Spine Arts Center

Male Health History Questionnaire
(To be completed by patient)

Name _____ **Date** _____

Address _____ Apt.#_____

City_____ State _____ ZIP _____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____

E-mail address: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

REFERRED BY:_____

Chief Complaint(s):

_____
_____
_____
_____
_____
_____

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

☐ Antacids, Zantac, Pepcid, Rolaids, etc.
☐ Chemotherapy

☐ Laxatives
☐ Ulcer Medications
☐ Antibiotic/Antifungal

☐ Anti-Diabetic/Insulin

☐ Oral Contraceptives
Medications

☐ Relaxants/Sleep pills
☐ Thyroid
☐ Radiation
☐ Antidepressants

☐ Aspirin/Acetaminophen

☐ Cortisone/Anti-Inflammatory
☐ Heart Medications
☐ High Blood Pressure Medicine
☐ Statins/Cholesterol Lowering

☐ Hormones – If so, what? _____ When? _____ Dosage? _____

Please list names of any medications you are currently taking:
_____
_____
_____
_____

Are you allergic to any drugs that you know of? (if so please list names):
_____
_____

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking:
_____
_____
_____

Surgeries, Accidents, Traumas – Please list any surgeries, accidents, or trauma's you have had. Please be sure to include dates as well.
_____
_____

Lifestyle

Dietary Habits: Describe the foods you normally eat:
BREAKFAST: _____
_____
LUNCH: _____
_____
DINNER: _____
_____
SNACKS: _____
_____

Do you consume the following?			**If so, how much?**
1. Soda or carbonated beverages?	YES	NO	_____
2. White flour products?	YES	NO	_____
3. Fried foods?	YES	NO	_____
4. Coffee?	YES	NO	_____
5. Fast foods regularly?	YES	NO	_____
6. Sweets and /or refined carbohydrates?	YES	NO	_____
7. Alcoholic beverages?	YES	NO	_____
8. Any tobacco products?	YES	NO	_____

Are you a vegetarian? YES NO
Are you currently involved in an exercise program? YES NO How often? _____
How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
How do you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

Sleep

How well do you sleep?

☐ Well ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Insomnia

What is the average number of hours you most often sleep each night? _____
Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO
If yes, how often? _____

Do you keep your room completely dark at night? YES NO

Male Anatomy

Have you had a vasectomy? YES NO When? _____

Experienced any symptoms related to the vasectomy? YES NO

If so, please explain: _____
_____

Reverse vasectomy? YES NO When? _____

Do you have any history of prostate problems? YES NO
If so, please explain: _____
_____

When was your last prostate exam? _____

What were your most recent PSA results? _____ Date: _____

Does your bladder always feel full?	YES	NO	SOMETIMES
Do you experience inconsistent pressure or pain during urination?	YES	NO	SOMETIMES
Does ejaculation cause pain?	YES	NO	SOMETIMES
Do you experience low sex drive?	YES	NO	SOMETIMES
Do you have premature ejaculation?	YES	NO	SOMETIMES

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New Patient Introduction Form

Dietary intake for 2 days before appointment:

	Day 1:	Day 2:
Breakfast		
Snacks		
Lunch		
Snacks		
Dinner		
Snacks		
Notes:		

Authorization Form:

Regarding the use of Nutrition Reponses Testing

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Spine Arts Center to perform a Nutrition Response Testing health analysis and to develop a natural, complementary, health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or to "cure" any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" any disease including conditions of cancer, AIDS, infections, or any other medical conditions, and that these are not being tested or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, by rather I understand that Nutrition Response Testing is a means by which the body's natural organ response can be used as an aid to determining possible nutritional imbalances, so that safe, natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

_____

Patient/Guardian (Please Print)

_____ Date: _____

Patient/Guardian (Signature)

PLEASE INITIAL NEXT TO EACH NUMBER.

_____ 1. You are expected to keep all appointments as scheduled in order to ensure maximum progress in your case. If for some reason, you cannot make an appointment, we require a minimum 24 hour advanced notice before cancellation or rescheduling. You will need to reschedule that appointment for the SAME week and not fall into the following week. Short notice or no notice may also incur an office visit charge.

_____ 2. Follow-up visits generally take 10 minutes or less. Extended visits, though rarely needed, are charged proportionally. To save time on your visits, write down your questions and let the practitioner know about these at the beginning of the visit. In between visits, it is highly recommended that you take up any questions with the Patient Advocate, either by phone or in person, since there is no charge for time spent with the Patient Advocate.

_____ 3. Fill out your Daily Record of Food Intake form as you eat each meal, snack, etc. between visits. Make it a habit to do it this way and not wait until the end of the day or later. This will ensure accurate information for the practitioner.

_____ 4. TRY NOT to miss any doses of your supplements. Missed doses will slow down improvement and extend the time it takes to complete your program. If you miss a dose, you make it up at a point later in the day. If this happens repeatedly, let the practitioner know so your supplement schedule can be modified.

_____ 5. Please keep in mind that our nutritional products DO NOT cause "side effects" as they are not drugs. Occasionally after starting a nutritional program, you may feel a temporary worsening or even feel "sick." If this occurs, do NOT cancel your appointment. Immediately call the office. Sometimes these "flare-ups" are actually a "Healing Crisis" which indicates your body is starting to heal by throwing off toxins that have been keeping you sick. By fine-tuning your program, we can help you get through these types of situations much more smoothly, if they even occur. When you are not doing well is when it is often most important to come in so we can fine-tune your program and help you correct the underlying cause of the problem more rapidly.

_____ 6. Please consider all the dynamics in your life that could interfere with or prevent you from doing or completing your health improvement program. If you need assistance in working out how to handle any obstacles in your quest for better health, please stay in communication with the patient advocate.