ELAN VITAL MEDICAL CTR
21 WEST STREET
WORCESTER, MA 01609
TEL. 508-753-0006
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PATIENT INFORMATION
(Please print clearly)

WELCOME

The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide if we can assist you. If we do not believe that your condition will respond to our care, we will not accept you as a patient but will refer you to another health care provider.

Last Name_____

First_____MI_____

Street_____

City_____State_____Zip_____

Phone ( ) _____-_____Email Address_____

Birth Date_____-_____-_____Sex:_____Male_____Female

Employer_____Work Phone ( )_____-_____

Who can we thank for referring you to our office?_____

I understand and agree that the doctor has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.
I further understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that, unless other arrangements are made with your office, all services are rendered to me are charged directly to me and that I am personally responsible for payment.

Signature_____Date_____-_____-_____

PLEASE VISIT US ONLINE AT: **WWW.EVMEDCENTER.COM**

Name_____

What is the reason for your visit?_____

_____

_____

What do you think caused your problem?_____

When did this condition begin?_____Has this condition occurred before? ( ) Y ( ) N
What type(s) of therapy have you tried for this condition?
( )conventional drugs ( )chiropractic ( )acupuncture
( )diet modification ( )vitamin/minerals ( )herbs
( )homeopathy ( )other_____

Laboratory tests performed (e.g. blood, urine, stool, hair analysis)_____
_____

Outcome of tests_____
What diagnosis were you given?_____

Is your health currently: ( )getting better ( )getting worse ( )staying same
How do you know?_____

Please list any other health concerns/conditions, even if you think they may not be important._____
_____
_____

Primary care physician_____Date of last physical exam_____

Please list all medications you have taken over the past 3 months (prescription or over the counter)

Drug Name	Start Date	Stop Date	Reason For It	Results

Please list all of your medication allergies

1. 2. 3.

4. 5. 6.

Please list all hospitalizations or surgeries

1._____Year_____

2._____ Year_____

3._____ Year_____

Have you EVER been on frequent or prolonged antibiotic therapy? ( )Y ( ) N
Any medications devices/prosthetics/implants ( )Y ( )N describe:_____

WOMEN

Age of onset of menstruation_____ Are you pregnant? ( ) Y ( ) N
Age of onset of menopause_____ Hysterectomy ( )Y ( )N
Number of children_____ Number of miscarriages_____
Length of menstrual cycle_____days Interval of time between cylces_____days
Duration of flow_____days Is your flow ( )Light ( )Medium ( ) Heavy
Date last period began_____ Date of last PAP_____
Do you have:
( )irregular periods ( )cramps/pain with period
( )tension/depression before period ( )hot flashes at any time
( )pain during intercourse ( )any unusual bleeding or discharge

Do you smoke cigarettes? ( )Y ( )N _____packs/day How many years____
Do you smoke cigars? ( )Y ( )N _____cigars/day How many years____
Do you do illegal drugs? ( )Y ( )N amount/type_____
Do you drink alcohol? ( )Y ( )N _____drinks/week
Do you drink caffeine ( )Y ( )N _____cups/per day
How many cups of water do you drink each day?_____
Do you exercise regularly? ( )Y ( )N If yes, what kind and how often?_____
_____

Are you on a special diet? ( )Y ( )N If yes, what kind?_____
_____

PLEASE USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR HEALTH HISTORY FROM BIRTH TO PRESENT. PLEASE INCLUDE YOUR MOTHER'S PRENATAL HEALTH HISTORY. FOR EXAMPLE, WAS SHE ON MEDICATIONS, WAS SHE SICK/STRESSED DURING PREGNANCY, WAS YOUR BIRTH VAGINAL OR C-SECTION, AND WERE THERE ANY COMPLICATIONS DURING PREGNANCY OR DELIVERY.

Please list everything you eat and drink for 3 days.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

Please list all supplements/herbs/homeopathic you are currently taking.

Name/Type	Dosage	Reason For It

Please list your special interests and passions:_____

_____

_____

Please check the boxes next to all illnesses you have or have had.

( ) Atrial Fibrillation	( ) Colon Polyps	( ) Cancer: Colon
( ) Angina Pectoris	( ) Irritable Bowel	( ) Cancer: Esophagus
( ) Artifical Heart Valve	( ) Ulcers	( ) Cancer: Stomach
( ) High Blood Pressure	( ) Crohn's Disease	( ) Cancer: Pancreas
( ) Pacemaker	( ) Ulcerative Colitis	( ) Cancer: Prostate
( ) High Cholesterol	( ) Liver Cirrhosis	( ) Cancer: Breast
( ) Heart Attack	( ) Hepatitis	( ) Excessive Alcohol Use
( ) Bleeding Disorder	( ) Gallstones	( ) Drug Abuse
( ) Emphysema	( ) Lactose Intolerance	( ) Depression
( ) Asthma	( ) Pancreatitis	( ) Anxiety
( ) Tuberculosis	( ) Diverticulosis	( ) Suicide Attempt
( ) HIV/AIDS	( ) Sprue	( ) Stroke
( ) Diabetes	( ) Esophagitis	( ) Migraine Headache
( ) Osteoporosis	( ) Anemia	( ) Endometriosis
( ) Thyroid Disorder	( ) Latex Allergy	( ) Arthritis

Have you had the following immunizations:

( ) Polio	( ) tetanus booster (last 10 yr)
( ) DPT (diphtheria/pertussis/tetanus)	( ) Hepatitis B
( ) Measles	( ) HPV (human papillo virus)
( ) Mumps	( ) Others_____
( ) Small Pox	

Please list any family members who have had any of the following problems.

Disease	Relation To You	Disease	Relation To You
Cancer: Colon		Colon Polyps	
Cancer: Breast		Colitis	
Cancer: Prostate		Bleeding Problems	
Cancer: Other		Alcohol Abuse	
Obesity		Hepatitis	
Diabetes		Osteoporosis	
Hypertension		Liver Disease	
Heart Disease		Other:	
High Cholesterol		Other:	

Please circle your answer:

Date of last colonoscopy (if over age 50)	Year:	Never – Don't know
Date of last mammogram (if female)	Year:	Never – Don't know
Date of last bone density test (for osteoporosis)	Year:	Never – Don't know

Symptoms		Physician Comment
Lack of energy	Yes No	Constitutional
Trouble sleeping	Yes No	
Weight loss (10 Ibs. in I yr.)	Yes No	
Weight gain (10 Ibs. in 1 yr.)	Yes No	
Fevers	Yes No	
Hard or infrequent bowel movements	Yes No	GI
Loose or frequent bowel movements	Yes No	
Blood in bowel movements	Yes No	
Vomit blood	Yes No	
Heartburn/indigestion	Yes No	
Food sticks when swallowing	Yes No	
Painful swallowing	Yes No	
Yellow iaundice	Yes No	
Chest pain	Yes No	Cardiovascular
Irregular heartbeat	Yes No	
Palpitations	Yes No	
Swollen legs	Yes No	
Fainting	Yes No	
Shortness of breath	Yes No	Respiratory
Wheezing	Yes NO	
Coughing up blood	Yes No	
Asthma	Yes No	
Frequent urination	Yes No	GU
Biood in urine	Yes No	
Difficulty urinating	Yes No	
Could you be pregnant	Yes No	
Painful menses	Yes No	
Joint swelling	Yes No	Musculoskeletal
Joint redness	Yes No	
Gout	Yes No	
Muscle aches	Yes No	
Breast lump	Yes No	Breast/skin
Unusual or new rash	Yes No	
Paralysis	Yes No	Neuro
Stroke	Yes No	
Seizures	Yes No	
Loss of memory	Yes No	
Depression	Yes No	Psychological
Suicide attempts	Yes No	
Anxiety	Yes No	
Diabetes	Yes No	Endocrine
Excessive thirst	Yes No	
Bleeding	Yes No	Heine
Easy bruising	Yes No	
Allergy to shellfish	Yes No	Allergy
Allergy to X-ray dye	Yes No	

Patient Signature: Date:

METABOLIC BIOTRANSFORMATION QUESTIONNAIRE

Patient Name:_____Date:_____
Rate each of the following symptoms based upon y our typical health profile
Point Scale 0-Never or almost never have the symptoms
1-Occasionally have it, effect is not severe
2-Occasionally have it, effect is severe
3-Frequently have it, effect is not severe
4-Frequently have it, effect is severe

HEAD
____Headaches
____Faintness
____Dizziness
____Insomnia
____Total

EYES
____Watery or itchy eyes
____Swollen, reddened or sticky eyelids
____Bags or dark circles under eyes
____Blurred or tunnel vision
____Total

EARS
____Itchy ears
____Earaches, ear infections
____Drainage from ear
____Ringing in ears, hearing loss
____Total

NOSE
____Stuffy nose
____Sinus problems
____Hay fever
____Sneezing attacks
____Excessive mucus formation
____Total

MOUTH/THROAT
____Chronic coughing
____Gagging, frequent need to clear throat
____Sore throat, hoarseness, loss of voice
____Swollen or discolored tongue, gums, lips
____Canker sores
____Total

SKIN
____Acne
____Hives, rashes, dry skin
____Hair loss
____Excessive sweating
____Flushing, hot flashes
____Total

HEART
____Irregular or skipped heartbeat
____Rapid of pounding heartbeat
____Chest pain
____Total

LUNGS
____Chest congestion
____Asthma, bronchitis
____Shortness of breath
____Difficulty breathing ____Total

DIGESTIVE
____Diarrhea
____Constipation
____Bloated Feeling
____Belching, passing gas
____Heartburn
____Intestinal/stomach pain
____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

WEIGHT
____Binge eating/drinking
____Craving certain foods
____Excessive weight
____Compulsive eating
____Water retention
____Underweight
_____Total

ENERGY/ACTIVITY
____Fatigue, sluggishness
____Apathy, lethargy
____Hyperactivity
____Restlessness
_____Total

MIND
____Poor memory
____Confusion, poor comprehension
____Poor concentration
____Poor physical coordination
____Difficulty in making decisions
____Stuttering or stammering
____Slurred speech
____Learning disabilities
____Total

EMOTIONS
____Mood Swings
____Anxiety, fear, nervousness
____Anger, irritability, aggressiveness
____Depression
_____Total

OTHER
____Frequent illness
____Frequent or urgent urination
____Genital itch or discharge
____Total

CARBOHYDRATE TOLERANCE ASSESSMENT

NAME:_____**DATE:**_____

For each of the questions, answer yes if it usually applies to you and no if it usually does not. Nevertheless, answer each question. Answer as if you were not on a diet or worrying about caloric consumption or about your weight.

PLEASE ANSWER YES OR NO TO EVERY QUESTION

(5)_____I have high blood pressure.
(3)_____I have high blood cholesterol.
(5)_____I have high blood triglycerides
(3)_____I get tired and or hungry in the mid-afternoon.
(5)_____I gain weight easily, especially around my waist and have difficulty losing it.
(5)_____An hour or two after eating a full meal that includes dessert, I want more sweets/snacks.
(5)_____I often experience mental confusion or brain fog.
(3)_____Once I start eating sweets, starches or snack food, I often have a difficult time stopping.
(5)_____I often experience fatigue and generalized weakness.
(3)_____I would rather have an ordinary meal that included dessert than a gourmet meal that did not include dessert.
(10)____I have diabetes/high blood sugar/my blood sugar is not stable.
(5)_____I have a family history of high blood sugar/diabetes.
(5)_____After finishing a full meal, I sometimes feel as if I could go back and eat the whole meal again.
(3)_____I have a family history or obesity/overweight relatives.
(3)_____A meal of only meat and vegetables leaves me feeling unsatisfied.
(3)_____If I am feeling down, a snack of cake, cookies, or chocolate makes me feel better.
(3)_____If potatoes, bread, pasta or dessert are on the table, I will often skip eating vegetables or salad.
(4)_____I get sleepy, almost "drugged" feeling after eating a large meal containing bread or pasta or potatoes and dessert.
(3)_____I have a hard time going to sleep at times without a bedtime snack.
(3)_____At times I wake in the middle of the night and can't go back to sleep unless I eat something.
(4)_____I get irritable if I miss a meal of mealtime is delayed.
(2)_____At a restaurant I almost always eat too much bread, even before the meal is served.

_____TOTAL SCORE

What your score indicates:

10-15	It is very unlikely that you are carbohydrate intolerant
16-20	There is a possibility that you are carbohydrate intolerant
21-40	Your symptomatology could be due to carbohydrate intolerance
40 and Above	You are definitely carbohydrate intolerant and need to discuss further with your doctor

AGREEMENT CONCERNING SCOPE OF CARE

Dear Patient,

You have come to as with the desire to improve your general health through Complementary and Alternative Medicine(CAM). You may or may not at the same time be under the care of another physician for primary care or for a specific aliment, it is important to understand clearly the scope and extent of CAM which we expect to render in your case. Since nutritional deficiency may or may not be associated with a specific disease, or may be the cause of that disease, or may **occur** as **a** result of that disease, our concern in your case **will** be with your nutritional program and your lifestyle and your ability to metabolize and utilize the nutrients you consume. If you have a specific disease and desire treatment for that specific disease entity, you should place yourself under the care of a specialist for such diagnosis and treatments as may be indicated or desired by you.

In our lifestyle changes, CAM and nutritional management of your case, we may prescribe vitamins, herbs, minerals, enzymes, and naturopathic and nutritional supplements. The purpose of these natural prescriptions is limited to:

-Improvement of your overall nutritional status
-Improvement of your metabolism
-Increasing your sense of well-being
-Normalizing your appetite
-Reducing your pain and discomfort
-Balance your mind body constitution

It is important to understand that you may not receive any of these benefits. Results do not occur predictably in every patient, and in some cases they do not occur at all.

Our viewpoint concerning Complementary and Alternative Medicine(CAM) and the diagnostic evaluation of disease is not necessarily shared by the American Medical Association, the Food and Drug Administration, the American Cancer Society, the Arthritis Foundation, the American Heart Association or similar agencies or organizations. Though significant evidence exists to consider such diagnostics and natural treatments safe and effective, the above agencies or organizations may consider them unproved, investigational or experimental. Signing below you acknowledge that, with full knowledge of these disagreements, you desire to undertake diagnostic evaluation and have prescribed in your case such nutritional supplements and natural treatments which, in our opinion, appear to be indicated in your condition.

I have read and understand the above. Under conditions indicated, I hereby place myself under your care for such diagnosis, care, treatment, prescription, and therapies that are indicated in your judgment.

PATIENT/DATE_____WITNESS_____