

Whole Health Associates

Center for Integrative Medicine

Thank you for choosing our office to meet your Traditional Chinese Medicine needs. In addition to Acupuncture, you will have access to Herbal medicine, Homeopathy, Neuro-Emotional Technique, Allergy Elimination, Nutritional counseling, Massage therapy, Chiropractic, and Jin Shin Jyutsu. Our goal is to provide a safe, healing environment and to support you in your pursuit of optimal well-being.

Your initial visit will take up to one and a half hours. Please plan your schedule accordingly. We will do a thorough health interview and history, a physical exam, and then work together with you to develop a personalized treatment plan. You will have ample time to ask any questions you may have.

Please note that because this time has been reserved especially for you, **we require at least 48 hours notification of any scheduling changes on first appointments, 24 hours on follow up appointments. You will be billed for any missed appointments at the regular appointment rate.**

If you are taking any medications, vitamins, herbs, or other supplements, please bring them in their original bottles with you. We wish to determine the impact they may be having on your body.

Directions to our office are in this packet.

To help us better serve you, please take some time to complete and sign the enclosed forms and **return them to our office by Fax (415-492-9350) or mail so we receive them at least two days prior to your appointment.** Please include copies of any recent laboratory test results that you may have. Please write "Attention: Patient Records" on the envelope. If you have any questions, feel free to call us.

Sincerely,

Stephen Zilber, L.Ac.



Stephen Zilber, L.Ac.

A Professional Corporation

Vibrant health comes naturally when the body, mind, and spirit are in balance. Too often in our demanding lives, we fall out of balance and experience the result as pain, fatigue, stress and illness. Acupuncture and herbal medicine alleviate pain, boost energy, calm the mind, and harmonize all levels of the body.

Using gentle and effective techniques, I can help you regain and maintain a state of natural balance and health. By giving you the tools to support your own healing, you and your family can enjoy life-long health. I bring compassion, understanding and skill to treat a wide range of conditions in adults and children, including:

- Acute and chronic pain
- PMS, Menopause, and Infertility
- Infant through adolescent health
- Stress, Anxiety, Depression, & Addiction
- Common Colds & Flu
- Allergies and Chemical sensitivities
- Rashes, Eczema and Psoriasis
- Respiratory and Digestive disorders
- Weight Management
- Fatigue and Insomnia
- Immunity disorders

I use a variety of diagnostic and treatment methods to identify and balance the body's underlying disharmonies and stresses that lead to symptoms and disease. These include Chinese, Japanese and Korean style acupuncture (non-needle available), Neuro-Emotional Technique, Integra Allergy Elimination, herbal medicine, homeopathy, BioTerrain analysis, Functional medicine testing, dietary counseling and nutritional supplementation.

I am California licensed and nationally board certified in acupuncture and Chinese herbology. An enthusiastic teacher, I have served on the faculty of the American College of Traditional Chinese Medicine in San Francisco, lectured at UCSF Medical School and Touro University College of Osteopathic Medicine and am a past board director of the California State Oriental Medical Association.



Center for Integrative Medicine

880 Las Gallinas Ave., Suite #1
San Rafael, California 94903
(415) 492-WELL (9355)
www.wholehealth.tv

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DIRECTIONS TO OUR OFFICE

From the North:

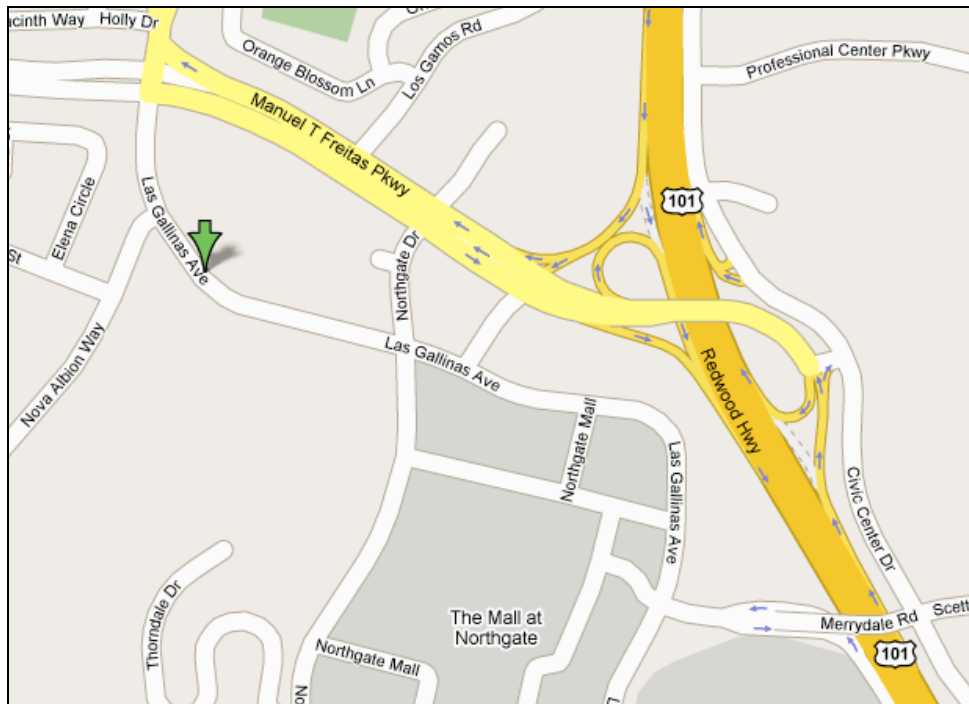
Go south on Highway 101 to the Freitas Pkwy/Terra Linda exit. Bear to the right after the exit (follow the sign to Terra Linda) onto Manuel T. Freitas Parkway. Just past the Safeway supermarket, turn left at the traffic light onto Las Gallinas Avenue. Continue through the next traffic light (Nova Albion Way). 880 Las Gallinas is the 2nd building on the left. Our office is in suite #1, at the rear of the courtyard on the upper level.

From the South:

Go north on Highway 101 to the Freitas Pkwy/Terra Linda exit. Continue straight on the exit ramp, crossing over the highway. Stay in the middle lane and continue straight onto Manuel T. Freitas Parkway. Just past the Safeway supermarket, turn left at the traffic light onto Las Gallinas Avenue. Continue through the next traffic light (Nova Albion Way). 880 Las Gallinas is the 2nd building on the left. Our office is in suite #1, at the rear of the courtyard on the upper level.

Parking:

2 hour un-metered street parking is available along Las Gallinas Avenue. You can also park in the lot under our building. This is accessed from Nova Albion Way – the alley that runs behind Safeway and our office building. Ours is the 2nd building down the alley on the right. Look for the Whole Health Associates banner on the building. Please park in the stalls marked “Reserved for Whole Health Associates.”



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Office Policies and Procedures

Initial Appointments:

- All initial paperwork must be completed, signed, and received by our office at least 2 business days prior to your scheduled appointment or your appointment may be cancelled. You may fax us these forms (415-492-9350), but the originals should be brought to our office at your visit.
- Any changes in scheduled first appointments must be made at least 2 business days in advance. **Missed or late changed appointments will be charged at the full visit rate.**

Cancellations and Changes:

- As a courtesy, our office will call you to confirm your appointment 1 business day in advance.
- If you cannot keep a scheduled appointment, you must notify us a minimum of 1 business day prior to your scheduled time, or you will be charged for the missed appointment.
- If your appointment is on Monday, please notify our office of changes or cancellations no later than noon on the previous Friday.
- Patients who forget their appointment or cancel less than 1 business day prior to their appointment will be required to pay for the missed visit. Please understand that a missed appointment could have gone to a patient on the waiting list. Reminder calls from our office are made as a courtesy; Patients are responsible for their scheduled appointments.

Your Visits:

- As a courtesy to patients with allergies and chemical sensitivities, please refrain from wearing perfumes or heavily scented products when in our office. Please turn off or silence your cell phone while in our office.
- We value our patients' time. In order to keep on schedule, we request that you arrive on time for your appointments. If you are more than 10 minutes late for a scheduled appointment, we may not be able to see you and will treat it as a missed appointment. Please allow sufficient travel time and take traffic conditions into consideration.
- Please allow enough time for your complete visit. If you know you need to leave our office by a specific time, please let us know when you first arrive and we will do our best to accommodate you.
- Laboratory test results must be received by our office at least 24 hours prior to the appointment where they will be discussed.

Herbs, Supplements & Prescriptions:

- If for any reason you are unable to take your prescribed items as directed or have questions about their use, please let our office know as soon as possible.
- Unopened bottles in resalable condition can be returned for office credit within 30 days of purchase.
- Refrigerated items cannot be returned. Special order items cannot be returned.

Payment:

- Payment is due at the time of your appointment, unless alternate financial arrangements have been made.
- Accepted methods of payment are: Visa, MasterCard, check and cash.
- We require all patients to have a current signed credit card authorization form on file to secure your appointments and mailed prescriptions.

Insurance:

In order to help control your health care costs, our office does not directly bill insurance companies. A "Superbill" receipt (form detailing diagnostic codes and fees) can be provided to you for each visit. This receipt can be submitted to your insurance carrier for reimbursement. Some services and conditions may not be covered by certain health insurance plans. It is your responsibility to know what your insurance plan covers. We are not responsible for unpaid claims by your insurance company for services we provide. Our office does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.

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(415) 492-9355

Today's Date: _____

Patient Information

Please Print Clearly

Name: _____ Gender: _____ Birth Date: _____

Preferred Name: _____ Place of Birth: _____

Mailing Address _____ City _____ State _____ Zip _____ Home Tel: _____

Social Sec # _____ Marital Status: _____ Mobile Tel: _____

Occupation: _____ Employer: _____ Work Tel: _____

Work Address _____ City _____ State _____ Zip _____

Email Address: _____

Relative or Friend to Contact in Case of Emergency:

Name _____ Relationship _____ Telephone _____

How did you hear about our clinic? _____

If the Patient is a minor, please complete the following information:

Responsible Party: Name _____ Relationship _____ Telephone _____

Address _____

Primary Insurance / Assignment and Release

Payment is required at the time of service. We accept cash, checks, Visa, and MasterCard. We will gladly provide you with a superbill to submit for insurance reimbursement. Please contact your insurance company for information about what services they will cover.

I, the undersigned certify that I (or my dependent) have insurance coverage with the stated insurance company and assign directly to the treating physician all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, such as lab work or Medicare.

Insurance Company: _____

Insurance Type: (please circle) HMO PPO/POS Auto/Med-Pay Medicare HSA / MSA

Yes, please provide me with a superbill for services

Signature _____ Date _____

Appointment Punctuality & Cancellation Notice

The appointment time you requested is reserved especially for you and your provider. Out of mutual respect, we request that you be on time for you appointment. If you arrive late, we will do our best to accommodate you; however, you will still be responsible for the full fee even though your appointment time may have to be shortened or rescheduled. **In addition, we ask at least 24 hours notice for any changes of your appointment.** This allows us to schedule other clients and helps you avoid paying for unattended office visits.

We understand that situations occur where it is in the best interest of both the client and provider to terminate the relationship. In these cases, we will do our best to refer the client to someone who may better meet their needs. However, we do maintain the option to deny services to anyone at any time. I have read, understand, and agree to the appointment punctuality and cancellation notice request.

Signature _____ Date _____

**Patient Authorization for Appointment Reminders
Scheduling-Related Matters, Related Health Services
and/or Related Health Products**

It is our desire for our staff to use your name, address, e-mail address and /or telephone number for the purpose of contacting you to remind you about scheduled appointments or other appointment-related issues. We would also like to advise you about health-related meetings, workshop, and products.

The use of this information is intended to make your experience with our office more efficient, and productive. We want to enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no effect on your care from Whole Health Associates or your relationship with our staff.

Please check here if address and phone numbers are the same as on the front. Please indicate which numbers to use for reminder calls, messages, or don't call.

Mailing Address

City	State	Zip
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E-Mail Address

Please indicate which number to use for:	Reminders	Messages	Don't Call
Home Telephone: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Telephone: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cell Telephone: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-Mail Address: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Would you like to be on our mailing list? Y N

Would you like to receive email newsletters? Y N

Your signature indicates your authorization of this activity.

Name (Printed)	Signature	Date
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You may revoke this authorization at any time. Please advise us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

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Credit Card Authorization

We require a current credit card number on file to secure your appointments and for any mailed prescriptions or special orders. We will never charge this number without giving you prior notice.

I, (print name) _____ authorize Whole Health Associates and its practitioners, located at 880 Las Gallinas Ave., Suite #1, San Rafael, CA 94903 to bill my credit card as listed below:

Name on Credit Card _____

Credit Card Details

Circle one: Visa MasterCard

Card # _____

Exp date: _____

CVS code (3 digit security code on back of card): _____

Billing Address

Address: _____

City: _____ State: _____ Zip: _____

Phone (include area code): _____

Authorization

Card Holder's Signature

Today's Date

This authorization can be revoked upon your written notice to our office.

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INFORMED CONSENT TO CARE AND TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various physical modalities, on me (or on the patient named below, for whom I am legally responsible) by licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up in this office.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, infrared therapy, electrical stimulation, massage, herbal medicine and nutritional counseling. I have had the opportunity to discuss with the treating physician or other clinic personnel the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a generally safe method of treatment, but as with all medical procedures, it may have some side effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this office uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental medicine, although some may be toxic in large doses. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs or nutritional supplements. I understand that some herbs or supplements may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of the treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interests. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent to treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE: X _____
(or Patient's Representative) (Indicate relationship if signing for patient)

DATE:

Health and Lifestyle Overview

Name: _____

Today's Date: _____

Please tell me what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach additional sheets if more space is required).

Is your health currently getting better, worse, or staying the same. How do you know?

What have you tried to do to improve your state of health (e.g. other doctors, treatments, etc)?

Please list the names, phone #'s and specialties of all other health care providers with whom you are currently working and the condition(s) they are treating:

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

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

- a.
- b.
- c.
- d.
- e.

Why did you choose our office?

For our time together to be successful, what do you want to take place over the course of your care here?

How long do you feel this will take?

Do you feel your pain and/or illness is a reflection of short-term superficial circumstances or longer term, potentially deeper-seated challenges?

Do you think the pain and/or symptoms that you are experiencing could be purposeful? Could they be your body's wisdom saying, "I need some help... let's change some things here!" Please explain:

What areas of your lifestyle are likely involved with your condition and you would like to improve:
(Prioritize # 1, 2, 3, etc.)

- | | |
|---|--|
| <input type="checkbox"/> My level of anxiety | <input type="checkbox"/> Not enough time spent in nature |
| <input type="checkbox"/> My pace of living | <input type="checkbox"/> My creative expression |
| <input type="checkbox"/> Not enough quiet time and rest | <input type="checkbox"/> My feelings around career |
| <input type="checkbox"/> My diet and nutrition program | <input type="checkbox"/> My social and family life |
| <input type="checkbox"/> My exercise program | <input type="checkbox"/> My communication skills |

Please list your special interests and passions:

Please list any self-destructive lifestyle habits (e.g. smoking, lack of exercise, insufficient sleep, addictions, etc.)

What might it cost you if you don't improve your lifestyle and underlying contributors to your compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

List your 3 highest priorities in life which come to mind and speak to your heart. Where does your health and vitality factor in?

- a.
- b.
- c.

What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed).

What obstacles could prevent you from changing those lifestyle factors that are undermining your health?

What might stop you from following the therapeutic protocols that I may prescribe for you?

Who would be willing to support you in your health goals?

Patient Medical History

Name _____ Sex ____ Date of Birth _____ Age _____
 Height _____ Weight _____ Place of Birth _____
 Religion (optional) _____
 Marital Status: Single Married Domestic Partner Divorced Widowed Other
 Names, Ages & Genders of children:

Occupation: _____

Women only (next four lines):

Age at onset of menstruation: _____ Date of most recent menses: _____
 Are you peri-menopausal? _____ Age at onset of menopause: _____
 # of pregnancies: _____ # of miscarriages: _____
 # of abortions: _____ # of deliveries: _____

How was your health as a child? (circle one): excellent good fair poor

Were there any complications with your delivery? Please explain: _____

Were you breast fed? _____ How long? _____

Did you have any serious emotional or mental traumas as a child? Please explain: _____

Check diseases for which you have been immunized:

Measles Mumps Rubella Small pox Influenza Tetanus Diphtheria other _____

What is your blood type? (circle one): **A** **B** **AB** **O** **don't know**

Serious Illnesses / Injuries / Surgeries	Date	Outcome

Allergies	Type of Reactions
Animal hair/dander:	
Chemicals:	
Drugs, medications:	
Dust, molds:	
Food:	
Grasses, weeds, pollen:	
Others:	

Tests History

Please list the date of your most recent procedures. Circle any that were abnormal:

Test	Year	Test	Year	Test	Year	Test	Year
<input type="checkbox"/> Chest x-ray		<input type="checkbox"/> TB Test		<input type="checkbox"/> Pap Smear		<input type="checkbox"/> PSA	
<input type="checkbox"/> Kidney x-ray		<input type="checkbox"/> EKG		<input type="checkbox"/> Mammogram		<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> G.I. Series		<input type="checkbox"/> MRI		<input type="checkbox"/> Sigmoidoscopy		<input type="checkbox"/> Others:	
<input type="checkbox"/> Colon x-ray		<input type="checkbox"/> CAT Scan		<input type="checkbox"/> Colonoscopy			
<input type="checkbox"/> Spine x-ray		<input type="checkbox"/> Cholesterol		<input type="checkbox"/> Rectal Exam			
<input type="checkbox"/> Blood Tests		<input type="checkbox"/> Cardiac Stress Test		<input type="checkbox"/> Hormone Tests		<input type="checkbox"/> Complete Physical Exam	

Health Habits (Please print clearly)

Please list all medications (prescription & OTC), vitamins & supplements, herbs, and homeopathic remedies you are currently taking, dosage, who prescribed or recommended them and the condition you take them for (attach a separate sheet if necessary):

Please circle any of the following medications you are currently taking or have taken within last 3 months:

- | | | | |
|---------------------------|---------------------|-------------------------|------------------|
| Allergy medication | Chemotherapy | Oral Contraceptives | Thyroid |
| Antacids | Cortisone | Pain Medication | Ulcer Medication |
| Anti-inflammatory | Heart Medications | Psychiatric medications | Other _____ |
| Antibiotic / Anti-fungal | High Blood Pressure | Radiation | _____ |
| Antidepressants | Hormones | "Recreational" Drugs | _____ |
| Antidiabetic/insulin | Laxatives | Relaxants | _____ |
| Aspirin / Tylenol / Advil | Lithium | Sleeping Pills | |

Do you now or have you in the past:
(Circle day / week / month, as appropriate):

- | | | |
|--|------------------------------|---------------------------|
| <input type="checkbox"/> Use tobacco (smoke/chew) | _____ packs per day / week | For how many years? _____ |
| <input type="checkbox"/> Smoke marijuana | _____ times per day / week | For how many years? _____ |
| <input type="checkbox"/> Use recreational drugs | _____ times per week / month | For how many years? _____ |
| Types: _____ | | |
| <input type="checkbox"/> Drink coffee | _____ cups per day / week | For how many years? _____ |
| <input type="checkbox"/> Drink black/green/chai tea | _____ cups per day / week | For how many years? _____ |
| <input type="checkbox"/> Drink alcohol (type: _____) | _____ drinks per day / week | For how many years? _____ |
| <input type="checkbox"/> Drink sodas | _____ drinks per day / week | For how many years? _____ |
| <input type="checkbox"/> Use artificial sweeteners | _____ packets per day / week | For how many years? _____ |

How many times a week do you eat in a restaurant? Breakfast _____ Lunch _____ Dinner _____

What types of restaurants _____

What are your favorite foods: _____

Do you crave sweets? _____ At what time?: _____ Do you salt your food at the table? _____

Are there other foods you crave? (Please Circle) Bread Pasta Dairy Meat Fried Salty
Other: _____

What foods do you really dislike: _____

Do you snack? _____ When (between meals, bedtime, nighttime, all day, etc.)? _____

What types (sweets, chips, nuts, fruit, etc.) _____

Do you regularly skip meals (please circle)? Breakfast Lunch Dinner

Do you make an effort to eat organically grown foods? _____ What % of your diet? _____

Do you drink purified or bottled water? _____ If so, what method/brand do you use? _____

Are you on a restricted diet due to religious or other beliefs (e.g. Hindu, Kosher, Halal, Vegan, etc.)? If so, please describe: _____

Are you on any other specific diet? If so, please specify: _____

Would you like to increase or decrease your weight? If so, by how much: _____

When did you last have a significant (more than 10 pounds) change in weight? _____

Do you currently or have you in the past had issues with eating disorders (anorexia, bulimia, yo-yo dieting, etc.)? If so, please describe: _____

What exercise do you do and how often? _____

How many hours of sleep do you get each night? _____ What time do you usually fall asleep? _____

Do you wake up during the night? What time(s)? _____ Do you wake in the morning rested? _____

Are you presently sexually active? _____ Any difficulties? _____ Method of B.C.? _____

Rate your current stress level from 1-10: _____ How much does this affect you (1-10)? _____

What are the major stresses in your life now? _____

Rate your current emotional health (please circle): excellent good fair poor unstable crisis

Are you currently in psychotherapy? _____ Do you have a good support network/team? _____

Do you have a regular meditative or contemplative practice? Describe: _____

How many hours of relaxation (not including sleep) do you give yourself during the work week? _____

During weekends? _____ Favorite recreational activities? _____

Describe your current living situation (apartment/house/other, rent/own, housemates, family members, etc):

Do you have pets? What types? _____

Does your home environment have a supportive effect on your health? _____ Describe any factors in your home environment that may be affecting your health (noise, mold/dampness, construction, conflicts, etc.)?

Do you have an air purifier in the room you sleep in? _____ What type/brand? _____

Have you traveled or lived in a developing country (where, when)? _____

When was your last eye exam? _____ Do you wear glasses/contacts? _____ Hard or soft? _____

When was your last dental exam/cleaning? _____
Do you have amalgam (silver) fillings? _____ Any other dental problems? _____

Have you been exposed to toxic chemicals? _____ If yes, which ones? _____

Are you considering any elective surgery or medical procedures in the near future? _____

Have you received acupuncture or Oriental Medicine Therapy in the past? With whom? For what condition? How did it work for you? _____

Do you have any questions or concerns about receiving acupuncture or other medical care (please describe)?

Personal Health History: Check the appropriate box if you have experienced any of the following:

<input type="checkbox"/> Adverse reaction to medical treatment	<input type="checkbox"/> Immune Disorder
<input type="checkbox"/> Alcoholism / Chemical Dependency Allergies	<input type="checkbox"/> Kidney Disorder
<input type="checkbox"/> Anemia	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Arthritis or rheumatism	<input type="checkbox"/> Musculo-skeletal Disorder
<input type="checkbox"/> Artificial heart, valve or joints	<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Cancer or Tumor	<input type="checkbox"/> Respiratory Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Eye Disorder	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Gout	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Headaches	<input type="checkbox"/> Stomach or Intestinal Disorder
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Hepatitis, jaundice or Liver disorder	<input type="checkbox"/> Transfusion (before March 1985)
<input type="checkbox"/> Herpes (oral, genital)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Ulcer
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Urinary Tract Disorder
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sexually Transmitted Disease

Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check (x) if your blood relatives have/had:	
					Disease	Relationship
Father					Arthritis, gout	
Mother					Asthma, Allergies	
Brothers					Cancer	
					Alcoholism/Chemical dependency	
					Diabetes	
					Heart disease, stroke	
Sisters					High blood pressure	
					Syphilis, gonorrhea	
					Tuberculosis	
					Mental Illness/Suicide	
					Other	

Diet Survey

Please list everything you eat and drink for 2-3 days:

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