



Health History & Neurotoxic Questionnaire

Date: Insurance:

Name:

Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

E-mail Address:

Age: Date of Birth: Gender: Male Female

Status:

- Married
- Separated
- Divorced
- Widowed
- Single
- Partnership

Live with:

- Spouse
- Partner
- Parents
- Children
- Friends
- Alone

Education:

Occupation: Hours per week: Retired

Employer	Work Address

In case of emergency, who should we contact?

Name	Relationship	Address	Phone

How did you hear about our Wellness and Nutrition Program?

What is your major complaint and when did these symptoms begin?

What are your current medications?

What are your current vitamins and/or supplements?

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

Is there anything in your medical history that you consider to be relevant?

What is your employment history? Please provide brief summary.

Please list past or present allergies, including allergies to medications.

Please list all past surgeries and the condition each surgery was for.

Please explain your housing history (type of homes, where and when).

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have amalgam (silver) fillings in your teeth?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever had them in the past?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Did your mother have amalgam when pregnant with you?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever worked in a dental office? If so, how long? _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you had any dental crowns, bridges, root canals, dry sockets or infected tooth extractions?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have any dental implants or other metal in your mouth?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Did you wear contact lenses during the 1980's or early 1990's?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Did you take oral contraceptives during the 1980's or early 1990's?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you noticed any adverse reactions to these shots?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have any tattoos with red ink?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your occupation involve soldering, metal salvage, old home repair or sandblasting?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you remodeled a home built before 1978?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you lived in a home built before 1978 for more than 5 years?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever worn cosmetics containing kohl?

General Toxicity

- Yes No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
- Yes No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)

Mold

- How old is the house you are living in? _____ How long have you lived there? _____
- Yes No Do you see mold growing at home, work or school?
- Yes No Have you ever had water damage at home, work or school?
- Yes No Does your home, workplace or school have a damp or mildew smell?
- Yes No Does spending time in your basement cause or worsen your symptoms?
- Yes No Does your basement ever get wet?
- Yes No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?

Lyme Disease

- Yes No Have you ever been diagnosed with Lyme disease?
- Yes No Have you ever been bitten by a tick or recluse spider?
- Yes No Have you ever seen a bulls-eye rash appear on any part of your body?
- Yes No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
- Yes No Was your mother ever diagnosed with Lyme Disease?
- Yes No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health

- Yes No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
- Yes No Do you have any history of kidney dysfunction?
- Yes No Is there a family history of breast, uterine, cervical or other female cancers?
- Yes No Is there a family history of PMS, fibroids or ovarian cysts?
(Please circle all that apply)
- Yes No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
- Yes No Are you currently having any thoughts of suicide?
- Yes No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
- Yes No Do you have a history of strokes?
- Yes No Have you ever been diagnosed with diabetes mellitus?
- Yes No Have you ever been in an auto accident, fallen or received a major physical injury?
- Yes No Are you in menopause?
- Yes No Do you have any allergies to food or medication?

Name: _____

Date: _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale		
0 = Never had the symptom	2 = Occasionally have it, severe effect	4 = Frequently have it, severe effect
1 = Occasionally have it, mild effect	3 = Frequently have it, mild effect	

Column #1

Anxiety
Mood swings
Enraged behavior or anger for no reason
Excessive shyness, timidity, social phobia (not typical to your personality)
Irritability (not typical to your personality)
Low body temperature (below 97.5°)
Insomnia (can't get to sleep or return to sleep)
Dizziness
Sound in ears (ringing or hearing your heart beat)
Psychological symptoms, even thoughts of suicide
Sensitivity to sound

Column #2

Sensitivity to light
Fatigue after exercising (feeling worse)
Bad night vision or seeing halos around lights
Shortness of breath, with very little effort
Excessive thirst and/or frequent urination
Red eyes or tearing
Blurred vision at times
Morning stiffness
Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
Chronic fatigue or weakness
Non-restful sleep

Indecisiveness
Feeling of being overwhelmed or fearful
Metallic taste in your mouth
Bad breath
Bleeding gums
Sensitive teeth
Canker sores or other sores in the mouth
Floater, shadows or swimmers when you read or look into the sky
Dyslexia or loss of place while reading, even as a child
Swelling eyelids
Peeling on top layer of skin (hands, feet)
Dry skin
Heart pain (angina) and you are under 45 years old
Depression
Gout (arthritic pain, especially in big toes)
Pain in shoulders or upper back
Twitching eyelids
Anemia (low iron/hemoglobin on blood test)
Wrist/ankle drop or weak extensor muscles
Hair falls out (not normal male pattern baldness)

Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
Trouble processing new information
Word reversal or trouble finding words
Sensitivity to touch
Short-term memory loss
Chronic sinus congestion
Dry non-productive cough
Muscle twitching
Excessive sweating, especially at night
Joint pain-not necessarily true arthritis-can move from joint to joint
Difficulty losing weight regardless of diet or exercise
Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
Frequent illness, prolonged illness or sick days
Numbness or weakness in arms and legs
Headaches
Trouble adding or dividing numbers in your head
Fluctuating constipation and diarrhea
Stomach pain for no apparent reason
Appetite swings
Frequent muscle aches, cramps, unusual sharp sudden pains
Rashes or rosacea
Cold extremities (hands and feet)

Total Columns 1 & 2