



Chesapeake Holistic Health Center

NEW PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone #: () _____ Evening Phone #: () _____

Cell Phone #: () _____ Email: _____

Date of Birth: _____ Place of Birth: _____ Time Born: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Referred by: _____

(Please note that payment is due at the time of service.)



PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Date:** _____

Chief complaint (the main reason you are seeking treatment/evaluation): _____

Duration of present condition: _____

What do you believe caused this condition: _____

When were you last seen by a health care professional for this condition?

Doctor's Name: _____

Doctor's Phone: () _____

Doctor's Diagnosis: _____

Describe all lab work done: _____

Please bring copies of most recent lab reports to your visit.

List current prescription medications:

List all over-the-counter medications you are currently taking:

List all over-the-counter medications you are currently taking:

Do you use any of the following: How much / How often?

- | | |
|--|--|
| <input type="checkbox"/> Coffee _____ | <input type="checkbox"/> Laxatives _____ |
| <input type="checkbox"/> Tea _____ | <input type="checkbox"/> Sugar _____ |
| <input type="checkbox"/> Alcohol _____ | <input type="checkbox"/> Artificial sweeteners _____ |
| <input type="checkbox"/> Soda _____ | <input type="checkbox"/> Recreational drugs _____ |
| <input type="checkbox"/> Chocolate _____ | <input type="checkbox"/> Smoking _____ |

List any foods you crave:

List any known allergies to foods / chemicals / drugs:

Are you on any special diets or restrictions? yes no (please describe)

What foods do you eat most frequently? (more than 3 times a week)

Do you consider yourself: Overweight Average Underweight

Height: _____ Weight: _____

Any significant weight changes in the last year? yes no

Are you able to work without limitations? yes no (please describe)

How often do you exercise /engage in physical activity? _____

Describe: _____

Have you had to cut down on exercise or recreation because of your health? yes no

Describe your hobbies or interests: _____

Rate your overall satisfaction with life: (1 being very low, 10 being excellent)

1 2 3 4 5 6 7 8 9 10

Rate your overall stress level: (1 being very low, 10 being very high)

1 2 3 4 5 6 7 8 9 10

Describe your sources of stress: _____

How do you cope with stress: _____

Do you suffer exhaustion or fatigue? yes (please describe) no

How often does this occur: _____

What time of day is it worst: _____

For females:

Are your menses regular irregular?

Describe your menstrual cycle: _____

Describe your PMS (if any): _____

Date of last menses: _____

Could you be pregnant: yes no unsure

Number of pregnancies: _____ Number of births: _____

Number of abortions: _____ Surgical or Medical? _____

Describe significant accidents, injuries, illnesses:

List hospitalizations, surgeries: _____

Do you have a pacemaker? yes no

List childhood diseases: mumps, measles, chicken pox, ear infections, tonsillitis, strep, rashes, eczema, asthma, scarlet fever:

List all vaccinations / immunizations received: _____

Describe any known exposure to occupational and / or environmental pollutants, toxins, etc.
 (please include childhood exposure in known polluted locations):

Family History:	Mother	Father	Siblings
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness / depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Still living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Age of mother upon death: _____ Cause of death: _____

Age of father upon death: _____ Cause of death: _____

Age of sibling upon death: _____ Cause of death: _____

Do you have:

Recurrent infections, sinusitis, postnasal drip, swollen lymph nodes?

- Never In the Past Yearly Monthly Weekly Daily

Bouts of diarrhea or constipation, bloating or gas?

- Never In the Past Yearly Monthly Weekly Daily

Irritability, nervousness, trembling, anxiety or memory problems?

- Never In the Past Yearly Monthly Weekly Daily

Cold fingers, toes, blood pressure problems, varicose veins or arteriosclerosis?

Never In the Past Yearly Monthly Weekly Daily

Reactions to pollens, molds, foods, seasonal irritants, chemicals, perfumes, animal dander, fibers?

Never In the Past Yearly Monthly Weekly Daily

Do you have a slow metabolism, always hungry, low energy at times of the day?

Never In the Past Yearly Monthly Weekly Daily

Mood swings, sleep problems, chemical imbalances?

Never In the Past Yearly Monthly Weekly Daily

Palpitations, arrhythmias, impairments from prior infections, weak valves?

Never In the Past Yearly Monthly Weekly Daily

Impotence, miscarriage, sterility, gynecological or genital disorders?

Never In the Past Yearly Monthly Weekly Daily

Recurrent yeast infections, frequent antibiotic use, poor diet?

Never In the Past Yearly Monthly Weekly Daily

Chronic fatigue, recurring infections, lowered immune response?

Never In the Past Yearly Monthly Weekly Daily

Diabetes, hypoglycemia, irritability or shaking if skipping meals?

Never In the Past Yearly Monthly Weekly Daily

Jaundice, high cholesterol, discomfort in liver region, hepatitis?

Never In the Past Yearly Monthly Weekly Daily

Arthritis, back pain, discomfort when moving, weather-triggered pains?

Never In the Past Yearly Monthly Weekly Daily

Digestive disturbances, high acidity, bloating or gas after meals?

Never In the Past Yearly Monthly Weekly Daily

Fibromyalgia, rheumatism, carpal tunnel, slow recovery after exercise?

Never In the Past Yearly Monthly Weekly Daily

Rashes, dryness or cracking scaly patches, eczema, acne, psoriasis?

Never In the Past Yearly Monthly Weekly Daily

Breast tumors, lipomas, problems burning fat?

Never In the Past Yearly Monthly Weekly Daily

Gallstones, discomfort after eating rich foods, low fat metabolism?

Never In the Past Yearly Monthly Weekly Daily

Spinal stiffness, pain, headaches, dizziness, depression?

Never In the Past Yearly Monthly Weekly Daily

Edema, gout, lower back discomfort?

Never In the Past Yearly Monthly Weekly Daily

Recurring bladder infections, itching, yeast problems, candida, painful urination, bed-wetting, loose bladder control?

Never In the Past Yearly Monthly Weekly Daily

PMS, menstrual pains, discomfort, irregular periods, mood swings?

Never In the Past Yearly Monthly Weekly Daily

Discomfort in prostrate region, frequent urination?

Never In the Past Yearly Monthly Weekly Daily

Sensitive teeth, pain, discomfort with gums or teeth, jaw, TMJ?

Never In the Past Yearly Monthly Weekly Daily

Do you experience physical ailments fro stress at work, home, finances, society, relatives?

Never In the Past Yearly Monthly Weekly Daily

Lack motivation, drive, perseverance, stamina, strength, durability, endurance?

Never In the Past Yearly Monthly Weekly Daily

Do you lack a sense of happiness, joy, feelings of fulfillment, positive outlook on life?

Never In the Past Yearly Monthly Weekly Daily

Are you susceptible to infections, allergies, environmental pollution, work environment?

Never In the Past Yearly Monthly Weekly Daily

Do you experience symptoms affecting your emotions, mental focus, all or part of your body?

Never In the Past Yearly Monthly Weekly Daily

Any other relevant information not listed previously:

PLEASE BRING MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING WITH YOU TO YOUR FIRST VISIT.



INFORMED CONSENT AGREEMENT

Patients Name: _____

BioSET is an alternative non-invasive technique that is used to eliminate food and environmental sensitivities. The technique utilizes acupuncture theory and techniques, as well as acupressure and dietary advice. This technique is not a cure-all. Rather it is one of many different treatments available to help patients regain their health.

RISKS / SIDE EFFECTS

Since BioSET is a non-invasive technique, nothing is placed inside the body. Therefore, the risk of side effects is negligible. However, with any form of treatment, there may be some unpleasant side effects during or after treatment. These side effects may include any of the following: fatigue, digestive upset, headache, insomnia or restlessness. Most of these symptoms are short lived and will subside within a few days. If any symptom persists beyond 48 hours, please contact the office. Since BioSET is non-invasive, we are not aware of any cases of anaphylactic reaction; however, anaphylaxis may occur in rare cases where the patient ingests a food that is highly reactive to that individual.

BioSET is not a traditional form of treatment for patient sensitivities. Traditional forms of treatment include but are not limited to the following: avoidance of the allergen, traditional allergy injections, antihistamines, rotation diet and steroidal medications.

I desire to be tested to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the testing procedure to be used is not generally employed by the majority of physicians for this purpose. I understand that the American Medical Association does not currently recognize a demonstrated scientific basis for this testing technique.

I choose to be tested with muscle testing and/or electrodermally. I understand that muscle testing and electrodermal testing has not been scientifically proven to be reliable and my practitioner must still rely upon my observations as to the efficacy of the test and any treatment based on the result of this test.

I further consent to have my finger pricked for the purpose of giving a blood sample as part of the testing process. I understand that other methods of allergy testing and treatment are available. These have been described to me.

I understand that I am responsible for payment of the normal and necessary fees associated with my tests and treatment. I have been provided with the opportunity to ask any pertinent questions I have regarding this testing and treatment program.

Patients Signature

Patient's Guardian Signature

Date

Date

Witness

Witness