies or organizations. Though significant evidence exists to consider such diagnostics and natural treatments safe and effective, the above agencies or organizations may consider them unproved, investigational or experimental. Signing below you acknowledge that, with full knowledge of these disagreements, you desire to undertake diagnostic evaluation and have prescribed in your case such nutritional supplements and natural treatments which, in our opinion, appear to be indicated in your condition.

I have read and understand the above. Under conditions indicated, I hereby place myself under your care for such diagnosis, care, treatment, prescription, and therapies that are indicated in your judgment.

PATIENT/DATE _____ WITNESS _____