



LAZARUS WELLNESS

Functional Medicine • Clinical Nutrition
Spinal Therapy • Fitness & Rehabilitation

Health History

Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Email _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit _____ Date began _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health overall:

- Diet modification Fasting Vitamins/minerals Herbs Homeopathy Chiropractic Acupuncture Conventional drugs
 Other _____

Do you experience any of these general symptoms on a regular basis?

- Debilitating fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation
 Depression Panic attacks Nausea Fecal incontinence Bleeding
 Disinterest in sex Headaches Vomiting Urinary incontinence Discharge
 Disinterest in eating Dizziness Diarrhea Low grade fever Itching/rash

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

Outcome: _____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): _____

Do you consider yourself: Underweight Overweight Healthy weight Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)?

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer
- Decreased sex drive

- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Age of first period _____
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
 - Cigarettes: # /day _____
 - Cigars: # /day _____
- Alcohol:
 - Wine: # glasses/d or wk _____
 - Liquor: # ounces/d or wk _____
 - Beer: # glasses/d or wk _____
- Caffeine:
 - Coffee: # 6 oz cups/d _____
 - Tea: # 6 oz cups/d _____
 - Soda w/caffeine: # cans/d _____
 - Other sources _____
- Water: # glasses/d _____

Exercise

- 5-7 days/wk
- 3-4 days/wk
- 1-2 days/wk
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk: #days/wk _____
- Run, jog, other aerobic - #days/wk _____

- Weight lift: #days/wk _____
- Stretch: #days/wk _____
- Other _____

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction

Specific food restrictions:

- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip meals (which ones) _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals (describe) _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

I Would Like to:

Energy, Vitality

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

Body Composition

- Lose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

Stress: Mental and Emotional

- Learn how to reduce stress
- Think more clearly and be more focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

Life Enrichment

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle





Part 1: Symptoms

Name _____ Date _____

Rate each of the following symptoms based on how you've been feeling for the: Past 48 hours Past week Past 30 days

Point Scale

0 — Never or almost never have the symptoms	2 — Occasionally have it; effect is severe
1 — Occasionally have it; effect is not severe	3 — Frequently have it; effect is not severe
	4 — Frequently have it; effect is severe

Head

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

Total _____

Eyes

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision (does not include near- or farsightedness)

Total _____

Ears

_____ Itchy ears

_____ Earaches, ear infections

_____ Drainage from ear

_____ Ringing in ears, hearing loss

Total _____

Nose

_____ Stuffy nose

_____ Sinus problems

_____ Hay fever

_____ Sneezing attacks

_____ Excessive mucus formation

Total _____

Mouth/Throat

_____ Chronic coughing

_____ Gagging, frequent need to clear throat

_____ Sore throat, hoarseness, loss of voice

_____ Swollen or discolored tongue, gums, or lips

_____ Canker sores

Total _____

Skin

_____ Acne

_____ Hives, rashes, dry skin

_____ Hair loss

_____ Flushing, hot flashes

_____ Excessive sweating

Total _____

Heart

_____ Irregular or skipped heartbeat

_____ Rapid or pounding heartbeat

_____ Chest pain

Total _____

Lungs

_____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing

Total _____

Digestive Tract

_____ Nausea, vomiting

_____ Diarrhea

_____ Constipation

_____ Bloating feeling

_____ Belching, passing gas

_____ Heartburn

_____ Intestinal/stomach pain

Total _____

Joints/Muscles

_____ Pain or aches in joints

_____ Arthritis

_____ Stiffness or limitation of movement

_____ Pain or aches in muscles

_____ Feeling of weakness or tiredness

Total _____

Weight

_____ Binge eating/drinking

_____ Craving certain foods

_____ Excessive weight

_____ Compulsive eating

_____ Water retention

_____ Underweight

Total _____

Energy/Activity

_____ Fatigue, sluggishness

_____ Apathy, lethargy

_____ Hyperactivity

_____ Restlessness

Total _____

Mind

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

Total _____

Emotions

_____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression

Total _____

Other

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

Total _____

For Practitioner Use Only:
Urinary pH _____

Grand Total _____



Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

Yes (1 pt.) No (0 pt.)

If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?

Cimetidine (2 pts.) Acetaminophen (2 pts.) Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:

- Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
- Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
- Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
- Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently within the last 6 months have you regularly used tobacco products?

Yes (2 pts.) No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?

Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?

Yes (1 pt.) No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?

Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?

Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

10. Do you have a personal history of:

- Environmental and/or chemical sensitivities (5 pts.)
- Chronic fatigue syndrome (5 pts.)
- Multiple chemical sensitivity (5 pts.)
- Fibromyalgia (3 pts.)
- Parkinson's type symptoms (3 pts.)
- Alcohol or chemical dependence (2 pts.)
- Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

Yes (1 pt.) No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?

Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

Total _____

Part 3: Alkalinizing Assessment

1. Do you have a history of or currently have kidney dysfunction?

Yes (1 pt.) No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?

Yes (1 pt.) No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?

Yes (1 pt.) No (0 pt.)

Total _____

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total _____ (High >50; moderate 15-49; low <14)

Part 2: XTT Total _____ (High >10; moderate 5-9; low <4)

Part 3: Alkalinizing Assessment Total _____ (High ≥1)

Urinary pH _____