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Apex, NC 27502
Phone: 919-363-0041
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DATE _____ REFERRED BY _____

NAME _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AGE _____ DATE OF BIRTH _____

SEX _____ MARITAL STATUS: M S D W Sep

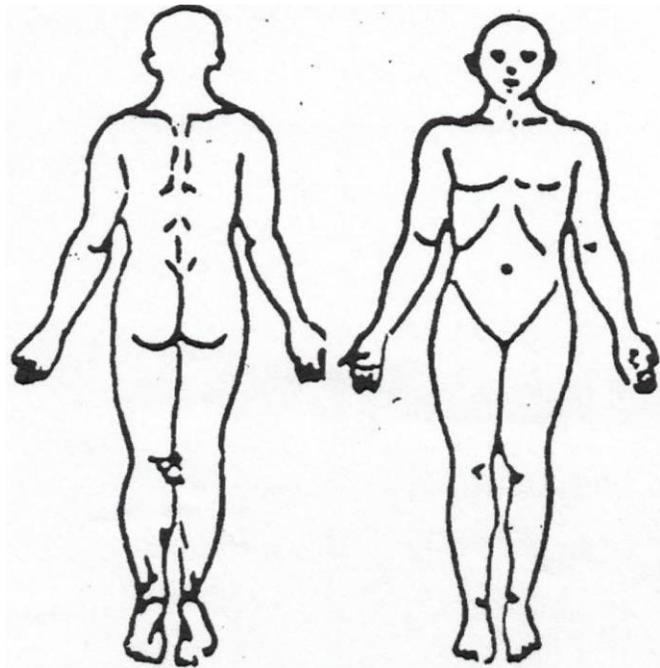
SPOUSE'S NAME _____

EMPLOYER _____

EMPLOYER ADDRESS _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

EMERGENCY CONTACT TELEPHONE NUMBER _____



PLEASE OUTLINE ON DIAGRAM - Please list your major problems **In order of their importance**

Describe the location and nature of your trouble

When was the first occurrence of this trouble

Is it accident related _____

How did it occur _____

When was the most recent occurrence of this difficulty

Which of these factors affect your problem? (Please check)

	No Effect	Better	Worse		No Effect	Better	Worse
Movement				Toward the End of the Day			
Sitting				During Time of Greatest Activity			
Standing				While Resting			
Walking				Before Meals			
Lying Down				During Meals			
During the Night				After Meals			
First Thing in the Morning				2-4 Hours After Meals			

What types of medication, vitamins, minerals, etc. are you now taking? _____

What previous methods have you tried to alleviate your problem? _____

Have you consulted another physician for this problem? (Give Name) _____

Have you been X-rayed in the last six months? _____

What type of X-rays were taken? _____

Where were the X-rays taken? (Give location, such as Hospital. etc.) _____

Weight _____ Gained or Lost over the last 5 years? _____

FAMILY HISTORY:

Answer the following: Mother, Father, Sisters, or Brothers have / had

Diabetes High Blood Pressure Cancer Low Blood Pressure Hypoglycemia

Heart Disease Stroke Other _____

Do you smoke? if yes, how much? _____

List your MAJOR car accident, falls, injuries, other related accidents. Give dates. _____

List ANY type of surgery. Give dates. _____

List any type of MAJOR dental work. Give dates. _____

Do you have any sexually related problems? Yes No

Do you sleep well? Yes No How long? _____

Number of times you urinate during Day & Evening _____ Night _____ (Please approximate)

How often do you have a bowel movement? _____ Do you ever feel constipated? _____

Are you under emotional stress? Yes No Rate your stress level (from 1-10) during the average week _____

Do you have sufficient energy for your normal activities? Yes No

How many times a week do you work out? _____

Do you smoke? Yes No If yes, how many times a day? _____

Have you been pregnant? Yes No How many times? _____ How many children? _____

Date of last menstrual period _____ How many days do you menstruate? _____

Number of days from beginning of period until beginning of next period? _____

List any premenstrual symptoms _____

List any menstrual discomfort _____

Do you use any form of birth control pills, IUD., etc.? _____

Diet / Foods

What foods, if any, disagree with you? _____

Do you / have you: (check)	Yes	No		Yes	No
Indigestion			Fond of Fruits		
Fond of Meats			Fond of Bread		
Fond of Fats			Fond of Butter		
Fond of Sweets			Fond of Salt		
Fond of Vegetables			Fond of Cereals		

What did you eat for breakfast yesterday?

What did you eat for lunch yesterday?

What did you eat for supper yesterday?

What beverages did you have yesterday?

Did you have food or beverages between meals? Yes No

If so, what? _____

How many of each do you eat **per week**? Write number in each box,

Whole Milk		Oranges	
Skim Milk		Grapefruit	
Buttermilk		Pineapple	
Half & Half		Apples	
Servings of Cheese		Bananas	
Eggs		Prunes	
Beef		Dates	
Pork		Raisins	
Bacon		Figs	
Liver		Dried Apricots	
Fowl		Applesauce	
Fish		Canned Fruits	
Bologna / Cold Meats		Dried or Frozen Fruit	
Canned Meat		Others	
Cereals			
Sugar-coated Cereals			
Pancakes		Peanuts	
Waffles		Peanut Butter	
Crackers		Other Nuts: Specify	
Rice		Honey	
Macaroni		Glasses of Colas	
Spaghetti		Bottles of Soda Pop	
Pie		7-Up	
Cake		Orange Juice	
Jello		Grapefruit Juice	
Candy		Grape Juice	
Candy Bars		Tomato Juice	
Cookies		Other:	
Doughnuts			
Ice Cream			
Desserts most Often eaten		How many/day?	
Potatoes – white or sweet		Pats of Butter	
Carrots		Pats of Margarine	
Beans – dries or string		Slices of White Bread	
Corn		Slices of Wheat Bread	
Parsley		Rye Bread	
Squash		Cornbread	
Spinach		Sweet Rolls	
Mustard / Turnip Greens		Glasses of Water	
Lettuce		Glasses of Alcohol	
Celery		Cups of Coffee	
Green Peas		Cups / Glasses of Tea	
Broccoli			
Asparagus			
Cole Slaw			
Onions			
Tomatoes			
Green Peppers			
Cabbage			
Others:			

What Vegetable oils, fats or compounds do you use in cooking:

What vegetable oil do you use in salad?

Do you put cream in your coffee, tea, etc.?

Yes No

Do you put sugar in your coffee, tea, etc.?

Yes No

If Yes, # tsp/day? _____

Do you use salt?

Sparingly
 Moderately
 Freely

Do you use vinegar?

Sparingly
 Moderately
 Freely

How many alcoholic beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

List the three worst foods you eat during the average week:

1. _____

2. _____

3. _____

List the three healthiest foods you eat during the average week:

1. _____

2. _____

3. _____

Is this your average diet for the past 3-4 years?

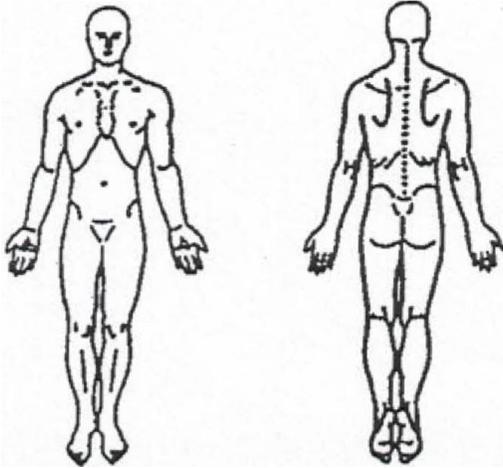
Yes No

History of Injuries

Name: _____

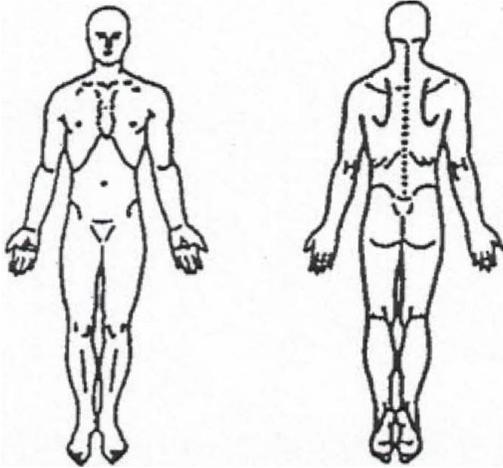
Date: _____

PLEASE MARK ALL PLACES THAT HAVE EVER BEEN INJURED
(Sprains/Strains, Broken Bones, Severe Bruises, Surgery, Scars, Head Bumps, Cuts, Burns, Etc.)



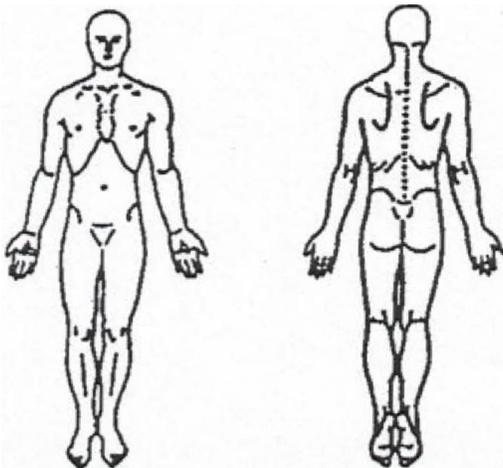
What happened?

When did it happen?



What happened?

When did it happen?



What happened?

When did it happen?

Medication History

Please circle any of the following medication you have taken or are currently taking.

Acetylcholine Receptor Antagonist – Anti-muscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist – Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators

Pralidoxime

Acetylcholine Receptor Antagonist – Neuromuscular Blockers

Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (Irreversible)

Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (Reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THCh. Erophonium. Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticides

Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Iuanxol, Clopixon, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder

Plumazenil

Monoamine Oxidase Inhibitor (MAOI)

Marpian, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitors

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil . Emocal, Serpam, Seropram, CipraleX, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers

Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricyclic Antidepressants (TCAs)

Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Osmanil, Aventyl, Pamelor, Opi Pramol, Vivactil, Rhotrimine, Surmontil

*Please refer to prescribing physician for nutritional interactions with any medications you may be taking.

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

Please list the 5 major health concerns in your order of importance:

- 1.
- 2.
- 3.
- 4.
- 5.

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always,

<p>Category I</p> <p>Feeling that bowels do not empty completely.....0 1 2 3</p> <p>Lower abdominal pain relief by passing stool or gas 0 1 2 3</p> <p>Alternating constipation and diarrhea.....0 1 2 3</p> <p>Diarrhea.....0 1 2 3</p> <p>Constipation.....0 1 2 3</p> <p>Hard, dry, or small stool.....0 1 2 3</p> <p>Coated tongue of "fuzzy" debris on tongue.....0 1 2 3</p> <p>Pass large amount of foul smelling gas.....0 1 2 3</p> <p>More than 3 bowel movements daily.....0 1 2 3</p> <p>Use laxatives frequently.....0 1 2 3</p> <p>Category II</p> <p>Excessive belching, burping, or bloating.....0 1 2 3</p> <p>Gas immediately following a meal.....0 1 2 3</p> <p>Offensive breath.....0 1 2 3</p> <p>Difficult bowel movements.....0 1 2 3</p> <p>Sense of fullness during and after meals.....0 1 2 3</p> <p>Difficulty digesting fruits and vegetables; undigested foods found in stools.....0 1 2 3</p> <p>Category III</p> <p>Stomach pain, burning, or aching 1-4 hours after eating.....0 1 2 3</p> <p>Use antacids.....0 1 2 3</p> <p>Feel hungry an hour or two after eating.....0 1 2 3</p> <p>Heartburn when lying down or bending forward.....0 1 2 3</p> <p>Temporary relief from antacids, food, milk, carbonated beverages.....0 1 2 3</p> <p>Digestive problems subside with rest and relaxation..0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine.....0 1 2 3</p> <p>Category IV</p> <p>Roughage and fiber cause constipation.....0 1 2 3</p> <p>Indigestion and fullness lasts 2-4 hours after eating.....0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage.....0 1 2 3</p> <p>Excessive passage of gas.....0 1 2 3</p> <p>Nausea and/or vomiting.....0 1 2 3</p> <p>Stool undigested, foul smelling, mucous-like, greasy, or poorly formed.....0 1 2 3</p> <p>Frequent urination.....0 1 2 3</p> <p>Increased thirst and appetite.....0 1 2 3</p> <p>Difficulty losing weight.....0 1 2 3</p>	<p>Category V</p> <p>Greasy or high-fat foods cause distress.....0 1 2 3</p> <p>Lower bowel gas and or bloating several hours after eating.....0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning.....0 1 2 3</p> <p>Unexplained itchy skin.....0 1 2 3</p> <p>Yellowish cast to eyes.....0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown.....0 1 2 3</p> <p>Reddened skin, especially palms.....0 1 2 3</p> <p>Dry or flaky skin and/or hair.....0 1 2 3</p> <p>History of gallbladder attacks or stones.....0 1 2 3</p> <p>Have you had your gallbladder removed.....0 1 2 3</p> <p>Category VI</p> <p>Crave sweets during the day.....0 1 2 3</p> <p>Irritable if meals are missed.....0 1 2 3</p> <p>Depend on coffee to keep yourself going or started...0 1 2 3</p> <p>Get lightheaded if meals are missed.....0 1 2 3</p> <p>Eating relieves fatigue.....0 1 2 3</p> <p>Feel shaky, jittery, or have tremors.....0 1 2 3</p> <p>Agitated, easily upset, Nervous.....0 1 2 3</p> <p>Poor memory/forgetful.....0 1 2 3</p> <p>Blurred vision.....0 1 2 3</p> <p>Category VII</p> <p>Fatigue after meals.....0 1 2 3</p> <p>Crave sweets during the day.....0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar.....0 1 2 3</p> <p>Must have sweets after meals.....0 1 2 3</p> <p>Waist girth is equal or larger than hip girth.....0 1 2 3</p> <p>Frequent urination.....0 1 2 3</p> <p>Increased thirst and appetite.....0 1 2 3</p> <p>Difficulty losing weight.....0 1 2 3</p> <p>Category VIII</p> <p>Cannot stay asleep.....0 1 2 3</p> <p>Crave salt.....0 1 2 3</p> <p>Slow starter in the morning.....0 1 2 3</p> <p>Afternoon fatigue.....0 1 2 3</p> <p>Dizziness when standing up quickly.....0 1 2 3</p> <p>Afternoon headaches.....0 1 2 3</p> <p>Headaches with exertion or stress.....0 1 2 3</p> <p>Weak nails.....0 1 2 3</p>
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Category IX

- Cannot fall asleep.....0 1 2 3
- Perspire easily.....0 1 2 3
- Under high amounts of stress.....0 1 2 3
- Weight gain when under stress.....0 1 2 3
- Wake up tired even after 6+ hours of sleep.....0 1 2 3
- Excessive perspiration or perspiration with little or no activity.....0 1 2 3

Category X

- Tired, sluggish.....0 1 2 3
- Feel cold — hands, feet, all over.....0 1 2 3
- Require excessive amounts of sleep to function properly.....0 1 2 3
- Increase in weight gain even with low-calorie diet..0 1 2 3
- Gain weight easily.....0 1 2 3
- Difficult, infrequent bowel movements.....0 1 2 3
- Depression, lack of motivation.....0 1 2 3
- Morning headaches that wear off as the day progresses.....0 1 2 3
- Outer third of eyebrow thins.....0 1 2 3
- Thinning of hair on scalp, face, or genitals or excessive falling hair.....0 1 2 3
- Dryness of skin and/or scalp.....0 1 2 3
- Mental sluggishness.....0 1 2 3

Category XI

- Heart palpitations.....0 1 2 3
- Inward trembling.....0 1 2 3
- Increased pulse even at rest.....0 1 2 3
- Nervous and emotional.....0 1 2 3
- Insomnia.....0 1 2 3
- Night sweats.....0 1 2 3
- Difficulty gaining weight.....0 1 2 3

Category XII

- Diminished sex drive.....0 1 2 3
- Menstrual disorders or lack of menstruation.....0 1 2 3
- Increased ability to eat sugars without symptoms..0 1 2 3

Category XIII

- Increased sex drive.....0 1 2 3
- Tolerance to sugars reduced.....0 1 2 3
- "Splitting" type headaches.....0 1 2 3

Category XIV (Males only)

- Urination difficulty or dribbling.....0 1 2 3
- Frequent urination.....0 1 2 3
- Pain inside of legs or heels.....0 1 2 3
- Feeling of incomplete bowel evacuation.....0 1 2 3
- Leg nervousness at night.....0 1 2 3

Category XV (Males only)

- Decrease in libido.....0 1 2 3
- Decrease in spontaneous morning erections.....0 1 2 3
- Decrease in fullness of erections.....0 1 2 3
- Difficulty in maintaining morning erections.....0 1 2 3
- Spells of mental fatigue.....0 1 2 3
- Inability to concentrate.....0 1 2 3
- Episodes of depression.....0 1 2 3
- Muscle soreness.....0 1 2 3
- Decrease in physical stamina.....0 1 2 3
- Unexplained weight gain.....0 1 2 3
- Increase in fat distribution around chest and hips...0 1 2 3
- Sweating attacks.....0 1 2 3
- More emotional than in the past.....0 1 2 3

Category XVI (Menstruating Females Only)

- Are you perimenopausal.....Yes No
- Alternating menstrual cycle lengths.....Yes No
- Extended menstrual cycle, greater than 32 days.....Yes No
- Shortened menses, less than every 24 days.....Yes No
- Pain and cramping during periods.....0 1 2 3
- Scanty blood flow.....0 1 2 3
- Heavy blood flow.....0 1 2 3
- Breast pain and swelling during menses.....0 1 2 3
- Pelvic pain during menses.....0 1 2 3
- Irritable and depressed during menses.....0 1 2 3
- Acne breakouts.....0 1 2 3
- Facial hair growth.....0 1 2 3
- Hair loss/thinning.....0 1 2 3

Category XVII (Menopausal Females Only)

- How many years have you been menopausal? _____
- Since menopause, do you ever have uterine bleeding? Yes No
- Hot flashes.....0 1 2 3
- Mental foggiess.....0 1 2 3
- Disinterest in sex.....0 1 2 3
- Mood swings.....0 1 2 3
- Depression.....0 1 2 3
- Painful intercourse.....0 1 2 3
- Shrinking breasts.....0 1 2 3
- Facial hair growth.....0 1 2 3
- Acne.....0 1 2 3
- Increased vaginal pain, dryness or itching.....0 1 2 3

Office Policy

Functional nutrition is a non-covered service by health insurance companies, as a result it is the patient's responsibility for payment of any and all services. Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor. We accept cash, check or credit card for services rendered.

Please Bring the Following with You on Your First or Second Appointment:

1. Any laboratory test or similar test results
2. Any supplements or medicine that are you taking

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____