Advanced Clinical Nutrition.com ♦ Dr. Donna F. Smith ♦ (940) 761-4045

File #:

Modified Wei Form

PATIENT HEALTH HISTORY **Date:** **Re-evaluation:** [ ]Yes

Using an ink (not gel) pen, complete each question, even if you have provided this information on other forms. If any do not apply to you, put "N/A" in the blank space to indicate that you have read the question.

1. Name: _____ Gender: [ ]M, [ ]F Age: ____ DOB: _____ Height: _____ Weight: _____
   Primary Physician: _____ Phone: _____ Fax: _____
   Primary Physician's Email: _____

2. Have you ever used: [ ] Clinical Nutrition [ ] Naturopathy [ ] Dietetics [ ]Chinese Herbal Medicine [ ]Homeopathy [ ]Acupuncture [ ]Chiropractic
   If yes, for what conditions? _____
   If no, would you like to hear about options for your condition (please circle)? Yes No

3. What is the reason for contacting Dr. Smith? What is your chief complaint? (Describe your condition at its worst)
   _____
   _____
   Other Complaints: _____
   Diagnosed Medical Conditions: _____

4. Cause of Health Conditions: [ ] Injury [ ] Auto Accident [ ] Personal Injury [ ] Other: _____
   Has the accident been reported? Yes No Reported to: [ ]Employer [ ]Auto Carrier [ ]Other: _____
   Are you now or have you ever been disabled? Yes No Date: _____ Cause:_____
   Have you ever retained an attorney? Yes No Name: _____ Phone: _____

5. Pain Symptoms: a._____ Began (Mo/Yr) _____ Previous Episodes (M/Y)_____
   (In Order b._____ Began (Mo/Yr) _____ Previous Episodes (M/Y)_____
   of Severity) c._____ Began (Mo/Yr) _____ Previous Episode (M/Y)_____

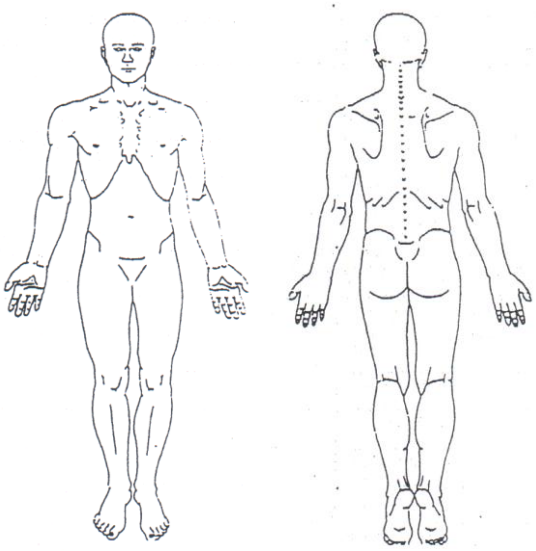
6. On Body Charts, please circle areas of pain or discomfort and mark them using the codes listed below:
   N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars

   List below the frequency and severity on a scale of 1 to 5 regarding your primary three conditions marked on Body Charts.:

Frequency:	Severity:
1=20% of the time	1=Annoying
2=40% of the time	2=Impairment to Activity
3=60% of the time	3=Need Medication
4=80% of the time	4=Impairment with Medication
5=100% of the time	5=Severe (Need Hospitalization)

	Location	Frequency	Severity	Initial Cause	Getting Worse?	
1.	_____	_____	_____	_____	Yes	No
2.	_____	_____	_____	_____	Yes	No
3.	_____	_____	_____	_____	Yes	No

   Circle None OR on Body Charts, please circle & mark with number any other areas affected by 1, 2, or 3 above and explain _____
   _____
   _____ Joint Separations ____ _____



7. Please put a **C (Currently have) or P (Past), Year for Onset and Duration** (Ex: P – 2005 / 3y) for onset

Osteoarthritis _____	Bone Spurs _____	Ganglion or Baker's Cyst (include Location) _____	
Bulging Disc _____	Tendonitis_____	Avascular Necrosis _____	Cartilage injury _____
Herniated Disc _____	Bursitis _____	Post-herpetic neuralgia _____	Meniscus Tear _____
DDD _____	Sprains _____	Intercostal Neuralgia _____	Chondromalacia _____
Stenosis _____	Non-union Fracture __	Morton's Neuroma ___ _____	Patellar Syndrome _____

8. Do any conditions interfere with (please circle): Work Sleep Other: _____
Please list conditions and provide details:: _____
Without treatment, how would it affect your quality of life? _____
_____

9. What seems to make the condition better? _____
What seems to make it worse? _____
What treatments have you tried? _____

10. If you are currently under the care of any other health care practitioner for any conditions or injuries, please provide:
Name: _____ Phone: _____ Email: _____
Description of Treatment: _____

11. Please list any current therapies: _____

12. Please complete or check box to describe your family health history: Note if more than one brother, sister or child has the same condition, list ages, and put check for each person. Ex: put two checks if two brothers had arthritis.

	You	Father	Mother	Spouse	Brothers	Sisters	Children
Age							
Arthritis							
Acid Reflux or Stomach Problems							
Allergy and Food Allergy							
Asthma or Hay Fever							
Back or Disc Problems							
Bursitis							
Cancer							
Constipation							
Emotion Problem							
Epilepsy							
Headaches or Migraines							
Heart Problems (Type)_____							
High Blood Pressure							
Insomnia							
Kidney Problems							
Liver Problems							
Lung Problems							
Obesity							
Scoliosis							
Sinus Problems							
Other:_____							

13. Please describe your lifestyle (please circle):

Appetite: Low Moderate High
Thirst for Water: Yes No _____ Glasses/Day
Coffee: Yes No _____ Cups/Day Past ____#Yrs*
Soda: Yes No _____ Cups/Day Past ____#Yrs
Artificial Sweeteners: Yes No Past _____# Yrs.
Cravings for Sugar: Yes No Past _____# Yrs
Cravings for Salty Foods: Yes No Past _____# Yrs
Stress Level: High Moderate Low
Alcohol (Current) Yes No _____ Glasses/Day
Alcohol (Past) Yes No _____ Glasses / Day – Week or Mon.
Smoking (Current) Yes No _____ Cigarettes**/Day
Smoking (Past) Yes No _____ Cigarettes**/Day
Marijuana: Yes No _____ Times/Day
Other Drugs : _____Current Past _____

Exercise (please circle):

None Active
Light Very Active
Moderate Elite Athlete

Type of Exercises: _____
_____
Frequency of Exercise: _____
_____
Occupational Hazards: _____

======= (*How Many Years Used in the Past; **Represents Cigarettes, Cigars and/or Snuff – Circle here which included.) ======

14. Have you taken any supplements in the past 2 months, other than those dispensed through Dr. Smith? Yes No
If Yes, have you provided Brand Name, Company Name, Dosage & Frequency information to Dr. Smith? Yes No
If No, please list information here to prevent contraindications: _____

15. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:

Anti-acids (please check): [ ] TUMS [ ] Zantac [ ] Other: _____

Proton Pump Inhibitors (please check): [ ] Prilosec [ ] Pepcid [ ] Prevacid [ ] Other: _____

Other Medications: _____

_____

16. Please describe your health history (check mark on line).

Now	Past		Now	Past		Now	Past		Now	Past	
___	___	Acid Reflux/Heart Burn	___	___	Diverticulitis	___	___	Influenza	___	___	Pulmonary Fibrosis
___	___	AIDS/HIV	___	___	Drug Withdrawal	___	___	IBD	___	___	Rheumatic Fever
___	___	Alcoholism	___	___	Emphysema	___	___	IBS	___	___	Rheumatoid Arthritis
___	___	Allergies	___	___	Epilepsy	___	___	Kidney Stone	___	___	Sarcoidosis
___	___	Anemia	___	___	Eczema	___	___	Lyme Disease	___	___	Scarlet Fever
___	___	Appendicitis	___	___	Fatty Liver	___	___	Measles	___	___	Seizures
___	___	Arthritis	___	___	Fibromyalgia	___	___	Mental Disorder	___	___	Stroke
___	___	Arteriosclerosis	___	___	Fibroid	___	___	Migraines	___	___	Thyroid Disorders
___	___	Asthma	___	___	Gall Bladder Stone	___	___	Multiple Sclerosis	___	___	Tuberculosis
___	___	Birth Trauma	___	___	Goiter	___	___	Mump	___	___	Typhoid Fever
___	___	Bronchiectasis	___	___	Gout	___	___	Ovarian Cyst	___	___	Ulcers, Location: _____
___	___	Breast Lump	___	___	Hernia	___	___	Pacemaker	___	___	Ulcerative Colitis
___	___	Cancer _____	___	___	Heart Disease: _____	___	___	Pancreatitis	___	___	Crohn's Disease
___	___	Chicken Pox	___	___	Heart Murmur	___	___	Pleurisy	___	___	UTI-Urinary Tract Infection
___	___	Chronic Bronchitis	___	___	Hepatitis	___	___	Pneumonia	___	___	Interstitial Cystitis
___	___	Cirrhosis	___	___	Herpes	___	___	Prostatitis	___	___	Vitiligo (Pigment Changes)
___	___	COPD	___	___	High Blood Pressure	___	___	Polio	___	___	Venereal Disease
___	___	Cystic Fibrosis	___	___	High Cholesterol	___	___	Psoriatic arthritis	___	___	Whooping Cough
___	___	Diabetes	___	___	Hyperlipidemia	___	___	Psoriasis	___	___	Other, Describe _____

17. Please use the point scales to rate your symptoms over the past three (3) months.

1 = Occasional, Not Severe **3 = Frequent, Not Severe**
2 = Occasional, Severe **4 = Frequent, Severe**

Digestive Tract
___Acid reflux/Heart Burn
___Poor Digestion
___Nausea & Vomiting
___Bloating
___Gas
___Hiccups
___Bad Breath
___Gluten Intolerance
___Food Allergies
___Chemical Sensitivities
___Malnutrition
___Difficulty Swallow
___Achalasia
___Diarrhea
___Constipation
___Laxative Use
___Blood in Stool
___Mucous in Stool
___Black Stool
___Stomach Pains/Cramps
___Abdominal Pain
___Abdominal Spasms
___Lack of Bowel Control
___Itchy Anus
___Rectal Pain
___Hemorrhoids
___Anal Fissures

Bowel Movements
Frequency (No. of Daily BMs _____

Bowel Movements (ctd.)
Color_____
Texture/Form_____
Odor_____

General
___Sweat Easily
___Night Sweats
___Gall Bladder Troubles
___Cold Hands or Feet
___Poor Circulation
___Shortness of Breath
___Spitting Blood
___Fever
___Chills
___Muscle Cramps
___Lower Extremity Edema
___Vertigo or Dizziness
___Bleed or Bruise Easily
___Frequent Illness
___Seasonal Allergy
___Addicted to Drugs
___Addicted to Smoking
___Peculiar Taste:
Describe: _____

Respiratory
___Tight Chest
___Shortness of Breath
___Difficulty Breathing
When Lying Down
___Itching Inside the Chest

Respiratory (continued)
___Wheezing
___Persistent Cough
___Coughing Blood
___Cough: Wet / Dry, Thick / Thin
Phlegm Color: ___ Yellow ___ Green ___ Brown ___Black

Urinary
___Bedwetting
___Blood in Urine
___Lack of Bladder Control
___Pain During Urination
___Frequent or Urgent Urination
___Incomplete Urination
___Wake to Urination
___Prostate Problem
___Genital Itch or Discharge
___Kidney Stone
___Kidney Failure
___Recurrent Bladder Infections
___Impotence
___Increased Libido
___Decreased Libido
___Premature Ejaculation
___Nocturnal Emission

Weight & Eating
___Recent Weight Loss/Gain
___Binge Eating/Drinking
___Craving Certain Foods
___Excessive Weight
___Compulsive Eating

Weight & Eating (ctd.)
___Poor Appetite
___Heavy Appetite
___Strongly Like Cold Drinks
___Strongly Like Hot Drinks
___Water Retention

Musculoskeletal
___Muscle Pains
___Muscle Cramps
___Pains or Aches in Joints
___Stiffness/Limited Range of Motion
___Limited Use
___Pains or Aches in Muscles
___Feeling of Weakness/Tiredness
___Swollen Tender Joints
___Growing Pains in Legs
___Hip Tightness/Coldness/Pain
___Rib Pain
___Neck/Shoulder Pain
___Upper Back Pain
___Back Pain
___Lower Back Pain
___Sciatic Pain

Cardiovascular
___Heart Murmur
___Heart Palpitations
___Heartbeat (Irregular or Skipped)
___Heartbeat (Rapid or Pounding)

Cardiovascular (ctd.)
___Chest Pain
___Shortness of Breath
___Difficulty Breathing
___High Blood Pressure
___Low Blood Pressure
___Blood Clots
___Anemia
___Fainting
___Vein Inflammation
___Tachycardia
___Post-stroke

Emotions
___Mood Swings
___Anxious, Fear, Nervous
___Angry Irritable, Aggressive
___Easily Stressed
___Argumentative
___Frustrated, Cries Easily
___Depression
___Abuse Survivor
___Considered/Attempted Suicide
___Seeing a Therapist

Mind
___Poor Memory
___Difficulty Completing Projects
___Difficulty with Mathematics
___Underachiever
___Poor/Short Attention Span
___Confusion
___Easily Distracted
___Difficulty Making Decisions
___Learning Disability

Neurological
___Seizures
___Numbness
___Tics
___Foot Neuropathy

Energy & Activity
___Apathy, Lethargy
___Attention Deficit

Energy & Activity (ctd.)
___Fatigue
___Lack of Strength
___Body Heaviness
___Hyperactivity
___Restlessness
___Shortness of Breath
___Stuttering or Stammering
___Slurred Speech

Ears
___Itchy Ears
___Ear Aches
___Ear Infections
___Drainage from Ears
___Hearing Loss
___Reddening of the Ears
___Ringing in the Ears
___Headaches
___Concussions

Nose
___Stuffy Nose
___Dryness Inside the Nose
___Chronically Red, Inflamed Nose
___Sinus Problem
___Hay Fever
___Sneezing Attacks
___Excessive Mucous Formation
___Back Dripping
___Nose Bleeding

Eyes
___Glasses/Contacts
___Watery or Itchy Eyes
___Red, Swollen or Sticky Eyelids
___Bags/Dark Circle Under Eyes
___Poor Vision
___Blurred or Tunnel Vision
___Sensitive to Sunlight
___Eye Strain
___Eye Pain
___Red Eye
___Itchy Eyes
___Easily Fatigued
___Spots in Eyes
___Night Blindness

Eyes (continued)
___Glaucoma
___Cataract

Head
___Headaches
___Migraines
___Faintness
___Dizziness
___Insomnia, Sleep Disorder
___Facial Flushing
___Facial Pain
___TMJ

Mouth & Throat
___Chronic Coughing
___Gagging, Often Clearing Throat
___Sore Throat, Hoarse, Voice Loss
___Swollen/Discolored Tongue/Lips
___Sores on Lips or Tongue
___Canker Sores
___Itching on Roof of Mouth
___Dry Mouth
___Excessive Saliva
___Recurrent Sore Throat
___Excessive Phlegm
Color: _____
___ Swollen Glands
___Lumps in Throat
____Enlarged Thyroid
____Teeth Problem
____Gum Problem
____Grinding Teeth

Skin & Hair
___Acne
___Itching
___Hives
___Rash
___Eczema
___Dry Skin
___Ulcerations
___Hair Loss
___Dandruff
___Flushing or Hot Flashes
___Change in Hair/Skin Texture
___Loss in Pigmentation
___Fungal Infections
___Scars

For Women Only
Age Menstrual Cycle Began: _____
Length of Cycle (Day 1 - Day 1): _____
Duration of Flow: _____
___Dark Color Flow
___Clots in Flow
___Excessive Flow
___Irregular Circle
___Painful Period
___Excessive Vaginal Discharge
___Menopause Symptoms
___Lump in Breast
___Vaginal Dryness
___Vaginal Sores
___Vaginal Odor
Vaginal Discharge Color: _____
# of Pregnancies: _____
# of Live Births: _____
# of Premature Births: ____
Age at Menopause: _____
Date of Last PAP: _____
Date Last Period Began: _____

Any Other Symptoms:
_____
_____
_____
_____
_____
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_____
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_____
_____
_____
_____

18. Operations and Procedures (If not listed or need more space, list with date on lines under **Any Other Symptoms** above.)

Date	**Date**	**Date**	**Date**
_____ Vaccinations	_____ Tubes in Ears	_____ Sinus	_____Testes L R
_____ Tonsillectomy	_____ Appendectomy	_____ Hernia	_____ Prostate
_____ Gall Bladder	_____ Stomach	_____ Thyroid	_____**Other**
_____ Back Operation	_____ Rectal Surgery	_____ Ovary L R	Describe Other _____
		_____ Uterus	_____

19. List and date any accidents or falls (please check):
[ ] Car _____, [ ] Recreation _____, [ ] Sports _____, [ ] School _____, [ ] Other _____
List any broken bones: _____
Have you ever had spinal taps or spinal injections (please circle)? Yes No Date: _____
Have you ever lost consciousness (please circle)? Yes No Why? _____
Have you ever had X-ray taken? Yes No Approximately how many times have you been X-rayed for any purpose: ____
Date of Last X-ray: _____ Purpose: _____ By Whom? _____
For what ailment were these X-rays taken? _____
Do you suffer from any condition other than that for which you are now consulting Dr. Smith? _____

I authorize Dr. Smith to analyze my health and provide Dietary, Clinical Nutrition and Naturopathic Therapies as deemed appropriate.

Patient's / Guardian's Signature: _____ Date: _____