Advanced Nutritional Medicine Center
Dr. Mark Schulz
713-557-1013

Welcome to **Advanced Nutritional Medicine Center**. This is your new patient information packet. Please take the time to read, fill out, and sign the appropriate sections. Please plan to arrive **15 minutes** prior to your scheduled appointment time as this allows us to better take care of your needs. If you wish to cancel or reschedule your appointment please contact our office **24 hours or more in advance**. It is our goal to provide each of our patients the best care possible. If you feel you have been treated otherwise, please let us know.

Patient Signature: _____ Date: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Address: _____ Social Security #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____ Phone #: _____

Occupation: _____

Which of our patient's recommended you to our office?

_____

List the main problem(s) you are having or the purpose for your consultation:

❑ Low back pain	❑ Neck pain	❑ Fatigue	❑ Osteoporosis
❑ Mid back pain	❑ Headaches	❑ Diabetes	❑ Arthritis
❑ Shoulder pain	❑ Elbow pain	❑ Thyroid disorder	❑ Cancer
❑ Hand/wrist pain	❑ Hip pain	❑ High blood pressure	❑ Acid reflux
❑ Knee pain	❑ Foot/ankle pain	❑ High cholesterol	❑ Other

Please elaborate on your condition below:

_____

_____

_____

_____

How long ago did your symptoms begin?

_____

What types of treatments have you received for your condition?

Have any of these treatments been helpful and if so which ones?

What makes your symptoms worse (i.e. certain movements, weather changes, etc.)?

Please describe your pain symptoms:

❑ Achy ❑ Sharp ❑ Dull ❑ Burning ❑ Tight ❑ Numb ❑ Stiff
❑ Throbbing ❑ Shooting ❑ Stinging ❑ Stabbing ❑ Other

How often do your symptoms occur?

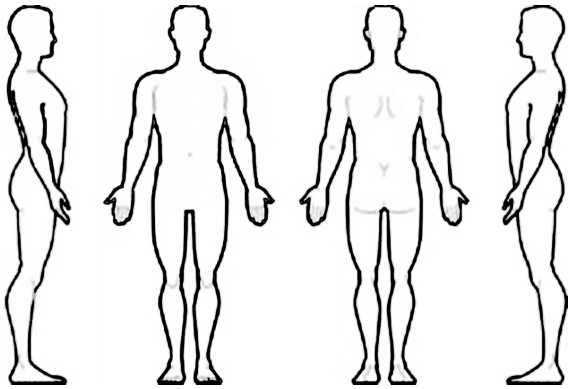
❑ Constant (all the time) ❑ Frequent ❑ Intermittent

Is it worse in the: ❑ A.M. ❑ P.M. ❑ With movement ❑ After activity

Other: _____

Please describe:

Please use the diagram below to demonstrate the location of your pain:



Rate the severity of your pain: No pain 0-1-2-3-4-5-6-7-8-9-10
Rate your overall health: Poor 0-1-2-3-4-5-6-7-8-9-10 Excellent
Rate your energy levels: Poor 0-1-2-3-4-5-6-7-8-9-10 Excellent

If you could make only one improvement in your health, what would it be?

Symptom Questionnaire: The following questions have been developed to help evaluate your health needs. The process is only as accurate as the information that you provide. If you feel that the topics below do not allow you to verbally express your problem(s), please elaborate during our personal consultation. I would like to remind you that all of this information is strictly confidential unless you state otherwise. If Yes or No does not apply to you then elaborate in the margin, or on the back of form.

		Yes	No
1.	Were you breastfed as a baby? If yes how long?		
2.	Were you delivered via cesarean section?		
3.	Have you been through any stressful situations recently?		
4.	Do you consider yourself to be a person who is easily stressed out?		
5.	Do you need glasses to read?		
6.	Do you need glasses to see things at a distance?		
7.	Do you ever have pain or pressure in your eyes?		
8.	Are your eyes often red or inflamed?		
9.	Do your eyes or face often appear puffy?		
10	Do your eyelids constantly twitch?		
11.	Are your eyes often dry and itchy?		
12.	Do you often have dark circles under your eyes?		
13.	Do you have to wear sunglasses outside?		
14.	Do you find it difficult to drive at night?		
15.	Do you have trouble see clearly in the dark lighting?		
16.	Are your mouth, eyes, or throat chronically dry?		
17.	Do you frequently have a sour or metallic taste in your mouth?		
18.	Do you have to wear lip balm regularly to keep your lips from chapping?		
19.	Do your lips crack and bleed on a regular basis?		
20.	Do fever blisters or canker sores often bother you?		
21.	Are you troubled by bleeding gums?		
22.	Have you lost any of your adult teeth?		
23.	Do you have a history of dental caries (cavities)?		
24.	Have you often had severe toothaches?		
25.	Do you have any dental implants?		
26.	Do you have any metal fillings?		
27.	Is your tongue usually badly coated?		
28.	Do you have chronic halitosis (bad breath)?		
29.	Have you ever had fluids leaking from your ear?		
30.	Do you wear hearing aid?		
31.	Do you have constant ringing or noises in your ear?		
32.	Do you get dizzy on a regular basis?		
33.	Do you have to clear you throat constantly?		
34.	Have you had your tonsils removed?		
35.	Are you often troubled with spells of sneezing or allergies?		
36.	Is your nose continually stuffed up?		
37.	Are you sensitive to fumes, smoke, perfumes, or other chemical odors?		
38.	Do you often find it difficult to breathe out of your nose?		
39.	Do you suffer from a constantly running nose?		

40.	Have you at times had bad nosebleeds?		
41.	Do you ever have spontaneous nosebleeds?		
42.	Have you noticed any changes in you ability to taste or smell recently?		
43.	Do you suffer from asthma or any other chronic lung disease?		
44.	Are you trouble by constant coughing?		
45.	Do you get sick more than twice per year?		
46.	Have you taken antibiotics recently?		
47.	Have you ever had to take antibiotics more than once for a chronic ailment?		
48.	Do you suffer from frequent or sever headaches?		
49.	Do you often have sinus congestion?		
50.	Is your appetite always poor?		
51.	Do you usually eat sweets or other foods between meals?		
52.	Do you always gulp your food hurriedly?		
53.	Do you often suffer from an upset stomach?		
54.	Do you usually feel bloated after eating?		
55.	Do you usually belch a lot after eat?		
56.	Are you often sick to your stomach?		
57.	Do you ever suffer from indigestion?		
58.	Do you often take medication for heartburn?		
59.	Have you ever been diagnosed with stomach ulcers?		
60.	Do you suffer from frequent loose bowel movements?		
61.	Do you experience gut pain shortly after bowel movements?		
62.	Do you have at least one bowel movement per day?		
63.	Do you ever experience a burning or itching sensation in the anus?		
64.	Have you ever had sever bloody diarrhea?		
65.	Is the color of your stool often tan?		
66.	Is the color of your stool ever dark black?		
67.	Were you ever troubled with intestinal worms or parasites?		
68.	Do you constantly suffer from constipation?		
69.	Have you ever had piles (rectal hemorrhoids)?		
70.	Have you traveled out of the country recently?		
71.	Have you ever had jaundice (yellow eyes and skin)?		
72.	Have you ever had serious liner or gall bladder trouble?		
73.	Do you find it difficult to get to sleep at night?		
74.	Do you have difficulty remembering dreams from the night before?		
75.	Are you bothered by nightmares?		
76.	Do you find it impossible to take a regular rest period each day?		
77.	Are you exhausted upon waking in the morning?		
78.	Do you need coffee to wake up and have energy in the morning?		
79.	Are you often exhausted or fatigued?		
80.	Do you sleep less than 8 hours a day?		
81.	Does every little effort wear you out?		
82.	Does nervous exhaustion run in the family?		
83.	Are you frequently confined to bed by illness?		
84.	Are you always in poor health?		
85.	Are you considered a sickly person?		
86.	Did you ever have scarlet fever?		

87.	As a child, did you have rheumatic fever?		
88.	Did you ever have malaria?		
89.	Were you ever treated for severe anemia?		
90.	Were you ever treated for venereal disease?		
91.	Do you have diabetes?		
92.	Did a doctor ever say you had goiter in your neck?		
93.	Did a doctor ever treat you for a tumor or cancer?		
94.	Do you suffer any chronic disease?		
95.	Did you ever have a serious operation?		
96.	Did you ever have a serious injury?		
97.	Are you joints often painfully swollen?		
98.	Do you have constant muscle aches and pains?		
99.	Do your muscles and joints constantly feel stiff?		
100.	Have you ever been told you have arthritis?		
101.	Do pains in the back make it hard for you to keep up with your work?		
102.	Do muscle cramps or spasms frequently bother you?		
103.	Do you have numbness or tingling in any part of your body?		
104.	Do your feet ever feel like they burn?		
105.	Have you ever had a seizure or convulsion?		
106.	Has a doctor ever told you your blood pressure is too high?		
107.	Has a doctor ever told you your blood pressure is too low?		
108.	Do you have pains in the heart of chest?		
109.	Are you often bothered by thumping of the heart?		
110.	Does you heart often race like mad?		
111.	Do you often have difficulty with breathing?		
112.	Do you run out of breath easily?		
113.	Do you sometimes get out of breath just sitting still?		
114.	Are your ankles often badly swollen?		
115.	Do cold hands or feet trouble you, even in hot weather?		
116.	Do you suffer from frequent cramps in your legs?		
117.	Has a doctor ever said you had heart trouble?		
118.	Does heart trouble run in your family?		
119.	Has your cholesterol ever been high?		
120.	Do you get up every night to urinate?		
121.	During the day, do you usually have to urinate frequently?		
122.	Do you often have sever burning when you urinate?		
123.	Do you sometimes lose control of your bladder?		
124.	Has a doctor ever said you had kidney or bladder disease?		
125.	Is your memory poor?		
126.	Do you have difficulty remembering daily tasks or recent events?		
127.	Do your thought seem foggy or cloudy?		
128.	Do you find it difficult to focus or concentrate on daily activities?		
129.	Hove you ever been under the care of a psychiatrist?		
130.	Does worrying continually get you down?		
131.	Do you feel alone and sad at the party?		
132.	Do you usually feel unhappy or depressed?		
133.	Do you often cry?		
134.	Have your ever had nervous break down?		

135.	Do you always do thing on sudden impulse?		
136.	Are you easily upset or irritated?		
137.	Do little annoyance get o your nerves and get you angry?		
138.	Do people often annoy and irritate you?		
139.	Do you often shake or tremble?		
140.	Are you constantly keyed up or jittery?		
141.	Do sudden noises name you jump or shake?		
142.	Do you tremble or feel weak whenever someone shouts at you?		
143.	Do frightening thoughts keep coming back in your mind?		
144.	Do you often become frightened for no apparent reason?		
145.	Do you often break out in a cold sweat?		
146.	Does life look entirely hopeless?		
147.	Do you often wish you were dead and away from it all?		
148.	Do you bruise easily?		
149.	Does it take longer than 10 days for a cut or bruise to heal?		
150.	Is acne constantly a problem?		
151.	Is you skin constantly broken out with bumps?		
152.	Do you have to wear lotion to keep your skin from drying out?		
153.	Do you break out in rashes on a regular basis?		
154.	Is you hair dry and brittle?		
155.	Did you hair turn gray prematurely?		
156.	Are you fingernails weak or ridged?		
157.	Do you have food cravings?		
158.	Do you crave ice?		
159.	Are you hungry shortly after a meal?		
160.	Do you eat out at restaurants frequently?		
161.	Do you consume fast food often?		
162.	Do you drink soda on a daily basis?		
163.	Do you have a history of sexual promiscuity with multiple partners?		
164.	Have you ever been diagnosed with a sexually transmitted disease?		
165.	Have you ever been a substance abuser?		
166.	Have you ever abused alcohol?		
167.	Do you drink alcohol on a daily basis?		
168.	Do you drink coffee on a daily basis?		
169.	Do certain foods make you feel ill? (corn, wheat, dairy)		
170.	Do you smoke or use any tobacco products?		
171.	Are you constantly exposed to second hand smoke?		
172.	Do you consider yourself to be over weight?		
173.	Do you consume less than 5 servings of fruits and vegetables per day?		
174.	Do you exercise 5 times per week?		
175.	Does fatigue keep you from exercise?		
176.	Is your water intake less than 64 ounces (8 glasses) per day?		
177.	Do you get less than 2 hours/week in direct sunlight without using sunscreen?		
178.	Do you consume a lot of foods, which contain artificial sweeteners?		

If you experience other symptoms not asked about, please elaborate below:

_____

_____

Past Medical History: please indicate below any health problems you have experienced in the past.

Major Illnesses (Please list dates when conditions were diagnosed):

Accidents or Major Trauma (Please list dates. For scars please give locations):

Surgeries/ Hospitalizations (Please list dates):

- ❑ Colostomy
- ❑ Gastric
- ❑ Hemorrhoidectomy
- ❑ Bowel (intestinal)
- ❑ Other
- ❑ Esophageal
- ❑ Ileostomy
- ❑ Tonsillectomy
- ❑ Vasectomy
- ❑ Cholecystectomy
- ❑ Nephrectomy
- ❑ Appendectomy
- ❑ Hysterectomy

Dental Procedures (Root canals, total number of cavities, etc.):

Allergies and/or Sensitivities (Drugs, chemicals, foods, environmental):

Occupational Exposures (i.e. mercury, asbestos, etc.):

Lifestyle – Check those that apply to you:

- ❑ Alcohol (daily weekly monthly)
- ❑ Housebound
- ❑ Soft drink consumption (/day)
- ❑ Sedentary job
- ❑ Sexually active
- ❑ Exercise (none daily weekly monthly)
- ❑ Smoker (packs/day)
- ❑ Coffee consumption (cups/day)
- ❑ Fast food consumption (daily weekly monthly)
- ❑ Married: yes no divorced)

Women Only: Last Pap - _____Date of Last menstrual period- _____
Marital History: Years married- _____# of children- _____Ages- _____
# of Pregnancies-_____Deliveries-_____Complications-_____
Use of Contraceptives?_____What type?_____
Currently menstruation:_____Abnormal Pap (HPV, CIN, etc.)?_____

If YES check any of the following symptoms you experience around your periods:

- ❑ Heavy Bleeding
- ❑ Painful cramping
- ❑ Intense mood swings
- ❑ Bloating
- ❑ Food cravings (sweets, chocolate, etc.)
- ❑ Headaches
- ❑ Irregularly timed cycles
- ❑ Breast tenderness
- ❑ Extreme fatigue
- ❑ Anxiety
- ❑ Depression

If peri/post-menopausal check any symptoms that you are currently experiencing:

- ❑ Hot/cold
- ❑ Vaginal dryness
- ❑ Hair loss
- ❑ Dry skin

Rate your job stress (0-10)- _____

Men Only: Date of last prostate exam-_____
Abnormal Prostate findings?:_____
Marital History: Years married-_____# of children_____

Rate your job stress (0-10)- _____

Nutritional (diseases, diet, food habit, etc.):

- ❑ Anorexia
- ❑ Bulimia
- ❑ Carbohydrate Loading
- ❑ Fasting (chronic)
- ❑ Fider Intake (high)
- ❑ Food Addictive Intake (high)
- ❑ Lactose Intolerance
- ❑ Oxalate Instate (high)
- ❑ Phytate Intake (high)
- ❑ Malnutrition
- ❑ Protein Intake (high)
- ❑ PUFA Intake (high)
- ❑ Salt Intake (high)
- ❑ Saturated Fat Intake (high)
- ❑ Tannic Acid Intake (high)
- ❑ Vegetarian Diet
- ❑ Vegan Diet
- ❑ Weight Loss (involuntary)
- ❑ Atkins Diet
- ❑ Hollywood Diet
- ❑ South Beach Diet

Other Diet: Please list and describe below:

_____
_____
_____
_____
_____
_____

Nutritional Supplements – Please use the chart below to list all vitamins, minerals, amino acids, or other supplemental products (meal replacement drinks bars, etc.) you are currently taking.

Supplements	Brand	Form	Dose/frequency	Length of Time
For Example Vitamin E	Nature's Made	Soft gel cap	400 IU/ 1X Day	6 months

Medications – Please list all medications (prescription and over the counter) you are currently taking.

Medications	Physician Contact #	Length of time	Dose	Frequency
For Example Ibuprofen	OTC	1 week	400 mg	2X daily

24 Hour Recall: Please list all the foods and beverages you have consumed in the past 24 hours.

Breakfast:

Lunch:

Dinner:

Snacks:

Family Medical History:

Please give age, lists of any illnesses, or if deceased.
If deceased, list cause of death and age of death.

Examples:
Arthritis- Type, Genetic Disease- Type, Celiac Disease, Alzheimer's, Allergies, Alcoholism, Asthma, Bleeding Tendency, Cancer- Type, Crohn's Disease, Diabetes- Age at Onset, Drug Abuse, Epilepsy, Gall Bladder, Glaucoma, Heart Disease – Type, High Blood Pressure, Hearing Loss, Hypoglycemia, Kidney Disease, Liver Disease – Type, Osteoporosis, Lupus, Mental Illness-Type, Multiple Sclerosis, Rheumatoid Arthritis, Thyroid Disease, Tuberculosis, Skin Disease-Type, Other Conditions.

Children:

Age	List any illnesses	Deceased (include age)	Cause

Mother:

Age	List any illnesses	Deceased (include age)	Cause

Father:

Age	List any illnesses	Deceased (include age)	Cause

Brothers and Sisters:

Age	List any illnesses	Deceased (include age)	Cause

Mother's Parents:

Age	List any illnesses	Deceased (include age)	Cause

Father's Parents:

Age	List any illnesses	Deceased (include age)	Cause

Genetic Ethnic Background/Ancestry (i.e. Irish, Scottish, Middle Eastern, etc.):

"Very Important Information"

Please Read Carefully and Sign After Reading.

Payment Requirements: Payment for all services is expected at the time of appointment. Visa, Master Card, Check, Cash, or Traveler's checks are accepted.

Appointments: Please kindly give more than a 24 hour notice if you must change or cancel your appointment. **We charge a $75 fee for missed appointments if less than a 24 hour notice is given.** Please remember that the charge for your first office visit and physical exam does not include lab or supplement prescription costs.

"I understand and agree that my health insurance is an agreement between my insurance company carrier and myself; and that all services furnished to me are charged directly to me. If I am Medicare, Medicaid, Champus, WPS, or TRICARE eligible I hereby waive my rights to file a claim and seek reimbursement for services performed through Advanced Nutritional Medicine Center."

I have read and understand the above statements.

Print Name: _____

Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Many of our patients bring in family members (spouses, parents, etc.) to their appointments. This is encouraged, as family support during your treatment is critical to you success. If you would like us to be able to communicate information (lab results, x-rays, etc.) about your condition to a family member or designed person in your absence, please list them below.

I _____ give Advanced Nutritional Medicine Center my permission to share my medical information with the following people in my absence (please list names below):

1. _____
2. _____
3. _____