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 _____

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

_____

_____

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

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

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? _____

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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 select from drop down menu

How often: Skip Days *Consistency:* Alternating with hard

Amount: Too Little *Color:* Whiteish *Other:* Lots of gas

Comments: _____

Female Specific Issues | Please choose Yes or No and fill in the blanks.

Are you pregnant No Going through menopause? No Have your periods stopped? No

Breast feeding? No Are your periods regular? (28 day cycle) No Do you have monthly periods? No

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: _____

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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
- ☐ Atkins/Zone diet
- ☐ No dairy
- ☐ Vegetarian
- ☐ Candida diet
- ☐ Vegan
- ☐ Yeast-free
- ☐ Any other diet _____
- ☐ Low salt
- ☐ Low fat
- ☐ Diabetic

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
Canned foods	☐	
Boxed cereal	☐	
Frozen dinners	☐	
Frozen juices	☐	
Take-out food	☐	

Harvest	C	O
Fresh vegetables	☐	☐
Fresh fruit	☐	☐
Whole grains	☐	☐
Whole beans	☐	☐

Meat/Fish	C	O
Beef, pork, lamb	☐	☐
Chicken	☐	☐
Turkey	☐	☐
Canned tuna	☐	☐
Fresh fish	☐	☐
Frozen fish	☐	☐
Restaurant fish	☐	☐

Dairy	C	O
Eggs	☐	☐
Butter	☐	☐
Milk	☐	☐
Milk, raw	☐	☐
Cheese	☐	☐

Condiments	C	O
Table salt	☐	☐
Sea salt	☐	☐
Ketchup	☐	☐
Mustard	☐	☐
Vinegar	☐	☐
Sweeteners	☐	☐

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

Stimulants		
Coffee (inc. decaf)	☐	____
Black tea, chai tea	☐	____
Soft drinks (cola, etc.)	☐	____
Drinks w/NutraSweet	☐	____
Alcohol	☐	____
Chocolate	☐	____
Candy, pastry, sweets	☐	____

Toxic Oils		
Fried foods	☐	____
Fast foods	☐	____
Potato or corn chips	☐	____
Roasted nuts	☐	____
Smoked meats	☐	____
Margarine	☐	____
Shortening	☐	____

Hormone Platters *(non-organic)*		
Beef	☐	____
Chicken	☐	____
Milk, Ice cream	☐	____
Cheese, butter	☐	____
Yogurt	☐	____
Hot dogs/sausage	☐	____
Pork, lunch meats	☐	____

Empty/Processed		
White pasta	☐	____
White bread	☐	____
Instant cereal	☐	____
Cookies	☐	____
Store-bought muffins	☐	____
Minute rice	☐	____
Bagels	☐	____

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