Confidential Patient History

Legal Name ____Name you preferred to be called ____________________________

Address ____ City ___________________________ State _______ Zip ___________

Home (______)___________________ Work (______)____________________Mobile (______)________________________

Sex: Male ☐ Female ☐ Age _________ DOB _________________ Social Security _________-_______-_____________

Email ____

Occupation ____ Employer ____

Names/Ages of Children ____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other____

Name of Partner ______________________________________ Partner's Employer _____________________________________

Name of Emergency Contact ____ Relationship ___________________________

Best Number to Contact Them ☐ Mobile ☐ Home ☐ Work ☐ Other (_________) _____________________________________

How did you hear about Dr. Hamel?____

Do you have health insurance? ☐ Yes ☐ No If you checked yes, please provide us with a copy of your insurance ID card(s).

Name of the insured____ Insured's date of birth_________________

What is their relationship to you? ☐ Spouse ☐ Child ☐ Other______________________________

Do they live at the same address as you? ☐ Yes ☐ No

If you checked no, what is their address__________________________________City_____________________ State________

Zip ______________ Phone Number (______) _________________________ Do you want to be added to Dr. Hamel's

Newsletter? Y N

Nutritional, Metabolic & Structural 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. Hamel?

____

Limitations | What limitations do you have, if any, in working with Dr. Hamel? (e.g. unwilling to take nutritional supplements, working in excess of 60 hours a week, won't give up smoking or alcohol, 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 ________________

Sleep Quality | How is your sleep? (check all that apply) ☐Restful ☐Restless ☐Hard to get 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-inflammatory ☐ Birth Control Pills ☐ Blood Pressure Meds ☐ Cardiac/Heart Meds
☐ Diuretics ☐ Hormones (estrogen, progesterone, DHEA, testosterone, thyroid)
☐ Muscle Relaxers ☐ Pain Killers ☐ Parasite Medication
☐ Steroids (prednisone, anabolic, cortisone) ☐ Yeast/Fungal Meds

____
____

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.) ___________________________________
____
____

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 fluorescent light? ______________ Hours of sunlight daily through windows? ______________________

Clothing | How often do you wear 100% natural clothing (cotton, ramie, wool, silk, linen)? ________________________________
How often to you wear 100% synthetic clothing (polyester, acrylic, nylon, rayon, etc.)? _____________ Blends? ______________

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal 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.

	N	P
General		
Weight loss	☐	☐
Weight gain	☐	☐
Head		
Headache	☐	☐
Dizziness	☐	☐
Head trauma	☐	☐
Fainting	☐	☐
Blacking out	☐	☐
Eyes		
Change in vision	☐	☐
Cataracts	☐	☐
Light sensitivity	☐	☐
Flashes in vision	☐	☐
Spots in vision	☐	☐
Mouth		
Bleeding gums	☐	☐
Cold sores	☐	☐
Dentures	☐	☐
Sore throat	☐	☐
Jaw pain	☐	☐
Changes in taste	☐	☐
Hoarseness		

	N	P
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	☐	☐

	N	P
G-I System		
Gas	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Ulcers	☐	☐
Vomiting/Nausea	☐	☐
Abdominal Pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gall bladder disease	☐	☐
Liver disease	☐	☐
G-U System		
Difficulty urinating	☐	☐
Pain urinating	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Foul odor of urine	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Urinary infection	☐	☐
Genital infection	☐	☐

	N	P
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	☐	☐
Itching	☐	☐
Peeling	☐	☐

	N	P
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	☐	☐
TIAs	☐	☐
Headache unlike any previously experienced	☐	☐

Bowel Movements | Please circle those that apply.
How often: daily | more than once a day | skip days Consistency: normal | too hard | too soft | diarrhea alternating with hard
Amount: normal | too little Color: brown | black | yellow | whitish Other: mucus | foul smell | lots of gas
Comments:____

Female Specific Issues | Please circle those that apply and fill in the blanks.
Are you pregnant? Y N Going through menopause? Y N Have your periods stopped? Y N
Breast feeding? Y N Are your periods regular? (28 day cycle) Y N Do you have monthly periods? Y N
Date of your last menstrual period? ___________ Have you had a hysterectomy (indicate date, partial or total):
__________________________ Have you been diagnosed with any of the following (circle) : endometriosis, PCOS, fibroids, PMS, dysmenorrhea, menorrhagia, infertility. Have you had any miscarriages? Y N

Emotional Tendency | Please check those emotions that you have a tendency towards.
☐ Anger ☐ Anxiety ☐ Criticism ☐ Fear ☐ Insecurity ☐ Worry ☐ Inability to forgive (self/others) ☐ Other ________________

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 ______________________ ☐ Deodorant _____________________ ☐ Toothpaste ______________________
☐ Body Soap ______________________ ☐ Hand/Body Lotion _______________ ☐ Laundry Soap ____________________
☐ Dish Soap ______________________ ☐ Household Cleaner ______________ ☐ Hairspray/Gel ____________________
☐ Nail Polish _____________________ ☐ Hair Coloring ___________________ ☐ Air Freshener ____________________
☐ Ant/Roach Spray ________________ ☐ Pesticides ______________________ ☐ Other ___________________________

Electromagnetic Exposure | How many hours do you spend daily:

☐ Watching TV ____________________ ☐ Talking on a cell phone ___________
☐ Wearing a pager _________________ ☐ Working on a computer ___________ ☐ Near electrical equipment _________
☐ Sleeping near an electric clock? _____

Water/Hydration | How many glasses (8-10 oz) 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 ☐ No dairy ☐ Vegan ☐ Low fat ☐ Any other diet _______________
☐ Vegetarian ☐ Yeast-free ☐ Diabetic
☐ Atkins/Zone diet ☐ Candida diet ☐ Low salt

Food Habits | How often do you eat out, and at what type of restaurants? ____
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	Harvest	C	O	Meat/Fish	C	O	Dairy	C	O	Condiments	C	O
Canned foods	☐	☐	Fresh vegetables	☐	☐	Beef, pork, lamb	☐	☐	Eggs	☐	☐	Table salt	☐	☐
Boxed cereal	☐	☐	Fresh fruit	☐	☐	Chicken	☐	☐	Butter	☐	☐	Sea salt	☐	☐
Frozen dinners	☐	☐	Whole grains	☐	☐	Turkey	☐	☐	Milk	☐	☐	Ketchup	☐	☐
Frozen juices	☐	☐	Whole beans	☐	☐	Canned tuna	☐	☐	Milk, raw	☐	☐	Mustard	☐	☐
Take-out food	☐	☐				Fresh fish	☐	☐	Cheese	☐	☐	Vinegar	☐	☐
						Frozen fish	☐	☐				Sweetener	☐	☐
						Restaurant fish	☐	☐						

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

Stimulants		Toxic Oils		Hormone Platters		Empty/Processed	
				(non-organic)			
Coffee (inc. decaf)	☐___	Fried foods	☐____	Beef	☐____	White pasta	☐____
Black tea, chai tea	☐___	Fast foods	☐____	Chicken	☐____	White bread	☐____
Soft drinks (cola, etc.)	☐___	Potato or corn chips	☐____	Milk, Ice cream	☐____	Instant cereal	☐____
Drinks w/NutraSweet	☐___	Roasted nuts	☐____	Cheese, butter	☐____	Cookies	☐____
Alcohol	☐___	Smoked meats	☐____	Yogurt	☐____	Store-bought muffins	☐____
Chocolate	☐___	Margarine	☐____	Hot dogs/sausage	☐____	Minute rice	☐____
Candy, pastry, sweets	☐___	Shortening	☐____	Pork, lunch meats	☐____	Bagels	☐____

Signature____ Date_______________________