



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

Whole Health Associates

Center for Integrative Medicine

DIRECTIONS TO OUR OFFICE

From the North:

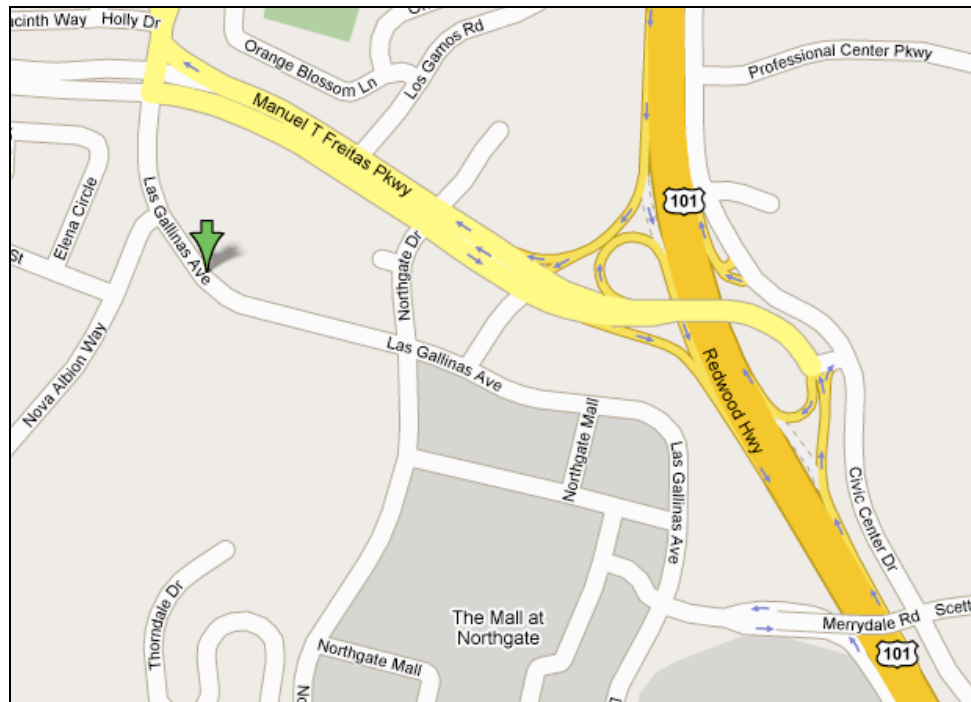
Go south on Highway 101 to the Freitas Pkwy/Terra Linda exit. Bear to the right after the exit (follow the sign to Terra Linda) onto Manuel T. Freitas Parkway. Just past the Safeway supermarket, turn left at the traffic light onto Las Gallinas Avenue. Continue through the next traffic light (Nova Albion 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.

Whole Health Associate
880 Las Gallinas Ave., Suite #1, San Rafael, CA 94903
(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
------	-------	-----

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.

Whole Health Associates

Center for Integrative Medicine

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:

Stephen Zilber, LAc, P.C.
 Whole Health Associates
 880 Las Gallinas Ave., Suite #1
 San Rafael, CA 94903
 415-492-WELL (9355) phone
 415-492-9350 fax

Pediatric Intake Form

Child's Name: _____ Birthdate: _____ Age: _____
 Mother's Name: _____ Father's Name: _____
 Siblings Names and Ages: _____
 School and Grade: _____
 Current Physician: _____ Referred by: _____

Please remember this is a confidential report. Your honest evaluation is both pertinent and necessary to better enable the doctor to accurately assess the health of your child and effectively work with you to improve your child's general well being.

I: Current Information:

Main health problem (when did it start, describe the course of symptoms, what treatment have you tried):

Is child currently taking any medication? Yes No

If so, what medicine and for what condition _____

II: Family Medical History: If any blood relative to your child have or have had any of the following illnesses, please check accordingly: M (Mother), F (Father), S (Sibling), PGM (Paternal Grandmother), PGF (Paternal Grandfather), MGM (Maternal Grandmother), MGF (Maternal Grandfather)

M	F	S	PGM	PGF	MGM	MGF	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy, asthma, or eczema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or low blood sugar
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure/Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological conditions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness/Nervous disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism/Addiction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

III: **Pregnancy:** Please check any area that applied to the child's mother before/during her pregnancy:

- | | | |
|---|--|---|
| <input type="checkbox"/> Child adopted | <input type="checkbox"/> Regular prenatal care | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Fertility treatments/IVF | <input type="checkbox"/> Attitude-Happy (majority of time) | <input type="checkbox"/> Allergic reactions |
| <input type="checkbox"/> Recreational drug use | <input type="checkbox"/> Attitude-Depressed | <input type="checkbox"/> Physical injury |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Complications in pregnancy | <input type="checkbox"/> Mental trauma |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Any diagnosed illnesses | <input type="checkbox"/> Toxic exposure |
| <input type="checkbox"/> Caffeine: cola,coffee,teas,chocolate,etc | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Premature contractions |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Immunization | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Daily vitamins/minerals | <input type="checkbox"/> Excessive decrease in weight | <input type="checkbox"/> Carried to full term |
| | <input type="checkbox"/> Excessive increase in weight | |

IV: **Labor and Delivery:**

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Home birth | <input type="checkbox"/> Greater than 12 hours | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Hospital birth | <input type="checkbox"/> Complications | <input type="checkbox"/> Forceps |
| <input type="checkbox"/> Birthing center | <input type="checkbox"/> Fetal monitor used | <input type="checkbox"/> Cesarean |
| <input type="checkbox"/> Premature delivery | <input type="checkbox"/> Other – please explain: _____ | |

V: **Newborn History:**

Pregnancy Duration (weeks) _____ Birth length _____ Birth weight _____

Please check any of the following areas your child had problems with at birth:

- | | | | |
|---------------------------------------|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Coloring | <input type="checkbox"/> Crying | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Choking | <input type="checkbox"/> Failure to thrive |
| <input type="checkbox"/> Other: _____ | | | |

Breast Fed Yes No For how long? _____
Bottle Fed Yes No For how long? _____ Type of Formula _____
History of colic? Yes No Normal Weight Gain? Yes No
At what age were solid food introduced? _____ What foods initially? _____

VI: **Immunizations:**

Please check all immunizations your child has received, at what age, and reactions, if any:

- | | |
|---|--|
| <input type="checkbox"/> Diphtheria – age/reaction: _____ | <input type="checkbox"/> Mumps - age/reaction _____ |
| <input type="checkbox"/> Pertussis – age/reaction: _____ | <input type="checkbox"/> Rubella - age/reaction _____ |
| <input type="checkbox"/> Tetanus – age/reaction: _____ | <input type="checkbox"/> Chickenpox- age/reaction _____ |
| <input type="checkbox"/> Polio - age/reaction: _____ | <input type="checkbox"/> Hep B - age/reaction _____ |
| <input type="checkbox"/> Measles – age/reaction: _____ | <input type="checkbox"/> HIB - age/reaction _____ |
| <input type="checkbox"/> Flu – age/reaction: _____ | <input type="checkbox"/> Pneumococcus - age/reaction _____ |

VII: Hospitalizations and Illnesses:

Has your child ever been hospitalized or operated on? Yes No

Explain: _____

Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)? Yes No

Explain: _____

Has your child ever had any of the following illnesses:

- | | | | |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> TB | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart/blood vessel disease | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other: _____ | |

Does your child have any allergy problems (rash, itching, swelling, difficulty breathing, sneezing, etc)

a) When eating food? Yes No What foods? _____

How does the child react? _____

b) When taking medication? Yes No What medicine? _____

How does the child react? _____

c) When near animals, furs, insects, dust, etc? Yes No What things? _____

How does the child react? _____

d) At certain times of year? Yes No When? _____

How does the child react? _____

VIII General: (Please check all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Insomnia/sleep problems | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Excess appetite | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Heavy sleeper | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Chills | <input type="checkbox"/> Wakes in a foul mood | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Fever | <input type="checkbox"/> Irregular naps | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Nail biting | <input type="checkbox"/> Sweats easily | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Snores while sleeping |
| <input type="checkbox"/> Sudden energy drops-at what time? _____ | | | |
| <input type="checkbox"/> Bleed or bruise easily-where? _____ | | | |

What time does child usually go to sleep at night? _____ What time does child usually wake? _____

Does child nap? Yes No When? _____

IX Skin and Hair: (Please check all that apply)

- | | | | |
|--|--------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Hives | <input type="checkbox"/> Moles/warts |
| <input type="checkbox"/> Change in hair/skin texture _____ | | | |
| <input type="checkbox"/> Other hair or skin problems _____ | | | |
- Complexion: Pallor Sallow Fair Dark Ruddy

X Head, Eyes, Ears, Nose, and Mouth: (Please check all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Cavities/fillings |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Braces/orthodonture |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Snotty/Runny nose | <input type="checkbox"/> Canker sores |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Corrective lenses | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> |
| <input type="checkbox"/> Headaches – where and when? _____ | | | |

Other head or neck problems? _____

XI Respiratory: (Please check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Wheezing/Asthma |
| <input type="checkbox"/> Difficulty in breathing when lying down | <input type="checkbox"/> Frequent or recurrent colds/flu | | |
| <input type="checkbox"/> Production of phlegm – color? _____ | | <input type="checkbox"/> Other lung problems: _____ | |

XII Gastrointestinal: (Please check all that apply)

- | | | | |
|-------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Sensitive abdomen | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Pain or cramps | <input type="checkbox"/> Black stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Gas | <input type="checkbox"/> Constipation | <input type="checkbox"/> Anal itching |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Laxative use: _____/week; Type: _____ | |

Other intestinal problems: _____

Bowel Movements: Frequency: _____ Color: _____ Odor: _____ Texture/Form _____

XIII Genito-Urinary: (Please check all that apply)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgency to urinate |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Wakes to urinate-How often _____/night | |
| <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Vaginal infections | | |
| <input type="checkbox"/> Discharge from vagina or penis | <input type="checkbox"/> Early sexual development | | |
| <input type="checkbox"/> Other urinary or genital problems: _____ | | | |

XIV. Musculoskeletal: (Please check all that apply)

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain – Where? _____ | | |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Joint pains – Where? _____ | | |
| <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> “Growing” pains | <input type="checkbox"/> Shin splints | <input type="checkbox"/> Excessively ticklish |
| <input type="checkbox"/> Other joint or bone problems: _____ | | | |

XV. Neuro-psychological: (Please check all that apply)

- Fidgety (hands and feet) Impatient Difficulty completing tasks
 Easily stressed/anxious Seizures Trouble with reading/Concentrating
 Bad temper Social difficulties Learning disabilities
 Hyperactive Nightmares/terrors Sleepwalks
 Predominant emotion/mood: Angry Sad Worried Happy Shy Fearful Depressed
 Treated for emotional problems – describe: _____
 Other neurological or psychological problems: _____

Please describe any emotional stresses, shocks, or traumas your child may have experienced: _____

XVI. Diet/Nutrition: (Please check all that apply)

D=Daily F=Frequently O=Occasionally R=Rarely N=Never

D	F	O	R	N	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fresh Fruits
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fresh Vegetables
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raw Foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sprouted Foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Whole Grains
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unrefined cereals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legumes/Beans
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nuts/Seeds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dairy Products
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peanut Butter
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Honey/Molasses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fruit Juices
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soy Products
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eggs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fish
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fowl
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Red meats/Cold cuts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	White Flour Products (Bread, bagels, crackers, pasta)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	White Sugar Products
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Sweeteners
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Colors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fried Foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fast Food
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-Packaged Foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soda Pop
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chocolate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Candy/Sweets/Desserts

List herb, vitamin & mineral supplements your child is currently taking: _____

