



Dear Patient of Center for Living Health,

Welcome to Center of Living Health, Inc. We look forward to having you as a patient and supporting you in a more balanced approach to health.

Enclosed is a copy of our new patient questionnaire. It can take awhile to fill out form completely; and we have found that a detailed patient history is the most effective way at discovering the root cause of troublesome symptoms. Please be sure to complete this form ahead of time and bring it to your visit.

As you are aware, we are an out of Network provider, which means we participate with any insurance company. All patients are to pay at time of service for their care. We will provide you with a form to submit to your insurance company. Please refer to our web site for ideas on lowering costs with insurance. We are not responsible for any claims that are unpaid or rejected. Please refer to our website for ideas on insurance.

We are located in Gold River at 11344 Coloma Road, Suite 445 (Bldg 400) in the Regent Park business complex (off of Sunrise Blvd near Hwy 50). You may want to plan on arriving early to account for difficulty finding the office, traffic, and filling out any additional registration forms (see our website for directions).

Again, welcome to the Center for Living Health. We look forward to seeing you soon!

Sincerely,
Michael Allen MD



Office Policies

1. Michael Allen, MD is out of network provider who does not accept insurance. The fee for service is due at the time of each visit. Initial_____
2. I am aware that the medical work as practiced by Michael Allen, MD may extend beyond conventional medical treatment. It is with this information that I request the services as provided and prescribed by Michael Allen, MD Initial_____
3. We recommend our patients maintain a primary care physician for after hours call, emergency, and hospital admissions. Initial_____
4. Office hours are Monday thru Friday 9:00am – 4:30pm. Please note we are not available for calls or visits outside of normal business hours. We are not open on weekends or holidays. Initial_____
5. If you are unable to keep your appointment for any reason, we require that you call as soon as possible to reschedule your visit. 24 Hours notice is required for cancellation of appointments.

I also acknowledge and agree to pay 50% of the visit for no-show appointments and for cancellations made less than 48 hours in advance. I agree to pay 50% of the visit for no-show appointments and for cancellations made less than 48 hours in advance. Initial _____

6. Patients agree to pay \$25.00 fee for returned checks. Initial _____
7. Refills need to be written by the doctor during your office visit, not by phone or fax. We will make exceptions for some patients with a 48 hour notice. Initial_____
8. Phone consultations available for established patients at the same rate as our in office visit fee's. Initial_____

WE APPRECIATE YOUR COOPERATION AND LOOK FORWARD TO SERVING YOUR HEALTH NEEDS.

I have read this form and fully understand it.

Patient's Signature_____Date_____

Print Name_____



Medical Questions

Name: _____

Please list your top five health concerns/reason for your visit:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any operations/hospitalizations and the year they took place _____

List any physical traumas (broken bones, stitches, accidents) you have had.

Please list any emotional trauma, stress or life changes that you have experienced.

Please list all the medications you are taking, either over the counter or prescription:

Please list any vitamins, herbs, homeopathics, anthroposophical remedies or supplements you are currently taking:

Please list known allergies to food, drugs, environment or animals

Have you ever lived: near a Refinery, high voltage power lines, or other highly polluted area in a house with lead based paint
 in a house with new paint, cabinets or carpet that seemed to affect child
 in a household that had a lot of mold in walls in a house with smokers

Are pesticides, herbicides or toxic cleaners used in the house where you live? yes no

Please check any you have or have had in the past:

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart failure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood fats (cholesterol, triglycerides) |
| <input type="checkbox"/> Broken/fractured bones | <input type="checkbox"/> High blood pressure (hypertension) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Irritable bowel |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Crohn's Disease or Ulcerative Colitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Epilepsy, convulsions, or seizures | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart attack/Angina | <input type="checkbox"/> headaches/head injuries |
| <input type="checkbox"/> Other (describe) _____ | |

Please check if any of these symptoms occurs presently or in the last 6 months:

GENERAL

- Cold hands & feet
- Cold intolerance
- Daytime sleepiness
- Difficulty falling asleep
- Early waking
- Fatigue
- Fever
- Flushing
- Heat intolerance
- Night waking
- Nightmares
- No dream recall

HEAD/EYES/EARS

- Conjunctivitis
- Distorted sense of smell
- Distorted taste
- Ear fullness
- Ear noises
- Ear pain
- Ear ringing/buzzing
- Eye crusting
- Eye pain
- Headache
- Hearing loss
- Hearing problems
- Lid margin redness
- Migraine
- Sensitivity to loud noises
- Vision problems

EMOTIONAL/NERVES

- Agoraphobia
- Anxiety
- Auditory hallucinations
- Black-out
- Depression
- Difficulty:
 - Concentrating
 - With balance
 - With thinking
 - With judgment
 - With speech
 - With memory
- Dizziness (spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic attacks
- Paranoia
- Seizures
- Suicidal thoughts
- Tingling
- Tremor/trembling
- Visual hallucinations

MUSCULOSKELETAL

- Back muscle spasm
- Calf cramps
- Chest tightness
- Foot cramps
- Joint deformity
- Joint pain
- Joint redness
- Joint stiffness
- Muscle pain
- Muscle spasms
- Muscle stiffness
- Muscle twitches:
 - Around eyes
 - Arms or legs
- Muscle weakness
- Neck muscle spasm
- Tendonitis
- Tension headache
- TMJ problems

SKIN PROBLEMS

- Acne on back
- Acne on chest
- Acne on face
- Acne on shoulders
- Athlete's foot
- Bumps on back of upper arms
- Cellulite
- Dark circles under eyes
- Ears get red
- Easy bruising

DIGESTIVE

- Bad teeth
- Bleeding gums
- Bloating
- Burping
- Canker sores
- Cold sores
- Constipation
- Cracking at corner of lips
- Diarrhea
- Difficulty swallowing
- Dry mouth
- Heartburn
- Hemorrhoids
- Liver disease/jaundice (yellow eyes or skin)
- Lower abdominal pain
- Nausea
- Periodontal disease
- Reflux
- Sore tongue
- Strong stool odor
- Undigested food in stools
- Upper abdominal pain
- Vomiting

Are you on a special diet? yes no

ovo-lacto vegetarian diabetic vegan dairy restricted blood type diet

other (describe): _____

Is there anything special about your diet that we should know? yes no

If yes, please explain:

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? yes no

If yes, are these symptoms associated with any particular food or supplement(s)? yes no

Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes _____ No _____

Do you feel much worse or better when you eat a lot of :

- | | |
|--|---|
| high fat foods refined sugar (junk food) | <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> neither |
| high protein foods fried foods | <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> neither |
| high carbohydrate foods (breads, pastas, potatoes) | <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> neither |
| 1 or 2 alcoholic drinks | <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> neither |

Please check below which most accurately describes information about your bowel movements:

FREQUENCY

- More than 3x/day Medium brown consistently
- 1-3x/day Very dark or black
- 4-6x/week Greenish color
- 2-3x/week Blood is visible.
- 1 or fewer x/week Varies a lot.

COLOR

- Medium brown consistently
- Very dark or black
- Greenish color
- Blood is visible
- Varies a lot
- Dark brown consistently
- Yellow, light brown
- Greasy, shiny appearance

CONSISTENCY

- Soft and well formed Often float
- Difficult to pass
- Diarrhea
- Thin, long or narrow
- Small and hard
- Loose but not watery
- Alternating between hard and loose/watery

Intestinal gas: Daily Present with pain Occasionally Foul smelling Excessive Little odor

Have you ever used alcohol? Yes No

If yes, how often do you now drink alcohol?

- No longer drinking alcohol
- Average 1-3 drinks per week
- Average 4-6 drinks per week
- Average 7-10 drinks per week
- Average >10 drinks per week

Have you ever had a problem with alcohol? Yes No If yes, when _____.

Have you ever used recreational drugs? Yes No

Are you exposed to second hand smoke regularly? Yes No

Have you ever used tobacco? Yes No

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

If yes, what type of nicotine have you used? Cigarette Smokeless Cigar Pipe Patch/Gum

Do you have mercury amalgam fillings? Yes No

Do you have any artificial joints or implants? Yes No Describe _____

Do you feel worse at certain times of the year? Yes No If yes, when? spring fall summer winter

Have you ever had psychotherapy or counseling? Yes No

Currently? Previously? If previously, from _____ to _____.

Describe _____

Are you currently single married or in a long term relationship divorced separated widowed

Comments _____

Do you have children? Yes No

If yes, how many and what are there ages _____

Please briefly describe your experience parenting (challenges, emotions, beliefs, etc...)

Hobbies and leisure activities: _____

Do you exercise regularly? Yes No

If so, how many times a week? _____ When you exercise, how long is each session? _____

What type of exercise is it?

jogging/walking tennis basketball /sports swimming home aerobics yoga other _____

Please say something about your spiritual life: _____

BIRTH HISTORY/CHILDHOOD

Please do your best to answer the following questions:

What type of delivery did you have? vaginal C-section forceps full term premie (how early) _____

Check all that your mother experienced during pregnancy: Cigarette smoking Lived with a smoker Drank Alcohol
 Recreational drugs Prescription Drugs Physical abuse Emotional abuse

Were you breastfed Yes No Until what age _____

Did you feel safe growing up? Yes No

Have you been involved in abusive relationships in your life? Yes No

Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships? Yes No

Please briefly describe your childhood:

FOR WOMEN ONLY

Have you ever been pregnant? Yes No If yes, how many times _____

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes No

Have you had other problems with pregnancy? Yes No

If so, please comment: _____

Age at first period _____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability(PMS)?

Yes No Not applicable

Please describe your cycle (regular, irregular, PMS, cramping, heavy/low flow, etc...) _____

Date of last Pap Smear _____ Normal Abnormal

Date of last Mammogram _____ Normal Abnormal

Have you ever used birth control pills? Yes No If yes, when _____

Are you taking the pill now? Yes No

Did taking the pill agree with you? Yes No Not applicable

Do you currently use contraception? Yes No

If yes, what type of contraception do you use? _____

Are you in menopause? Yes No If yes, age at last period _____

Do you take any hormone supplements Yes No

If yes, Estrogen Ogen Estrace Premarin

Progesterone Provera Other (specify) _____

How long have you been on hormone replacement therapy (if applicable)? _____

Thank You for taking the time to fill out this form so that we may better know you. We look forward to supporting you in a more balanced approach to health.