



Why did you choose to come to this clinic? (If someone referred you please let us know who as we have an referral appreciation program and would like to thank them)

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits? (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

**CURRENT HEALTH**

Please list your major health concerns in order of importance:

(Complaint)	(Duration)	(Possible Causes)
(Complaint)	(Duration)	(Possible Causes)
(Complaint)	(Duration)	(Possible Causes)
(Complaint)	(Duration)	(Possible Causes)
(Complaint)	(Duration)	(Possible Causes)

Please list any current MEDICATIONS (prescription, over-the-counter, etc.):

(Medication)	(Duration)	(Adverse Effects, if any)
(Medication)	(Duration)	(Adverse Effects, if any)
(Medication)	(Duration)	(Adverse Effects, if any)
(Medication)	(Duration)	(Adverse Effects, if any)
(Medication)	(Duration)	(Adverse Effects, if any)
(Medication)	(Duration)	(Adverse Effects, if any)
(Medication)	(Duration)	(Adverse Effects, if any)
(Medication)	(Duration)	(Adverse Effects, if any)

Please list any current SUPPLEMENTS (vitamins, minerals, herbs, etc.)

(Supplement)	(Duration)	(Adverse Effects, if any)
(Supplement)	(Duration)	(Adverse Effects, if any)
(Supplement)	(Duration)	(Adverse Effects, if any)
(Supplement)	(Duration)	(Adverse Effects, if any)
(Supplement)	(Duration)	(Adverse Effects, if any)

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(Supplement)

(Duration)

(Adverse Effects, if any)

Digestion

How many bowel movements do you have/day?  
week:

If not every day, then per

Is the stool hard, loose or formed?

Any pain?

Bleeding?

Mucus?

Sleep

How many hours of sleep do you get per night on average?

How long does it take you to fall asleep?

How many times do you wake up during the night on average?

Do you have trouble falling back to sleep?

Stress

Please list the main sources of your stress:

How has this stress affected your life?

On a scale of 1 to 10 with 10 being the highest, please indicate your stress level now.

Fitness

Do you exercise? Yes / No

What type?

How often?

Diet:

How many meals do you typically eat each day? \_\_\_\_\_

Who cooks or prepares your food? \_\_\_\_\_

How many days per week do you eat out/order out? \_\_\_\_\_

Do you have any food allergies? Yes/No

Which food(s)? \_\_\_\_\_

Do you have any food cravings? Yes / No

If yes, which food(s)? \_\_\_\_\_

Do you exclude any foods from your diet? Yes / No

If yes, which food(s)? \_\_\_\_\_

What percentage of your diet is organic? \_\_\_\_\_

Fill in what you consume for the following:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

Are you satisfied with your current diet? Yes / No

How many glasses of water do you drink per day? \_\_\_\_\_

Do you tend to be thirsty? Yes / No

Which of the following do you currently use?

Coffee	Yes / No	How Often? _____
Tobacco	Yes / No	How Often? _____
Alcohol	Yes / No	How Often? _____
Recreational Drugs	Yes / No	How Often? _____

Toxin/Chemical Exposure

Please indicate which of the following personal care products you use:

Antiperspirant	Mouthwash	Moisturizer
Perfume	Hairspray	Make-Up
Aftershave	Gel	Teeth Whitening Products
Cologne	Antibacterial Soap	Hair Dye

Please indicate which of the following you use in your home:

Bleach	Windex	Other:
Air Freshener	Carpet Cleaner	Other:

Do you microwave?

Do you use plastic water bottles?

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (arsenic, cadmium, lead, mercury, etc.) at home or at work?

Please list:

MEDICAL HISTORY:

Please list any major injuries you have sustained:

1. \_\_\_\_\_  
(Injury) (Year) (Long Term Effects)
2. \_\_\_\_\_  
(Injury) (Year) (Long Term Effects)
3. \_\_\_\_\_  
(Injury) (Year) (Long Term Effects)

Please list all surgeries:

1. \_\_\_\_\_  
(Procedure) (Year) (Complications, if any)
2. \_\_\_\_\_  
(Procedure) (Year) (Complications, if any)
3. \_\_\_\_\_  
(Procedure) (Year) (Complications, if any)

Which of the following conditions have you had? (Check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Crohn's Disease      | <input type="checkbox"/> Liver/Pancreatic Disease |
| <input type="checkbox"/> Measles        | <input type="checkbox"/> Ulcerative Colitis   | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Appendicitis         | <input type="checkbox"/> Gall Bladder Disease     |
| <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Kidney Problems          |
| <input type="checkbox"/> Mumps          | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Cushing's Disease        |

Dr. Natasha Zajmalowski ND: Proactive Health Care

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Whooping Cough             | <input type="checkbox"/> Sciatica                 | <input type="checkbox"/> Addison's Disease    |
| <input type="checkbox"/> Scarlet Fever              | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Hypothyroidism       |
| <input type="checkbox"/> Polio                      | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Hyperthyroidism      |
| <input type="checkbox"/> Reye's Syndrome            | <input type="checkbox"/> Sinusitis                | <input type="checkbox"/> Eating Disorder      |
| <input type="checkbox"/> Worms/Parasites            | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Schizophrenia        |
| <input type="checkbox"/> Malaria                    | <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Bipolar Disorder     |
| <input type="checkbox"/> Food Poisoning             | <input type="checkbox"/> Pneumonia/Pleurisy       | <input type="checkbox"/> Clinical Depression  |
| <input type="checkbox"/> Typhoid                    | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Suicidal Tendencies  |
| <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Boils/Impetigo             | <input type="checkbox"/> Rickets                  | <input type="checkbox"/> Lupus                |
| <input type="checkbox"/> Shingles                   | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Myasthenia Gravis    |
| <input type="checkbox"/> Keloids                    | <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Psoriasis                  | <input type="checkbox"/> Environmental Illness    | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Warts                      | <input type="checkbox"/> Human Papillomavirus     | <input type="checkbox"/> Fainting             |
| <input type="checkbox"/> Herpes (Cold Sores)        | <input type="checkbox"/> Chlamydia                | <input type="checkbox"/> Heart Murmurs        |
| <input type="checkbox"/> Canker Sores               | <input type="checkbox"/> Syphilis                 | <input type="checkbox"/> Heart Palpitations   |
| <input type="checkbox"/> Skin Cancer                | <input type="checkbox"/> HIV                      | <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> Yeast Infections (Candida) | <input type="checkbox"/> Genital Herpes           | <input type="checkbox"/> Varicose Veins       |
| <input type="checkbox"/> Colitis                    | <input type="checkbox"/> Gonorrhea                | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Diverticulitis             | <input type="checkbox"/> Spleen Disease           | <input type="checkbox"/> Reynaud's Disease    |
| <input type="checkbox"/> Stomach/Duodenal Ulcers    | <input type="checkbox"/> Hypoglycemia             | <input type="checkbox"/> Platelet Disorder    |
| <input type="checkbox"/> Hiatal Hernia              | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Constipation               | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Uterine Prolapse     |
| <input type="checkbox"/> Pre-eclampsia              | <input type="checkbox"/> Ovarian Cysts            | <input type="checkbox"/> Epilepsy             |
| <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Vaginitis                | <input type="checkbox"/> Meningitis           |
| <input type="checkbox"/> PMS                        | <input type="checkbox"/> Infertility              | <input type="checkbox"/> Cancer, Specify:     |
| <input type="checkbox"/> Uterine Fibroids           | <input type="checkbox"/> Migraine Headaches       | <input type="checkbox"/> Other:               |
| <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Other:               |

Which of the following vaccinations have you received? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> DPT (Diphtheria, Pertusis, Tetanus) | <input type="checkbox"/> Hepatitis B                   |
| <input type="checkbox"/> Haemophils Influenza B              | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) |
| <input type="checkbox"/> Hepatitis A                         | <input type="checkbox"/> Polio                         |
| <input type="checkbox"/> Tetanus Booster; When_____          | <input type="checkbox"/> Smallpox                      |
| <input type="checkbox"/> Flu Shot                            |  |
| <input type="checkbox"/> Other(s) _____                      |  |

Have you ever had an adverse reaction to a vaccination? Yes / No

If yes, which one(s)? \_\_\_\_\_

## SYMPTOMS

Please check all that currently apply to you. Write P for any symptom you experienced in the past.

### GENERALS

- Increase in appetite
- Decrease in appetite
- Weight gain
- Weight loss
- Cancer
- Diabetes
- Poor sleep
- Fatigue
- Allergies
- Chills and fevers
- Night sweats
- Sweat easily
- Cravings
- Strong thirst

### SKIN/HAIR/NAILS

- Rash
- Itchy skin or scalp
- Eczema
- Acne
- Loss of hair
- Dandruff
- Recent moles
- Change in mole
- Color changes
- Lumps
- Dryness
- Hives/allergic reactions
- Boils
- Brittle nails
- Bite nails
- Use nail polish
- Have artificial nails
- Other:

### HEAD/EYES/EARS/NOSE/ THROAT

- Ear aches
- Ear infections
- Ringing in the ear
- Impaired hearing

- Sinus infection
- Enlarged glands
- Recurrent sore throat
- Hoarse voice
- Gums bleed
- Gum pain
  - Tonsillitis
  - Mercury (silver) filling
  - Sores in mouth (canker)
  - Nasal obstruction
  - Post nasal drip
  - Nosebleeds
  - Mouth breather due to stuffiness
  - Snore
  - Headaches
  - Head injury
  - Loss of taste/smell
  - Eye pain
  - Eye strain
  - Itchy eyes
  - Blurry vision
  - Vertigo (dizziness)
  - Blind spot
  - Red eyes
  - Yellowing in eyes
  - Spots in visual field
  - Cataracts
  - Glaucoma
  - Glasses or Contacts
  - Facial pain/tics
  - Jaw pain or clicks
  - Other:

### CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Congestive heart failure
- Chest pain
- Heart attack
- Phlebitis

- Stroke
- Pacemaker or similar device
- Artificial valve
- Irregular heartbeat
- Murmurs
- Palpitations
- Dizziness
- Fainting
- Varicose veins
- Cold hands and feet
- Skin looks blue
- Swelling of limbs

### RESPIRATORY

- Difficulty breathing
- Chronic cough
- Bronchitis
- Asthma
- Emphysema
- Shortness of breath
- Shortness of breath when lying
- Pain on breathing
- Coughing blood
- Throat phlegm
- Wheezing
- Other:

### MUSCLE/BONE/ JOINTS

- Neck pain
- Back pain
- Muscle pain
- Muscle weakness
- Arthritis
- Bursitis
- Artificial joint
- Other:

### GASTROINTESTINAL

- Heartburn
- Ulcer

- Black stool
- Clay colored stool
- Gas
- Burping
- Bad breath
- Constipation
- Diarrhea
- Incomplete bowel movements
- Abdominal pain or cramps
- Nausea
- Vomiting
- Chronic laxative use
- Rectal pain
- Hemorrhoids
- Blood in stool
- Constant hunger
- Bloating
- Gall bladder problems
- Intestinal worms
- Jaundice (yellowing of skin)
- Other:

NEUROLOGICAL

- Loss of balance
- Irritable
- Poor memory
- Anxiety
- Depression
- Dizziness
- Numbness or Tingling
- Twitching
- Lack of coordination
- Seizures/epilepsy
- Concussion
- Loss of sensation on body
- Emotional ups and downs
- Other:

INFECTIONS:

- Hepatitis
- Tuberculosis
- HIV/AIDS

GENITOURINARY

- Frequent urination
- Urgency to urinate
- Pain on urination

- Wake up at night to urinate
- Incontinent (can't hold urine)
- Kidney stones
- Kidney infection
- Blood in urine
- Frequent infections
- Other:

MALE

- Prostate problem
- Impotent
- Sores on genitals
- Pain
- Low sperm count/infertility
- STD
- Hernia
- Sexually active
- Sexual difficulties
- Other:

FEMALE

- Use birth control
- Type:
  - Irregular periods (not every month)
  - Heavy period
  - Light period
  - Clots in period
  - Painful period
  - Vaginal discharge
  - Vaginal Itch
  - Low libido
  - Sexually active
  - Pregnant
  - Trying to conceive
  - Infertility
  - Vaginal sores
  - Mood changes with period
  - Cravings with period
  - Water retention with period
  - Headaches due to period
  - Sore breasts
  - STD
  - Date of last PAP:
  - Age of first period:

- Menopausal (no period for 1 year)
- Age of last period if menopausal:
- Number of pregnancies:
- Births:
- Miscarriages:
- Abortion:

**FAMILY HISTORY:**

Please indicate if the family member is deceased. Please indicate if the family member suffered from any diseases such as: Cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, mental health problems, asthma, allergies, thyroid problems, rheumatoid or osteoarthritis, MS, kidney disease, drug or alcohol abuse, and any other illness not mentioned above.

Relationship	Diseases Suffered
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	
Father	
Mother	
Brother(s)	
Sister(s)	
Paternal Uncles	
Paternal Aunts	
Maternal Uncles	
Maternal Aunts	

**HEALTH CARE PROVIDERS:**

Who is your family physician? \_\_\_\_\_

When was your last physical? \_\_\_\_\_

Who is your regular optometrist? \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_

Who is your regular dentist? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Do you have mercury fillings? Yes / No If yes, how many?\_\_\_\_

Do you have a Chiropractor? Yes / No \_\_\_\_\_  
(Name)

Do you have a Massage Therapist? Yes / No \_\_\_\_\_  
(Name)

Have you recently visited a specialist? Yes / No \_\_\_\_\_  
(Name) (Specialty)

(Date)

Please list any other health care you are receiving:

\_\_\_\_\_