Alternative Health Care Center
Dr. Marc D'Andrea DC

(770) 992-4222

Patient #_____

NUTRITIONAL NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE: _____

NAME:_____E-MAIL ADDRESS:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

CELL#: (_____)_____ HOME #: (____)_____ WORK #: (____)_____

DATE OF BIRTH: _____-_____-_____ **REFERRED BY:**_____

OCCUPATION:_____ EMPLOYER:_____

OVERALL HEALTH: EXCELLENT / GOOD / FAIR / POOR

PLEASE LIST ANY PROBLEMS YOU ARE EXPERIENCING:_____

LIST ANYTHING RELATED TO YOUR HEALTH YOU FEEL IS NOT NORMAL – EVEN THINGS YOU HAVE GOTTEN USED TO:_____

WHAT DO YOU CONSIDER YOUR MAJOR HEALTH PROBLEM?_____

Office Use Only:

HAVE YOU EVER BEEN TREATED FOR ANY OF THESE ELSEWHERE? _____

IF YES, WHERE?_____ DR.'S NAME:_____

ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN OR OTHER HEALTH CARE PRACTITIONER?_____

IF YES, WHEN WAS YOUR LAST VISIT?_____ DR.'S NAME:_____

CURRENT MEDICATION/DRUGS BEING TAKEN:_____

NUTRITIONAL SUPPLEMENTS YOU ARE TAKING:_____

DO YOU (IF YES, HOW MUCH): SMOKE:_____ COFFEE:_____ ALCOHOL:_____ EXERCISE:_____

HISTORY

LIST ANY MAJOR ILLNESSES (WITH DATES):_____

LIST ANY SURGERIES (WITH DATES):_____

PAST ACCIDENTS OR INJURIES:_____

MARITAL STATUS: S M D W NAME OF SPOUSE:_____

DESCRIBE HEALTH OF SPOUSE:_____

NUMBER OF CHILDREN (IF ANY):_____

NAME OF CHILD:	AGE	SEX	ANY PHYSICAL CONDITIONS OR CONCERNS?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SIGNATURE:_____ DATE:_____

Family Health History

Alternative Health Care Center

Name: _____ Date: _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by using the designation **C** under his or her column. Use the designation **P** to indicate a past problem. Leave blank those spaces that do not apply. Use the reverse side if you need more space.

Condition	FATHER Age___	MOTHER Age___	SPOUSE Age___	BROTHER(S Age___	Age___	Age___	SISTER(S) Age___	Age___	Age___	CHILDREN Age___	Age___	Age___
Arthritis												
Allergies-Asthma												
Back Trouble												
Bursitis												
Cancer												
Constipation												
Diabetes												
Disc Problem												
Emotional Problems												
Emphysema												
Epilepsy												
Headaches												
Heart Trouble												
High Blood Pressure												
Insomnia												
Kidney Trouble												
Liver Trouble												
Migraine												
Nervousness												
Neuritis												
Pinched Nerve												
Scoliosis												
Sinus Trouble												
Stomach Trouble												
Menstrual Cramps												
Multiple Sclerosis												
Ear Infection												
Unexplained Pains												

If any of the above family members are deceased, please list their age at death and cause_____

_____

_____

_____

Toxicity Questionnaire

7/30/2008

Name: _____ **Section I: Symptoms** **Date: _____**

Mark the corresponding number for each symptom using the following scale and your health profile for the last 90 days

0	Rarely or Never experience the symptom
1	Occasionally experience the symptom; Effect is not severe
2	Occasionally experience the symptom; Effect is severe
3	Frequently experience the symptom, Effect is not severe
4	Frequently experience the symptom, Effect is severe

1. DIGESTION		**6.HEAD**		**11. SKIN**	
Nausea and/or vomiting	0 1 2 3 4	Headaches	0 1 2 3 4	Acne	0 1 2 3 4
Diarrhea	0 1 2 3 4	Faintness	0 1 2 3 4	Hives, rashes, dry skin	0 1 2 3 4
Constipation	0 1 2 3 4	Dizziness	0 1 2 3 4	Hair loss	0 1 2 3 4
Bloated feeling	0 1 2 3 4	Pressure	0 1 2 3 4	Flushing	0 1 2 3 4
Belching and/or passing gas	0 1 2 3 4	**TOTAL**		Excessive sweating	0 1 2 3 4
Heartburn	0 1 2 3 4	**7. LUNGS**		**TOTAL**	
TOTAL		Chest congestion	0 1 2 3 4	**12. HEART**	
2. EARS		Asthma, Bronchitis	0 1 2 3 4	Skipped heartbeats	0 1 2 3 4
Itchy ears	0 1 2 3 4	Shortness of breath	0 1 2 3 4	Rapid heartbeats	0 1 2 3 4
Earaches, ear infections	0 1 2 3 4	Difficulty breathing	0 1 2 3 4	Chest pain	0 1 2 3 4
Drainage from ear	0 1 2 3 4	**TOTAL**		**TOTAL**	
Ringing in ears; ,hearing loss	0 1 2 3 4	**8. MIND**		**13. JOINTS/MUSCLES**	
TOTAL		Poor memory	0 1 2 3 4	Pain or aches in joints	0 1 2 3 4
3. EMOTIONS		Confusion	0 1 2 3 4	Rheumatoid arthritis	0 1 2 3 4
Mood swings	0 1 2 3 4	Poor concentration	0 1 2 3 4	Osteoarthritis	0 1 2 3 4
Anxiety, fear, nervousness	0 1 2 3 4	Poor coordination	0 1 2 3 4	Stiffness, limited movement	0 1 2 3 4
Anger, irritability	0 1 2 3 4	Difficulty making decisions	0 1 2 3 4	Pain, aches in muscles	0 1 2 3 4
Depression	0 1 2 3 4	Stuttering, stammering	0 1 2 3 4	Recurrent back aches	0 1 2 3 4
Sense of despair	0 1 2 3 4	Slurred speech	0 1 2 3 4	Feeling of weakness or tiredness	0 1 2 3 4
Apathy/lethargy	0 1 2 3 4	Learning disabilities	0 1 2 3 4	**TOTAL**	
TOTAL		**TOTAL**		**14. WEIGHT**	
4. ENERGY/ACTIVITY		**9. NOSE**		Binge eating/drinking	0 1 2 3 4
Fatigue/sluggishness	0 1 2 3 4	Stuffy Nose	0 1 2 3 4	Craving certain foods	0 1 2 3 4
Hyperactivity	0 1 2 3 4	Sinus Problems	0 1 2 3 4	Excessive weight	0 1 2 3 4
Restlessness	0 1 2 3 4	Hay fever	0 1 2 3 4	Compulsive eating	0 1 2 3 4
Insomnia	0 1 2 3 4	Sneezing attacks	0 1 2 3 4	Water retention	0 1 2 3 4
Startled awake at night	0 1 2 3 4	Excessive mucous	0 1 2 3 4	Underweight	0 1 2 3 4
TOTAL		**TOTAL**		**TOTAL**	
5. EYES		**10. MOUTH/THROAT**		**15. OTHER**	
Watery, itchy	0 1 2 3 4	Chronic coughing	0 1 2 3 4	Frequent illness	0 1 2 3 4
Swollen, reddened or sticky eyelids	0 1 2 3 4	Gagging, frequent need to clear throat	0 1 2 3 4	Frequent or urgent urination	0 1 2 3 4
Dark circles under eyes	0 1 2 3 4	Swollen or discolored tongue, gums, lips	0 1 2 3 4	Leaky bladder	0 1 2 3 4
Blurred/tunnel vision	0 1 2 3 4	Canker Sores	0 1 2 3 4	Genital itch, discharge	0 1 2 3 4
TOTAL		**TOTAL**		**TOTAL**	
				SECTION I TOTAL	

SECTION II: RISK OF EXPOSURE

Rate each of the following situations based on your environmental profile for the last 120 days.

Use the scale defined below for the following questions									
0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a	How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc)	0 1 2 3 4
b	How often are pesticides used in your home?	0 1 2 3 4
c	How often do you have your home treated for insects?	0 1 2 3 4
d	How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?	0 1 2 3 4
e	How often are you exposed to nail polish, perfume, hair spray, and other cosmetics?	0 1 2 3 4
f	How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0 1 2 3 4
	TOTAL	

Use the scale defined below for the following questions							
0	No	1	Mild change	2	Moderate change	3	Drastic change

a.	Have you noticed any negative change since you moved into your home or apartment?	0 1 2 3
b.	Have you noticed any negative change in your health since you started your new job?	0 1 2 3
	TOTAL	

For the following questions, answer yes or no by selecting the number that corresponds to yes or no

		No	Yes
a.	Do you have a water purification system in your home?	2	0
b.	Do you have any indoor pets?	0	2
c.	Do you have an air purification system in your house?	2	0
d.	Are you a dentist, painter, farm worker, or construction worker?	0	2
	TOTAL		

SECTION II TOTAL	

GRAND TOTAL (Section I and Section II)	

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a Clinical Purification™ program.

Adapted with permission from the author of Clinical Purification™: A Complete Treatment and Reference Manual, Dr. Dr. Gina L. Nick.

Alternative Health Care Center

Allergy Questionnaire

Name: _____ **Date: _____**

This questionnaire is designed to help us understand the extent to which allergens may be affecting you.

For each question, check the box corresponding to yes or no based on your health profile for the last year.		
	Yes	**No**
Do you sneeze a lot?		
Do you experience bloating after eating?		
Is your "stomach" always churning?		
Do you have trouble with your sense of smell?		
Do You have trouble with your sense of taste?		
Do you feel nauseous after you eat much of the time?		
Do you experience headaches, which seem to be caused by sinus pressure?		
Do you have an aversion to "good food"?		
Does your mouth seem too dry frequently?		
Do you have cravings for certain foods?		
Do you have a place on your body, which always itches?		
Do you have any rashes on your skin?		
Do you have unexplained joint pains?		
Do certain places always make you sick?		
Do you notice that you feel more congested after resting?		
Are you tired too much of the time?		

If yes, which time of the day	morning	afternoon	evening
TOTAL (Number of checks in the column labeled "Yes")			

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Dr. Marc D'Andrea DC, CCN

Phone 770-992-4222

PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at the Alternative Health Care Center to perform 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 "cure" of 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 Nutritional Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for 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, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes 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 slip form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____-_____

Signed: _____ Witness: _____
(If minor, signature of parent or guardian required)