CONFIDENTIAL PATIENT RECORD

Name _____ Sex _____ Age _____ DOB _____ **Date** _____

Address _____ City _____ State _____ Zip _____

Home _____ Mobile _____Carrier_____

Email _____

Occupation _____ Employer _____

Names/Ages of Children _____ Marital Status (*circle one*) MARRIED SINGLE WIDOWED DIVORCED

Name of Spouse _____ Spouse's Employer _____

Name and Phone of Emergency Contact _____ Relationship _____

How did you hear about our office? _____

Nutritional & Metabolic Evaluation

Please complete the following information as completely as possible. This helps us to address your concerns and needs, and to build a health program personally designed for you.

Complaints | Please rank your health complaints and rate their severity (on a scale from 1-10, 10 being the worst).

_____

_____

_____

_____

Other Information | Please tell us any additional information or concerns about your health.

_____

_____

_____

Goals | What are your goals for seeing Dr. Barsten? _____

Limitations | What limitations do you have, if any, in working with Dr Barsten? (e.g. unwilling to take nutritional supplements, working in excess of 60 hours a week, won't give up smoking or alcohol, expect immediate results, etc).

_____

Stress Level | Rate your stress level currently on a scale from 1-10 (10 being the most stress). Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, road rage, not happy with life, depression, etc.

Overall stress:_____ Main reasons for stress _____

_____

If over a level 5, what steps are you currently taking to reduce your stress? _____

Energy Level | List on a scale from 1-10 (1 is lowest, 10 is highest) what is your energy level during the following times:

AM _____ Afternoon _____ Evening _____ Late PM _____ After meals _____ Overall _____

HealthQuest
Dr. Greg Barsten, DC, MS, CCN, RH (AHG)

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Sleep Quality | How is your sleep? (check all that apply) ❑ Restful ❑ Restless ❑ Hard to get to sleep Wake up often ❑ Nightmares ❑

What time do you usually go to sleep? _____ Hours of sleep/night? _____

Type of mattress? _____ How old is it? _____ Type of pillows, sheets, and blankets? _____

Exercise | Do you exercise? _____ How often? _____ For how long per session? _____

What type of exercise do you do? _____

Medical History | Please describe any conditions which are under the care of a physician.

Diagnosis _____

Date of onset _____ Duration of current symptoms _____

Doctor(s) involved, their specialty _____

How diagnosed (what tests)? _____

Current treatment (medication, etc.) _____

Treatment received in past, if any, and how it worked _____

Medications | Please list any medications you are taking, or have taken in the past, and for how long. State the reason for taking it.

❑ Antacids	❑ Anti-inflammatories	❑ Diuretics	❑ Muscle Relaxors	❑ Steroids (prednisone, anabolics, cortisone)
❑ Antibiotics	❑ Birth Control Pills	❑ Hormones (estrogen, progesterone, DHEA, testosterone, thyroid)	❑ Pain Killers	❑ Yeast/Fungal Medications
❑ Antidepressants	❑ Blood Pressure Medication		❑ Parasite Medication	
❑ Antihistamines	❑ Cardiac/Heart Medication			

_____

_____

Childhood | How would you describe your childhood: ❑ Often sick? ❑ Robust. Full of energy ❑ Somewhere inbetween?

Drugs | This is strictly confidential. Please list any recreational drugs used now or in the past: _____ _____ How often? _____ How long? _____ _____

Surgeries/Hospitalizations | What surgeries, operations, traumas, fractures, car accidents, etc. have you had?

❑ Appendectomy	❑ Breast Implants	❑ C-Sections	❑ Eye Surgery	❑ Laparoscopy
❑ Arthroscopy	❑ Biopsies	❑ D&Cs	❑ Implants/Prostheses	❑ Tonsils/Adenoids
❑ Cosmetic Surgery	❑ Body piercings	❑ Plastic or metal inside your body		

Other (please list all with brief details such as date, outcome, etc.) _____

_____

_____

Immune | When was the last time you had a fever_____ Have you ever had a tick bite?_____

Childbrith | ❑ Vaginal delivery ❑ C-Section ❑ Premature Were you breastfed? _____ How long _____

Scars | Describe any scars on your body (major and minor ones) _____

Smoking | Do you currently smoke? _____ How much? _____ How long? _____

Dental Work | Indicate how many of the following you have:

❑ Silver fillings _____	❑ Composites _____	❑ Veneers _____	❑ Dentures _____	❑ Porcelain crowns _____
❑ Root canals _____	❑ Grinded/worn teeth _____	❑ Posts _____	❑ Sensitive teeth _____	❑ Gold crowns _____
❑ Extractions _____	❑ BioCalex root canals _____	❑ Extractions _____	❑ Temporaries _____	❑ Steel crowns _____
❑ Implants _____	❑ Bleeding gums _____	❑ New cavities _____	❑ Infections/pockets _____	

Do you need further dental work? _____ If so, what? _____

Sunlight | Amount of natural sunlight you receive daily outside? _____

Hours spent daily under flourescent light? _____ Hours of sunlight daily through windows? _____ ____

Clothing | How often do you wear 100% natural clothing (cotton, ramie, wool, slik, linen)? _____

How often to you wear 100% synthetic clothing (polyester, acrylic, nylon, rayon, etc.)? _____ Blends? _____

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal		*Paternal*							
	Grandma	*Grandpa*	*Grandma*	*Grandpa*	*Mother*	*Father*	*Brother*	*Sister*	*Onset*	*Outcome*
Allergies	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Arthritis (type)	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Cancer (type)	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Mental Disease	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Thyroid Imbalance	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____

Other _____

Review of Systems | Please check the "NOW" box for all conditions that you are now experiencing and mark the "PAST" box for any condition or symptoms experienced at any time in your life.

	NOW	PAST
General		
Weight loss	❑	❑
Weight gain	❑	❑
Head		
Headache	❑	❑
Dizziness	❑	❑
Head trauma	❑	❑
Fainting	❑	❑
Ear Infections	❑	❑
Eyes		
Change in vision	❑	❑
Cataracts	❑	❑
Light sensitivity	❑	❑
Dark circles-eyes	❑	❑
Spots in vision	❑	❑
Mouth		
Bleeding gums	❑	❑
Cold sores	❑	❑
Dentures	❑	❑
Sore throat	❑	❑
Jaw pain	❑	❑
Changes in taste	❑	❑
Hoarseness		

	NOW	PAST
Nose		
Nosebleeds	❑	❑
Sinus problems	❑	❑
Lungs		
Difficulty breathing	❑	❑
Asthma	❑	❑
Pneumonia	❑	❑
Wheezing	❑	❑
Persistent cough	❑	❑
Coughing phlegm	❑	❑
Coughing blood	❑	❑
Tuberculosis	❑	❑
Vascular		
Chest pain	❑	❑
Palpitations	❑	❑
Ankle swelling	❑	❑
Cold feet/hands	❑	❑
Leg cramps	❑	❑
Calf pain	❑	❑
Varicose veins	❑	❑
Low blood pressure	❑	❑
High blood pressure	❑	❑

	NOW	PAST
G-I System		
Gas	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Ulcers	❑	❑
Vomiting/Nausea	❑	❑
Abdominal Pain	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Blood in stool	❑	❑
Hemorrhoids	❑	❑
Gall bladder stones	❑	❑
Liver disease	❑	❑
G-U System		
Difficulty urinating	❑	❑
Pain urinating	❑	❑
Blood in urine	❑	❑
Incontinence	❑	❑
Foul odor of urine	❑	❑
Increased urination	❑	❑
Decreased urination	❑	❑
Urinary infection	❑	❑
Kidney Stones	❑	❑
Genital infection	❑	❑

	NOW	PAST
Panic/anxiety attack	❑	❑
Brain Fog/Memory	❑	❑
Neurologic	❑	❑
Seizures/Epilepsy	❑	❑
Strokes	❑	❑
Tingling sensation	❑	❑
Numbness	❑	❑
Weakness	❑	❑
Difficulty walking	❑	❑
Poor coordination	❑	❑
Muscle/Bone	❑	❑
Joint pain	❑	❑
Stiffness	❑	❑
Muscle ache	❑	❑
Arthritis	❑	❑
Bone pain	❑	❑
Fractures	❑	❑
Dislocations	❑	❑
Skin	❑	❑
Rash	❑	❑
Bruising	❑	❑
Brittle nails	❑	❑
Changes in moles	❑	❑
Psoriasis	❑	❑
Eczema/Hives	❑	❑

	NOW	PAST
Conditions		
Hypertension	❑	❑
Diabetes	❑	❑
Thyroid condition	❑	❑
Heart condition	❑	❑
Rheumatic arthritis	❑	❑
Rheumatic fever	❑	❑
Glaucoma	❑	❑
Alcoholism	❑	❑
Cancer/Tumor	❑	❑
Polio	❑	❑
Parkinson's	❑	❑
Multiple Sclerosis	❑	❑
Gout	❑	❑
Anemia	❑	❑
Osteoporosis	❑	❑
Osteoarthritis	❑	❑
High cholesterol	❑	❑
Migraines	❑	❑
Allergies (Food)	❑	❑
Allergies (Environmental)	❑	❑

Bowel Movements | Please circle those that apply.

How often: daily | more than once a day | skip days *Consistency:* normal | too hard | too soft | diarrhea alternating with hard

Amount: normal | too little *Color:* brown | black | yellow | whitish *Other:* mucus | foul smell | lots of gas

Comments: _____

Female Specific Issues | Please circle those that apply and fill in the blanks.

Are you pregnant? Y N Going through menopause? Y N Have your periods stopped? Y N

Breast feeding? Y N Are your periods regular? (28 day cycle) Y N Do you have monthly periods? Y N

Date of your last menstural period? _____ Have you had a hysterectomy (indicate date, partial or total): _____

Emotional Tendency | Please check those emotions that you have a tendency towards.

❑ Anger ❑ Anxiety ❑ Criticism ❑ Fear ❑ Insecurity ❑ Worry ❑ Inability to forgive (self/others) ❑ Other _____

Appliances/Cookware | Please check which of the following you use:

❑ Gas stove
❑ Electric stove
❑ Electric blanket
❑ Microwave oven
❑ Water bed
❑ Iron cookware
❑ Aluminum cookware
❑ Teflon cookware
❑ Stainless steel cookware
❑ Air purifier (brand:_____)
❑ Water purifier (brand:_____)
❑ Shower filter (brand:_____)

Date filter was last changed: _____

Toxic Inventory / Personal Care Products | Please list any toxins, chemicals, or solvents you have had exposure to or use of. These can include products for the yard, work, furniture, art, building/carpentry, etc. (list the brand names in the space provided):

❑ Shampoo _____
❑ Body Soap _____
❑ Dish Soap _____
❑ Nail Polish _____
❑ Ant/Roach Spray _____
❑ Deodorant _____
❑ Hand/Body Lotion _____
❑ Household Cleaner _____
❑ Hair Coloring _____
❑ Pesticides _____
❑ Toothpaste _____
❑ Laundry Soap _____
❑ Hairspray/Gel _____
❑ Air Freshener _____
❑ Other _____

Electromagnetic Exposure | How many hours do you spend daily:

❑ Watching TV _____
❑ Wearing a pager _____
❑ Talking on a cell phone _____
❑ Working on a computer _____
❑ Near electrical equipment _____
❑ Sleeping near an electric clock? _____

Water/Hydration | How many glasses (8-10oz) of plain water do you drink in an average day? _____ Do you drink tap water? _____
What brand(s) of drinking water do you use? _____
Do you cook with tap, bottled, or filtered water on a regular basis? _____
If you have a home water purifier, when was the last time you changed the cartridge? _____

Diets | Please check any applicable diet that you are currently on.

❑ Allergy rotation/desensitization ❑ No dairy ❑ Candida diet ❑ Yeast-free ❑ Low salt ❑ Low fat ❑ Diabetic
❑ Atkins/Zone diet ❑ Vegetarian ❑ Vegan ❑ Any other diet _____

Food Habits | How often do you eat out, and at what type of restaraunts? _____
How often do you prepare meals at home? _____ Do you avoid food/drinks that list "natural flavors" on the label? _____
Please check if you do any of the following:
❑ Eat while working, watching TV, driving, etc. ❑ Eat food past 7pm ❑ Eat/chew food too fast ❑ Skip meals often (which ones) _____

Food Choices | Please check each type of food you eat twice a week or more. (C=commercially grown, O=organically grown)

Premade Foods	C	O	**Harvest**	C	O	**Meat/Fish**	C	O	**Dairy**	C	O	**Condiments**	C	O
Canned foods	❑		Fresh vegetables	❑	❑	Beef, pork, lamb	❑	❑	Eggs	❑	❑	Table salt	❑	❑
Boxed cereal	❑		Fresh fruit	❑	❑	Chicken	❑	❑	Butter	❑	❑	Sea salt	❑	❑
Frozen dinners	❑		Whole grains	❑	❑	Turkey	❑	❑	Milk	❑	❑	Ketchup	❑	❑
Frozen juices	❑		Whole beans	❑	❑	Canned tuna	❑	❑	Milk, raw	❑	❑	Mustard	❑	❑
Take-out food	❑					Fresh fish	❑	❑	Cheese	❑	❑	Vinegar	❑	❑
						Frozen fish	❑	❑				Sweeteners	❑	❑
						Restaurant fish	❑	❑						

Food Stressors | Please check which of the following you have every week, and indicate how many times per week you consume it.

Stimulants			**Toxic Oils**			**Hormone Platters** *(non-organic)*			**Empty/Processed**		
Coffee (inc. decaf)	❑	____	Fried foods	❑	____	Beef	❑	____	White pasta	❑	____
Black tea, chai tea	❑	____	Fast foods	❑	____	Chicken	❑	____	White bread	❑	____
Soft drinks (cola, etc.)	❑	____	Potato or corn chips	❑	____	Milk, Ice cream	❑	____	Instant cereal	❑	____
Drinks w/NutraSweet	❑	____	Roasted nuts	❑	____	Cheese, butter	❑	____	Cookies	❑	____
Alcohol	❑	____	Smoked meats	❑	____	Yogurt	❑	____	Store-bought muffins	❑	____
Chocolate	❑	____	Margarine	❑	____	Hot dogs/sausage	❑	____	Minute rice	❑	____
Candy, pastry, sweets	❑	____	Shortening	❑	____	Pork, lunch meats	❑	____	Bagels	❑	____