The Center for Medicine and Healing Arts, LLC

610 Eastbury Dr. #5, Iowa City, IA 52240
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Karyn M. Shanks, MD, FACP, Founder and Director
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Health and Medical Questionnaire for Comprehensive Nutritional Consult

Name_____

Date_____

Date of Birth_____Age_____E-mail_____

Home Address _____ City, Zip _____

Phone number (daytime)_____ Phone number (cell or home)_____

Please list the name and address of your primary health care professional (doctor, nurse practitioner, naturopath, etc.).

_____

Credit Card Information (this information will be kept in a secure location and used to cover the cost of phone consultations, nutritional supplement orders, missed appointments and/or other services)

Card type _____Card number_____

Expiration_____ Security code_____

Medical Insurance (we do not bill insurance but may need to know your policy information for laboratory testing.) Primary insurance company _____

Name of policy holder _____Date of birth_____

Employer_____

What is the purpose of your visit today? _____

_____

What is the primary health concern(s) that you are seeking nutritional consultation for? (for example: IBS, reflux, high cholesterol, hypothyroidism, weight problems, etc.)

_____

Has this condition been diagnosed by a health care professional? If so, please list by whom.

_____

Please list all current and past health concerns/diagnoses.

Nature of Problem	**How long have you had it?**	**Who diagnosed it?**

Please circle any of these past or present health problems that apply to you:

Allergies
Anemia
Anxiety
Arthritis
Asthma
Autoimmune disease
Bleeding problems
Breathing problems
Cancer (explain below)
Chronic Fatigue
Clotting problems
Colitis
Depression
Diabetes
Eating Disorder
Epilepsy
Fibromyalgia
Food Sensitivities (list foods)
Fracture (explain below)
Heart trouble (explain below)
Heartburn
High blood pressure
High blood sugar
High cholesterol
Jaundice/Hepatitis
Kidney problems
Mental health disorders
PMS/Menopausal symptoms
Stroke
Thyroid Disorder

Please give any further explanations needed for these health problems:

_____

_____

Please list all medications and supplements you are currently taking.

Medication or supplement	Amount	When taken	How long have you taken?

Do you have any food allergies? If so, please list the foods and your symptoms.

Do you have any food intolerances? If so, please list the foods that bother you and your symptoms.

Please list any other allergies (such as environmental or medical).

Nutritional deficiency symptoms

Please circle any of the following symptoms that apply to you:

Bleeding gums
Swollen or very cracked lips
Cracks at the corners of the mouth
Swollen or discolored tongue
Swelling in neck or cheeks
Constipation
Small bumps on the backs of arms or on your trunk
Horizontal ridges in fingernails
Spoon-shaped fingernails
Club-shaped fingernails

Please remember to send in or bring copies of any recent (in the last year) laboratory blood work you have had drawn that might be relevant (for example, vitamin D, vitamin B-12 or folic acid, iron levels, albumin, hormones, thyroid levels, homocysteine, cholesterol, blood sugar, CRP, ANA, ESR, etc.)

Personal habits

Do you drink alcohol? Yes____ No____ If so, how many drinks per week? _____
What kind of alcohol? _____

Do you drink caffeinated beverages? Yes____ No____ If so, what kind? _____
How many per day?_____

Do you smoke? Yes_____ No _____ In the past_____

Do you use recreational drugs? Yes____ No_____
If so, what kind and how often?

How many hours per night do you sleep? _____
Do you normally feel you get enough sleep? Yes_____ No_____

If not, please explain.

Do you exercise regularly? Yes____ No_____ If so, please explain what exercise you do and how often you do it.

Job:

What kind of work do you do?

How many hours per week?

Please rate your satisfaction with your current job on a scale of 1-10, with 1 being very dissatisfied and 10 being very satisfied. _____

Stress

Please rate your overall level of stress in your life from 1-10, with 1 meaning little stress and 10 meaning extremely stressed. _____

History

Do you have any metal or silver-colored fillings in your teeth? Yes____No____ If so, how many?___

Have you had metal fillings removed from your teeth? Yes____ No _____

Have you been frequently exposed to environmental toxins in your life? (Examples include pesticides and herbicides on farms or applying lawn chemicals, living near a coal-burning power plant, laboratory or mechanical work with solvents, factory work, etc). Yes_____ No_____ If so, please describe

_____

_____

Have you ever had Lyme disease, or any other tick-borne illness (examples include, but are not limited to, anaplasmosis, babesiosis, ehrilichiosis, Rocky Mountain Spotted fever, tularemia). Yes____ No_____

Have you ever been diagnosed with any chronic or persistent viral or bacterial infections (examples include Epstein-Barr, HIV, cytomegalovirus)? Yes_____ No_____

If yes to either of the last two questions, please fill in a few details about your illness.

Date symptoms started:_____

Approximate date of diagnosis:_____ Name of disease_____

What was your treatment? _____

Do you feel that all your symptoms are gone? Yes_____ No _____

If no, please explain_____

_____

Do you have any lasting side effects from your treatment? Yes _____ No_____ If yes, what are the effects? _____

Have you ever been on any special diets in the past? Yes_____ No_____ If so, please briefly describe what they were and how long you were on them. _____

_____

Have you ever experienced severe physical or emotional trauma? (Examples include car accidents, abuse, death of a parent when you were a child, or anything that had a profound negative effect on you).

Yes_____No _____ If you wish, please briefly describe the event(s). _____

_____

_____

On a scale of 1-10, how safe and secure did you feel as a child and teenager (1=very unsafe, 10=totally safe and secure) _____

Family history

Please detail the health problems of your close blood relatives, if known. (If adopted, please use any information that is known about your biological relatives.)

Family member	Age	Current health problems	Age at death	Cause of death
Mother				
Father				
Sister/brother				
Sister/brother				
Sister/brother				
Sister/brother				
Maternal G'ma				
Maternal G'pa				
Paternal G'ma				
Paternal G'pa				
Your children				
Daughter/son				
Daughter/son				
Daughter/son				
Daughter/son				

Please add any other relevant information that you would like the nutritionist to know. A brief timeline of your when your symptoms started and how they have changed is very helpful.

Three Day Food Log

Please write down everything you eat and drink for three full days. Use two weekdays and one weekend day. Please be as specific as possible. Include all beverages, condiments, and extras like added butter. If the food is cooked, write down how it is prepared (baked, fried in oil or butter, steamed, etc.). Measure or estimate portion sizes; for example, 1 teaspoon oil, ½ cup cooked rice, 3 ounces meat or meat the size of the palm of my hand.

Time	Food Item and Method of Preparation	Amount Eaten	Where

Three Day Food Log, continued Day 2

Time	Food Item and Method of Preparation	Amount Eaten	Where

Three Day Food Log, continued Day 3

Time	Food Item and Method of Preparation	Amount Eaten	Where

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Physician Referral for Nutrition Consult

(This form is optional, but may help you receive insurance reimbursement)

Dear Client:

Please have your physician or nurse practitioner fill out this form with your medical diagnosis and a signature before you schedule an appointment with our functional nutritionist. Either mail the completed form back to us at The Center for Medicine and Healing Arts with the rest of your paperwork, or have your physician's office fax it to us at 319-358-9524.

Completing this form may increase the likelihood that you will receive reimbursement from your health insurance company (although we unfortunately cannot guarantee that they will reimburse for a nutritional consultation).

Client name _____Date of birth_____

Reason for seeking nutritional consultation_____

Relevant diagnoses_____

Name and address and signature of referring physician or nurse practitioner:

_____

_____

Signature _____

MSQ - Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale:

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Frequently have it, effect is not severe
3 = Occasionally have it, effect is severe
4 = Frequently have it, effect is severe

Digestive Tract	____ Nausea or vomiting ____ Diarrhea ____ Constipation ____ Bloated Feeling ____ Belching or passing gas ____ Heartburn Total _____	Lungs	____ Chest Congestion ____ Asthma, bronchitis ____ Shortness of breath ____ Difficulty Breathing Total _____
Ears	____ Itchy Ears ____ Ear aches, ear infections ____ Drainage from ears ____ Ringing in ears, hearing loss Total _____	Mind	____ Poor memory ____ Confusion, poor comprehension ____ Difficulty in making decisions ____ Stuttering or stammering ____ Slurred speech ____ Learning disabilities Total _____
Emotions	____ Mood swings ____ Anxiety, fear or nervousness ____ Anger, irritability or aggressiveness ____ Depression Total _____	Mouth/ Throat	____ Chronic coughing Gagging frequently; need to clear throat ____ Sore throat, hoarseness, loss of voice ____ Swollen or discolored tongue, gums, lips ____ Canker sores Total ____ _____
Energy & Activity	____ Fatigue, sluggishness ____ Apathy, lethargy ____ Hyperactivity ____ Restlessness Total _____	Nose	____ Stuffy nose ____ Sinus problems ____ Hay fever ____ Sneezing attacks ____ Excessive mucus formation Total _____
Eyes	____ Watery or itchy eyes ____ Swollen, reddened or sticky eyelids ____ Bags or dark circles under eyes ____ Blurred or tunnel vision (does not include near or far sightedness) Total _____	Skin	____ Acne ____ Hives, rashes, or dry skin ____ Hair loss ____ Flushing or hot flashes ____ Excessive sweating Total _____
Head	____ Headaches ____ Faintness ____ Dizziness ____ Insomnia Total _____	Weight	____ Binge eating ____ Craving certain foods ____ Excessive weight ____ Compulsive eating ____ Water retention ____ Underweight Total _____
Heart	____ Irregular or skipped heartbeat ____ Rapid or pounding heartbeat ____ Chest Pain Total _____	Other	____ Frequent illness ____ Frequent or urgent urination ____ Genital itch or discharge Total _____
Joints & Muscles	____ Pain or aches in joints ____ Arthritis ____ Stiffness or limitation of movement ____ Pain or aches in muscles ____ Feeling of weakness or tiredness Total _____		*Grand Total* _____