PEINE
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MEDICINE

Thank you for taking the time to fill out the following New Patient Information Form prior to your first visit. **It is our office policy that you must return your completed and signed New Patient Information Form to our office before we will schedule your first appointment. To return your form, you may email (info@drpeine.com), mail, fax (208-947-0926), or drop it off at the office. Upon receiving and processing your paperwork, we will call to schedule your appointment.** We require your completed paperwork be returned ahead of time to make your time with the physician more efficient and productive.

For your initial appointment:

- It is not necessary to bring copies of your films to your initial visit. Do bring a copy of any blood (lab) work that has been done in the past year, as well as any reports from relevant past imaging studies (x-rays, MRI, CT scans, etc) that you would like your provider to review. Your doctor's office may fax this information directly to us at (208) 947-0926.

- You will need your insurance card, or a copy of the front and back of your insurance card.

- Please bring a credit card, check, or cash for your insurance copayment, coinsurance, or deductible. Please be punctual in order to benefit fully from your appointment. **There will be a $100 fee assessed if cancellation is not made at least 24 hours prior to your appointment or you to fail to show up.**

- Please call the front desk if you are running more than five minutes late to your appointment.

- If you cancel your first New Patient appointment, all of your follow-up appointments will automatically be cancelled.

We accept most forms of insurance with the exception of **Regence Blue Shield of Idaho, Select Health, Health Shares, Medicaid, and Medicare.** Please contact your insurance or the office to verify benefits and coverage prior to scheduling an appointment. If you have an insurance we do not accept, we offer a discount for cash payment made at the time of service. If we are an out-of-network provider for your insurance, we can provide you with a statement you may submit to your insurance. If you have a question about your bill, please contact the billing line: (208) 947-0925, option 2.

Our office address is 2717 West Bannock Street, Suite 101, Boise, Idaho 83702. We are located two blocks from Whittier Elementary School and four blocks from Quinn's Pond. From Highway 184 E (the Connector), take Fairview Avenue Exit 3 and follow the off ramp under the highway. Continue northeast on Fairview Avenue, crossing over the river. Turn left (north) onto 27th street. Drive two blocks and turn left (west) onto Bannock Street. Our office is in the second free-standing building on your left. Please call with any questions or for help finding our location.

Please feel free to contact us at (208) 947-0925 if you have any questions or concerns.

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NEW PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: ☐ M ☐ F Date of Birth: _____ Age: _____ SSN: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Long-term Partnership

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Island ☐ Hispanic ☐ Caucasian ☐ Other ☐ Decline to Answer

Ethnic Group (please specify, for example: Argentinean, Chilean, etc): _____

Primary Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Japanese ☐ Russian ☐ Spanish
☐ Vietnamese ☐ Other

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Responsible Party Name (if patient is a minor): _____

Relationship to Patient: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Do you have an Advanced Medical Directive and/or Living Will and Durable Power of Attorney? ☐ Yes ☐ No

Preferred Reminder Method: ☐ Mobile Phone ☐ Home Phone ☐ Email

Email Address: _____ I was referred by: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Names of any specialists you see (please provide phone and fax numbers if available): _____

_____

_____

_____

_____

_____

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INSURANCE INFORMATION

We are **not in network with Regence Blue Shield of Idaho, Select Health, Health Shares, Medicare, or Medicaid;** however, we are able to accept you as a cash pay patient and offer discounts depending on your current plan.

Primary Insurance: _____

Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

Member ID: _____ Group ID: _____

Secondary Insurance: _____

Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

Member ID: _____ Group ID: _____

Consent for treatment and financial responsibility:
I hereby consent to such treatment/procedures as may be rendered by Dr. Peine or Benjamin Prinzing. I authorize the release of any information necessary to process my claim and the direct payment of benefits to Peine Osteopathic Medicine. I understand that I may be charged for late appointments or no shows. I assume all financial responsibility for the balance of charges not included in the insurance coverage. I understand that Dr. Peine/Benjamin Prinzing is not my primary care physician and that I will contact my primary care physician or dial 911 in the event of an emergency.

Signature/Type Name Here (parent signature if patient is a minor): _____

☐ I attest that my typed name serves as my signature.

Printed Name: _____ Date: _____

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INSURANCE INFORMATION (CONTINUED)

I, _____, understand the following statements and responsibilities:

PATIENT INITIALS

_____ I acknowledge that Peine Osteopathic Medicine is not contracted with Medicare, Medicaid, or any advantage or supplemental plans. My visit costs are fully my responsibility at the 45% discount provided.

_____ I understand that my visits cannot be submitted by myself or my doctor for reimbursement through Medicare or Medicaid.

_____ I understand that if Peine Osteopathic Medicine is in-network with my insurance, they are required to bill my visits through my insurance. Any remainder will be my responsibility.

_____ I understand LDIs and supplements cannot be billed through insurance, but I may use an FSA or HSA card if my plan permits.

_____ I am able to request a statement from my visit after it has processed through billing.

_____ I understand that Peine Osteopathic Medicine is not accepting Workmans' Compensation or motor vehicle claims but I can request bills to resubmit to my insurance.

_____ There will be a $100 fee assessed if cancellation is not made at least 24 hours prior to your appointment or you to fail to show up.

Signature/Type Name Here (parent signature if patient is a minor): _____

☐ I attest that my typed name serves as my signature.

Printed Name: _____ Date: _____

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LOW DOSE IMMUNOTHERAPY INFORMATION AND INFORMED CONSENT

Low Dose Immunotherapy (LDI) is a treatment for increasing immune "tolerance" of an overactive immune system. Allergy and autoimmunity represent an alteration or overactivation of appropriate immune tolerance. LDI retrains the immune system for specific antigens, thereby decreasing overactive immune response and decreasing symptoms.

This type of immunotherapy was discovered in Great Britain in the 1970s and called "Enzyme Potentiated Desensitization" (EPD). The technique utilized very small concentrations of antigens along with an enzyme, beta glucuronidase, which helps educate the T cells involved in the immune response. This treatment was brought to the US, but in the early 1990s the FDA stopped the importation of EPD. At this point, Dr. Shrader reproduced the mixtures of EPD and called them LDA. LDA originally used antigens causing certain allergies and the technique was later expanded by Dr. Vincent to treat various autoimmune conditions using a variety of different antigens, called LDI.

LDI is not approved by the Federal Drug Administration (FDA), just like vitamins and other herbal supplements. LDI is currently classified as experimental treatments and as such, we do not bill for antigen mixtures, only our time and supplies.

PROCEDURE

Patients will first undergo a history and physical to determine if LDI is an appropriate therapeutic technique. Often lab work will be done prior to LDI therapy to help guide therapy. LDI doses are given by administering a small drop (less than 1 ml) of the antigen mixture under the tongue. Doses are typically repeated every 7 weeks, as needed, but "booster" doses can be given as soon as 2 weeks, based on response to the first dose.

AVAILABLE ALTERNATIVES

I am aware of various alternatives to treat my condition(s). Alternatives may include: pharmaceuticals to treat condition; vitamins and supplements to treat condition; dietary and lifestyle modifications to improve condition; interventional procedures such as IV therapy or steroid injections, or electing to do nothing to treat my condition.

POTENTIAL RISKS (SIDE EFFECTS) AND BENEFITS

There is a risk of a flare in your symptoms for 1 day or more after LDI treatment. Often, if a patient gets a flare of their symptoms with an LDI, the flare will become less with each subsequent treatment. If a patient experiences a flare with LDI, it means we have chosen the correct antigen, but the dose is too high (this is a good thing!). If a symptom flare becomes too much to handle, a course of Prednisone can be prescribed to alleviate symptoms.

You may benefit significantly from LDI treatments. Possible benefits include: total relief of your symptoms, partial relief of your symptoms, or reduction or elimination of previous medications used to treat your symptoms.

PREGNANCY

LDI is generally regarded as "safe" during pregnancy; however, LDI has not been extensively studied in pregnancy and so the effects on pregnancy are unknown. As such, it is your choice to continue LDI during pregnancy.

(continued)

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LOW DOSE IMMUNOTHERAPY INFORMATION AND INFORMED CONSENT (CONTINUED)

COSTS

LDI is not FDA approved and is **not** covered by medical insurance. Your provider visit can be billed to insurance; however, you will be required to pay for the cost of the LDI therapy received at the time of service. All patients receiving LDI therapy are required to have a credit card on file. The cost for each LDI dose is $45, charged at the time the dose is drawn up. If your LDI is shipped, you will be charged a flat rate shipping fee. There are no refunds or returns on LDIs.

DISCONTINUATION OF TREATMENT

I am free to discontinue treatment at any time, without prejudice, or when I feel I no longer require LDI therapy.

Signature/Type Name Here (parent signature if patient is a minor): _____

☐ I attest that my typed name serves as my signature.

Printed Name: _____ Date: _____

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INFORMED CONSENT REGARDING NUTRITIONAL SUPPLEMENT AND FUNCTIONAL MEDICINE LABORATORY TESTING

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term drug is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications, nutritional supplements, herbs, or hormones you may be taking.

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results. There are no supplement returns or exchanges.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical physician may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctors.

My signature acknowledges I have read and understand the above.

Signature/Type Name Here: _____ Date: _____

☐ I attest that my typed name serves as my signature.

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PROVIDER NOTICE OF PRIVACY PRACTICES

In accordance with federal law, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you with your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

YOUR RIGHTS

You have the right to your medical records and information. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgment of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area.

PATIENT RIGHTS

You can also request a copy of our notice at any time. For more information about our privacy practices, contact Peine Osteopathic Medicine PLLC. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Peine Osteopathic Medicine, PLLC. You may also send a written complaint to the U.S. Department of Health and Human Services.

I acknowledge I have read and understand the above Notice of Privacy Practices:

Signature/Type Name Here (parent signature if patient is a minor): _____

☐ I attest that my typed name serves as my signature.

Printed Name: _____ Date: _____

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PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVES

I, _____, give my authorization to release my protected health information, including results of my laboratory tests, x-ray, CT, and/or other relative information to the following designated representative(s):

PATIENT INITIALS	DESIGNATED REPRESENTATIVES
_____	Spouse: _____
_____	Children: _____
_____	_____
_____	_____
_____	Other: _____
_____	May be left on my answering machine at home.
_____	May be left on my mobile phone voicemail.
_____	May not be given to anyone other than myself.

Signature/Type Name Here (parent signature if patient is a minor): _____

☐ I attest that my typed name serves as my signature.

Printed Name: _____ Date: _____

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MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these written questions. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and provide more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will help us formulate a treatment plan.

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? _____

_____

_____

_____

When was the last time you felt healthy? _____

_____

_____

Did something trigger your change in health? _____

_____

_____

What makes you feel worse? _____

_____

_____

What makes you feel better? _____

_____

_____

What is your current age? _____

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MEDICAL QUESTIONNAIRE (CONTINUED)

ALLERGIES ☐ None

Please list any allergies to medications, supplements, or foods. Environmental allergies such as dust or pollen are unnecessary.

MEDICATION/FOOD/SUPPLEMENT	REACTION

MEDICATIONS ☐ None

Please include non-prescription medications.

MEDICATION NAME	DATE STARTED	DOSAGE/FREQUENCY TAKEN

NUTRITIONAL SUPPLEMENTS ☐ None

List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate dosage in mg or IU and the form (e.g., calcium carbonate vs. calcium lactate) when possible.

SUPPLEMENT NAME	DATE STARTED	DOSAGE/FREQUENCY TAKEN

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MEDICAL HISTORY

Please carefully review the following list and indicate any conditions that apply to you: in the **past** (**mark with a P**) or if it is an issue for you **currently** (**mark with a C**). Please record any other pertinent information in the comments section, and feel free to attach any documents, lab results, notes, etc. that are relevant.

DISEASE CONDITION	P=PAST C=CURRENT	DATES/DETAILS
Gastrointestinal		
Crohn's Disease or Ulcerative Colitis		
Gallstones		
Irritable Bowel Syndrome		
Ulcers		
Reflux/Heartburn		
Celiac Disease		
Chronic Constipation		
Other		
Cardiovascular		
Heart Attack/Angina		
Congestive Heart Failure		
Stroke		
Arrhythmia/Irregular Heartbeat		
High Cholesterol/Triglycerides		
High Blood Pressure (Hypertension)		
Heart Valve Disease/Rheumatic Fever		
Blood Clots		
Other		
Metabolic/Endocrine		
Diabetes (specify borderline, type 1 or type 2)		
☐ Low Thyroid ☐ High Thyroid		

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MEDICAL HISTORY (CONTINUED)

DISEASE CONDITION	P=PAST C=CURRENT	DATES/DETAILS
Metabolic/Endocrine		
Low Blood Sugars (Hypoglycemia)		
Polycystic Ovary Syndrome (PCOS)		
Infertility		
Unexplained Weight Gain		
Unexplained Weight Loss		
Eating Disorder (please specify type)		
Other		
Cancer—please enter type(s) below:		
Type:		
Type:		
Genital/Urinary		
Kidney Stones		
Recurrent Urinary Tract Infections (UTI)		
Recurrent Yeast Infections		
Gout		
Enlarged Prostate		
Sexual or Erectile Dysfunction		
Renal Failure		
Endometriosis/Menstrual Problems		
Other		
Musculoskeletal/Pain		
Osteoarthritis		
Chronic Pain (please specify area)		

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MEDICAL HISTORY (CONTINUED)

DISEASE CONDITION	P=PAST C=CURRENT	DATES/DETAILS
Musculoskeletal/Pain		
Spinal Disc Degeneration		
Fracture (please specify bone)		
Osteoporosis/-penia		
Shoulder Injury		
Knee Injury		
Other Joint Injury		
Carpal Tunnel Syndrome		
Other		
Inflammation/Autoimmune		
Fibromyalgia		
Rheumatoid Arthritis		
Chronic Fatigue Syndrome		
Lupus		
Immune Deficiency Disease (HIV)		
Frequent Infections (please describe)		
Environmental Allergies		
Food Allergies/Sensitivities		
Chemical Sensitivities		
Other		
Respiratory/Pulmonary		
Asthma		
Emphysema		
Chronic/Recurrent Sinusitis		

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MEDICAL HISTORY (CONTINUED)

DISEASE CONDITION	P=PAST C=CURRENT	DATES/DETAILS
Respiratory/Pulmonary		
Chronic/Recurrent Bronchitis		
Sleep Apnea		
Pneumonia		
Other		
Skin Diseases		
Eczema		
Psoriasis		
Acne		
Skin Cancer (please specify type)		
Other		
Neurological		
Autism		
Tension Headaches		
Migraine Headaches		
Parkinson's Disease		
Multiple Sclerosis		
Seizure Disorder		
Dementia/Alzheimer's Disease		
Stroke/Transient Ischemic Attack		
Peripheral Neuropathy		
Other		
Injuries		
Back Injury (please describe)		

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MEDICAL HISTORY (CONTINUED)

DISEASE CONDITION	P=PAST C=CURRENT	DATES/DETAILS
Injuries		
Neck Injury (please describe)		
Head Injury (please describe)		
Other		
Other		
Hematologic		
Anemia		
Other		

SURGERIES/MEDICAL PROCEDURES ☐ None

Please list the dates and types of surgery or medical procedures you have undergone.

DATE	TYPE OF SURGERY OR MEDICAL PROCEDURE

COMMENTS/OTHER IMPORTANT INFORMATION:

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MEDICAL HISTORY (CONTINUED)

FAMILY HISTORY

Please indicate family members with any of the following conditions. Please specify your relationship using the following key:

mother = M
father = F
brother = B
sister = S

paternal grandfather = PGF
paternal grandmother = PGM
maternal grandfather = MGF

maternal grandmother = MGM
paternal uncle = PU
paternal aunt = PA

maternal uncle = MU
maternal aunt = MA
cousin = C

CONDITION	RELATIONSHIP	NOTES
Alcoholism		
Anxiety		
Asthma		
Enlarged Prostate		
Breast Cancer		
Stroke		
Colon Cancer		
Coronary Artery Disease		
Depression		
Diabetes, Type 2		
High Cholesterol		
High Blood Pressure		
Low Thyroid		
Heart Attack		
Osteoarthritis		
Ovarian Cancer		
Prostate Cancer		
Other		
Other		
Other		

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MEDICAL HISTORY (CONTINUED)

PSYCHOSOCIAL/STRESS HISTORY

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Long-term Partnership

Number of children: _____ Who lives in your household? _____

Hobbies and leisure activities: _____

Do you drink alcohol? ☐ Yes ☐ No

# of drinks per week: _____ # of drinks per day: _____

Have you ever had a problem with drugs or alcohol? ☐ Yes ☐ No

If yes, please indicate time period (month/year): from _____ to _____

Have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No

If yes, number of years as a nicotine user: _____ Amount per day: _____ Year quit: _____

What kind of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Vape ☐ Patch/Gum

Are you exposed to secondhand smoke regularly? ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you require medication or alcohol to fall asleep? ☐ Yes ☐ No

Do you have trouble staying asleep? ☐ Yes ☐ No Estimated number of awakenings per night: _____

Are you sensitive to bright lights, loud noises, or strong odors? ☐ Yes ☐ No

Do you feel overwhelmed easily? ☐ Yes ☐ No

Do you feel worse at certain times of the year? ☐ Yes ☐ No

If yes, when? ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

What are the sources of your stress? _____

_____

_____

How do you deal with your stress? _____

_____

_____

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MEDICAL HISTORY (CONTINUED)

PSYCHOSOCIAL/STRESS HISTORY

Have you ever been abused, a victim of crime, or experienced a significant trauma? ☐ Yes ☐ No

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No

☐ Currently ☐ Previously If previously, from _____ to _____

Comments: _____

_____

MENTAL HEALTH HISTORY

Please indicate if you suffer from or have been diagnosed with any of the following, and the time period experienced:

CONDITION	P=PAST C=CURRENT	S=SUSPECTED D=DIAGNOSED	DATES/DETAILS
Depression			
Mania/Bipolar Disorder			
Feeling anxious			
Generalized Anxiety Disorder			
Insomnia			
Attention Deficit Disorder (ADD)			
Attention Deficit/Hyperactivity Disorder (ADHD)			
Obsessive-Compulsive Disorder			
Personality Disorder (please specify)			
Schizophrenia			
Other (please specify)			

Have you ever been hospitalized for any of the above? ☐ Yes ☐ No

COMMENTS/OTHER IMPORTANT INFORMATION:

_____

_____

_____

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MEDICAL SYMPTOMS

Name: _____ **Date:** _____

Please rate each of the following symptoms based upon your typical health profile since your last appointment using the point scale to the right:

POINT SCALE

0 = Never or almost never have the symptom
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**

GENERAL

_____ Chills
_____ Fatigue
_____ Fever
_____ Night sweats
_____ Weight gain
_____ Weight loss

Total _____

EYES

_____ Blurred vision (not near- or far-sightedness)
_____ Eye drainage

Total _____

EARS

_____ Ear pain
_____ Ringing in ears
_____ Hearing loss
_____ Itchy ears

Total _____

NOSE

_____ Stuffy nose/nasal congestion
_____ Runny nose
_____ Seasonal allergies
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Sore throat
_____ Hoarseness
_____ Swollen or discolored tongue, gums, or lips
_____ Canker sores

Total _____

HEART

_____ Chest pain
_____ Irregular or skipped heartbeat (palpitations)
_____ Rapid or pounding heart (tachycardia)
_____ Swelling of legs, ankles, or feet

Total _____

LUNGS

_____ Chronic cough
_____ Shortness of breath
_____ Difficulty breathing/wheezing

Total _____

GENITOURINARY

_____ Genital itching or discharge
_____ Frequent or urgent urination

Total _____

Continued on next page/back of page —>

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MEDICAL SYMPTOMS (CONTINUED)

POINT SCALE

0 = **Never or almost never** have the symptom
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**

DIGESTIVE TRACT

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching or passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Joint pain
_____ Joint stiffness or limitation of movement
_____ Pains or aches in muscles
_____ Back pain
_____ Neck pain

Total _____

SKIN

_____ Acne
_____ Dry skin
_____ Rashes

Total _____

NEUROLOGICAL

_____ Headaches
_____ Fainting
_____ Memory loss
_____ Vertigo
_____ Dizziness
_____ Numbness
_____ Weakness

Total _____

ENDOCRINE

_____ Hair loss
_____ Heat or cold intolerance
_____ Flushing or hot flashes
_____ Excessive sweating

Total _____

HEMATOLOGIC

_____ Easy bruising/excessive bleeding
_____ Swollen lymph nodes

Total _____

IMMUNOLOGY

_____ Frequent illness

Total _____

MIND

_____ Anxiety
_____ Depression
_____ Hyperactivity
_____ Loss of interest in pleasurable activities
_____ Feeling stressed
_____ Mood swings
_____ Poor concentration
_____ Insomnia/sleep disturbance
_____ Irritability

Total _____

GRAND TOTAL _____