

NUTRITION HISTORY FORM

Rose Clinic, A Professional Medical Corp.

530 Lomas Santa Fe Drive Suite B-1 Solana Beach, CA 92075

Phone: 858-755-8955 Fax: 858-755-8959

www.roseclinic.us

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Occupation:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
Street address, cont'd:			Work phone no.: ()		Cell phone no.: ()		
City:		State:		ZIP Code:		Email Address:	
How did you hear about Rose Clinic?							
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	<input type="checkbox"/> Internet		
Other family members seen here:							

NUTRITION HISTORY QUESTIONS

1. Do you smoke? _____ **Toxins, Stress, NT Imbalance**
2. Drink alcohol? _____ **Toxins, Stress, NT Imbalance**
3. How much/when? _____
4. Do you drink caffeine every morning? **Stress, Toxins, IR** _____
5. Do you have food allergies, restrictions, or sensitivities? _____ **Gut/Food Allergies**
Describe your daily energy levels: Stress, Sleep, Nutrient Deficiencies

6. Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? _____ **Stress, IR**
7. Do you crave certain foods? _____ **NT Imbalances, Stress, Nutrient Deficiencies, Food Allergies**
8. If so, which foods and when? _____

9. Do you crave any of the following?

<input type="checkbox"/> Sugar	<input type="checkbox"/> Meat Fat	<input type="checkbox"/> Chocolate	<input type="checkbox"/> Fish	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Desserts	<input type="checkbox"/> Milk	<input type="checkbox"/> Bread	<input type="checkbox"/> Fried foods	<input type="checkbox"/> other _____

10. Do you take any nutritional supplements or vitamins? _____ If so, which ones? (Be specific. Attach sheets if necessary) **Nutrient Deficiencies, Toxins** _____

11. Which oils do you use/consume? **AA/EPA Ratio, Toxins, Nutrient Deficiency**

<input type="checkbox"/> Butter	<input type="checkbox"/> Peanut Oil	<input type="checkbox"/> Canola	<input type="checkbox"/> Margarine	<input type="checkbox"/> Corn Oil
<input type="checkbox"/> Sun/Safflower	<input type="checkbox"/> Olive Oil	<input type="checkbox"/> Crisco	<input type="checkbox"/> Mayonnaise	<input type="checkbox"/> Coconut Oil

<input type="checkbox"/> Vegetable Oil	<input type="checkbox"/> Flaxseed Oil	<input type="checkbox"/> Soybean Oil	<input type="checkbox"/> other _____	
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12. Do you eat primarily organic foods? **Toxins** _____
13. How many bowel movements do you have a day? **Gut Health, Nutrient Deficiency** _____
14. Rank your skin without lotion:

<input type="checkbox"/> Very Dry	<input type="checkbox"/> Dry	<input type="checkbox"/> Normal	<input type="checkbox"/> Oily	<input type="checkbox"/> Combination
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15. Please check off any of the following that pertain to you (past or present – please mark present conditions with a P next to it):

<input type="checkbox"/> Acne Toxins, GUT, NUT DEF, HOR IMB <input type="checkbox"/> Addiction (alcohol, drugs) NT IMB, STRESS <input type="checkbox"/> Anemia NUT DEF <input type="checkbox"/> Anorexia NUT DEF <input type="checkbox"/> Anxiety or nervousness NT IMB, STRESS <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) GUT, EFA DEF <input type="checkbox"/> Bladder infections (Cystitis) <input type="checkbox"/> Bloating, gas or indigestion GUT <input type="checkbox"/> Blood Sugar STRESS, IR <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer STRESS <input type="checkbox"/> Chronic fatigue STRESS, NUT DEF <input type="checkbox"/> Cold Sores STRESS <input type="checkbox"/> Colds or flu (frequent) <input type="checkbox"/> Constipation GUT, NUT DEF, Thyroid <input type="checkbox"/> Dandruff NUT DEF <input type="checkbox"/> Depression NT IMB <input type="checkbox"/> Diabetes I (insulin dependent) <input type="checkbox"/> Diabetes II (adult onset) IR <input type="checkbox"/> Diarrhea GUT, NUT DEF <input type="checkbox"/> Difficulty gaining weight <input type="checkbox"/> Difficulty losing weight <input type="checkbox"/> Emotional problems (instability or sensitivity) NT IMB <input type="checkbox"/> Emphysema <input type="checkbox"/> Fainting <input type="checkbox"/> Gall bladder problems NUT DEF <input type="checkbox"/> Panic attacks NT <input type="checkbox"/> Gout IR <input type="checkbox"/> Hair loss Thyroid NUT DEF, <input type="checkbox"/> Headaches NT IMB, NUT DEF	<input type="checkbox"/> Heart disease IR <input type="checkbox"/> Heartburn GUT <input type="checkbox"/> Hemorrhoids GUT, NUT DEF <input type="checkbox"/> Herpes simplex Stress <input type="checkbox"/> High blood pressure IR, STRESS <input type="checkbox"/> High cholesterol IR, Thyroid <input type="checkbox"/> HIV <input type="checkbox"/> Hot flashes HOR IMB, STRESS <input type="checkbox"/> Hypoglycemia STRESS, IR <input type="checkbox"/> Insomnia NT IMB, NUT DEF, STRESS <input type="checkbox"/> Intestinal problems GUT <input type="checkbox"/> Kidney stones NUT DEF <input type="checkbox"/> Liver problems TOXINS <input type="checkbox"/> Loose stools GUT, NUT <input type="checkbox"/> Memory loss or confusion IR <input type="checkbox"/> Multiple chemical sensitivity Toxins <input type="checkbox"/> Nails, poor growth NUT DEF <input type="checkbox"/> Parasites GUT <input type="checkbox"/> Pregnant /nursing NUT DEF <input type="checkbox"/> Respiratory problems <input type="checkbox"/> Ringing in ears STRESS <input type="checkbox"/> Seizures NT IMB <input type="checkbox"/> Severe mood swings NT IMB <input type="checkbox"/> Skin conditions NUT DEF, GUT <input type="checkbox"/> Stroke IR <input type="checkbox"/> Suicidal tendencies NT HOR IMB, <input type="checkbox"/> Thyroid condition Thyroid <input type="checkbox"/> Ulcer GUT, STRESS <input type="checkbox"/> Yeast infections Toxins, STRESS
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<u>Women: Please check all that pertain:</u>	<u>Men: Please check all that pertain:</u>
<input type="checkbox"/> PMS HOR IMB, STRESS <input type="checkbox"/> Irregular periods HOR IMB, STRESS <input type="checkbox"/> Painful periods HOR IMB, STRESS <input type="checkbox"/> Loss of periods HOR IMB, STRESS <input type="checkbox"/> Menopause HOR IMB, STRESS <input type="checkbox"/> Painful intercourse HOR IMB, STRESS <input type="checkbox"/> Children HOR IMB, STRESS <input type="checkbox"/> Hysterectomy HOR IMB, STRESS	<input type="checkbox"/> Frequent urination HOR IMB, STRESS <input type="checkbox"/> Difficulty urinating HOR IMB, STRESS <input type="checkbox"/> Difficulty with erection HOR IMB, STRESS <input type="checkbox"/> Loss of libido HOR IMB, STRESS <input type="checkbox"/> Prostate enlargement HOR IMB, STRESS

16. Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease). **IR, THYROID, TOXINS**

17. How is your dental health?

18. Have you had silver dental fillings? _____ How many? _____

19. Have they been removed? _____

20. Do you use environmentally friendly household products?

21. Do you exercise? _____ If so, what kind?

22. How often: Since when?

23. Please rate the following:

a. Daily energy level:

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	
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b. Energy level after exercise:

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	
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c. Daily stress level:

<input type="checkbox"/> Very High	<input type="checkbox"/> High	<input type="checkbox"/> Moderate	<input type="checkbox"/> Low	<input type="checkbox"/> None
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d. Do you have a support system of family and friends? _____

e. General enjoyment of life:

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	
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f. How many hours do you sleep? _____ Do you sleep throughout the night? _____

g. Do you wake up without an alarm? _____

h. Do you wake up feeling rested? _____ Do you fall asleep within 15 minutes? _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a Notice of Privacy Policies, from Jeanne Stryker MD detailing how my information may be used and disclosed as permitted under federal and state law. I understand that the Privacy Practices describes the personal information your office collect and how and when your office use or disclose that information. It also describes my rights as they relate to my protected health information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations. If I do not accept this disclosure I understand that I must be notified when anything in my medical chart is going to be disclosed, to another physician or medical professional and that I must come in and sign for the medical release form of the items that are requested. I have listed below the following person(s) within my family or close friend(s) whom Dr. Jeanne Stryker can discuss my personal medical information with:

Name:	Relationship to patient:	Home phone no.:	Work phone no.:	Cell phone no.:
1.				
2.				
3.				
4.				
5.				

I accept my medical information may be disclosed under federal and state law.

I hereby authorize payment directly to Dr. Jeanne Stryker for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Dr. Jeanne Stryker and/ or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature:	Date
Print Name:	Date
Reviewed by:	Date

PAYMENT INFORMATION

Payment is required in full for each visit. We are happy to provide you with coding information which you may submit to your insurance company for reimbursement. If you would like to keep a credit card on file for payments and or shipments please provide us with your credit card information.

Credit Card Number:	Expiration Date: / /	VISA, AMEX, MasterCard	Security Code:
Cardholder Name:	Signature:	Date: / /	

I authorize Dr. Jeanne Stryker to keep my signature on file and charge services and/or products on an ongoing basis. I understand this form is valid unless I cancel the authorization through written notice.

I have read the above billing information and give my consent for treatment at Rose Clinic.