VITAL ENERGY NUTRITION CENTER
203 N. Main Street, Suite 100
Lexington, VA 24450

(540) 464-3031

Name_____ Date_____

Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____

Email_____

Date of Birth_____Gender: Male____Female___ Age_____

Height_____Weight_____

Married_____WIdowed_____Single_____Separated_____Divroced_____Partnership_____

Live with: Spouse_____Children_____Partner_____Parents_____Friends_____Alone_____

Education_____

Occupation_____

Empoyer_____Work Address_____

How do you prefer we contact you? Email_____Phone_____

Contact in case of emergency:

Name_____Relationship_____Telephone_____

How did you hear about our wellness and nutrition program?_____

Please list name and types of your other current health care practitioners:

_____

_____

What is your major complaint? List when each symptom began; be descriptive. Use back of page if necessary.

_____

_____

_____

_____

_____

What are your current medications?

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

What are your current vitamins and/or supplements? Please List all and amounts and dosage

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.):

_____

_____

_____

_____

Is there anything else in your medical history that you consider to be relevant (even from childhood)?

_____

_____

_____

_____

_____

What is your employment history? Please provide brief summary including dates if possible, esp. any esposures:

_____

_____

_____

_____

_____

Please list past or present allergies, including allergies to medications:

_____

_____

_____

Please list all past surgeries and the condition each surgery was for, including dates:

_____

_____

_____

_____

_____

Please explain your housing history (type of homes, where and when:

_____

_____

_____

_____

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

☐ Yes ☐ No Do you have amalgam (silver) fillings in your teeth? If yes , how many? _____

☐ Yes ☐ No Have you ever had an amalgam removed? If Yes, how many_____

☐ Yes ☐ No If you had amalgams removed, was it done by a biological dentist using a safe protocol?

☐ Yes ☐ No Did your mother have amalgam when pregnant with you?

☐ Yes ☐ No Have you ever worked in a dental office? If so, how long? _____

☐ Yes ☐ No Have you had any dental crowns? If yes, how many_____

☐ Yes ☐ No Have you had any bridges?

☐ Yes ☐ No Have you had any root canals?

☐ Yes ☐ No Have you had any tooth extractions?

☐ Yes ☐ No Do you have any dental implants, retainers or other metal in your mouth?

☐ Yes ☐ No Did you wear contact lenses during the 1980's or early 1990's?

☐ Yes ☐ No Did you take oral contraceptives during the 1980's or early 1990's?

☐ Yes ☐ No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?

☐ Yes ☐ No Have you noticed any adverse reactions to these shots?

☐ Yes ☐ No Do you have any tattoos with red ink?

☐ Yes ☐ No Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

☐ Yes ☐ No Does your occupation involve soldering or metal salvage?

☐ Yes ☐ No Have you done any old home repair or sandblasting? If so, When_____

☐ Yes ☐ No Do you do a lot of painting?

☐ Yes ☐ No Was your home built before 1978?

☐ Yes ☐ No Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment)

☐ Yes ☐ No Are you around a lot of fake leather, or vinyl?

☐ Yes ☐ No Do you get stomach aches in the morning?

General Toxicity

☐ Yes ☐ No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.

☐ Yes ☐ No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc. If yes, please explain)

☐ Yes ☐ No Do you have your house sprayed with pesticides for pest control?

☐ Yes ☐ No Do you spray herbicide (weed killers) in or around your home?

☐ Yes ☐ No Do you use conventional insect repellants on yourself or family?

☐ Yes ☐ No Do you use conventional sunscreen?

☐ Yes ☐ No Do you use conventional perfume or cologne every day?

☐ Yes ☐ No Do you get your hair colored? If so, is it on the scalp?

☐ Yes ☐ No Do you use aerosol hairspray?

☐ Yes ☐ No Do you get your nails done? If so , how often? _____

☐ Yes ☐ No Do you use air freshener in your house, work or car?

☐ Yes ☐ No Do you drink filtered water? If so, what type of filter do you have?_____

☐ Yes ☐ No Do you drink bottle water? If so what kind?

☐ Yes ☐ No Do you have a water filtration system for your entire house or shower filtration? If so, what type?_____

☐ Yes ☐ No Does your spouse or other family members work around chemicals?

☐ Yes ☐ No Can you think of any other toxic exposures you may have had?

MOLD How old is the house you are living in? _____ How long have you lived there? _____ Have you noticed any new symptoms since moving in?_____ If so, what?_____

☐ Yes ☐ No Do you see mold growing at home, work or school?

☐ Yes ☐ No Have you ever had water damage at home, work or school?

☐ Yes ☐ No Does your home, workplace or school have a damp or mildew smell?

☐ Yes ☐ No Does spending time in your basement cause or worsen your symptoms?

☐ Yes ☐ No Does your basement ever get wet?

☐ Yes ☐ No Does anyone in your family have chronic sinus infections or irritations?

☐ Yes ☐ No Does your basement or crawl space have a sump pump?/ crawl space?

☐ Yes ☐ No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?

☐ Yes ☐ No Does your car have a mildew smell?

☐ Yes ☐ No Does anyone in your home have asthma like symptoms?

Lyme Disease

☐ Yes ☐ No Have you ever been diagnosed with Lyme Disease?

☐ Yes ☐ No Have you had dry sockets or infected tooth extractions?

☐ Yes ☐ No Do you have small joint pain?

☐ Yes ☐ No Have you ever been bitten by a tick or recluse spider?

☐ Yes ☐ No Have you ever seen a bulls-eye rash appear on any part of your body?

☐ Yes ☐ No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?

☐ Yes ☐ No Was your mother ever diagnosed with Lyme Disease?

☐ Yes ☐ No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

☐ Yes ☐ No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?

☐ Yes ☐ No Does anyone in your family experience similar symptoms to yours?

☐ Yes ☐ No Do you have any history of kidney dysfunction?

☐ Yes ☐ No Do you or any immediate family member have a history with cancer?

☐ Yes ☐ No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?

☐ Yes ☐ No Are you currently having any thoughts of suicide?

☐ Yes ☐ No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?

☐ Yes ☐ No Do you have a history of strokes?

☐ Yes ☐ No Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?

☐ Yes ☐ No Have you ever been in an auto accident, fallen or received a major physical injury?

☐ Yes ☐ No Are you in menopause?

What is your birth order (i.e. first born, second, third, etc.)? _____.

Microbiome Health

☐ Yes ☐ No Do you get foul or sulfur smelling gas (distention, bloating, belching, feeling full and a noisy gut) after eating carbohydrates (ie. grains and vegetables) or fermented foods and/or probiotics?

☐ Yes ☐ No Do you often have gas that has a sulfur or foul smell?

☐ Yes ☐ No Are you sensitive to supplements?

☐ Yes ☐ No Have you ever been vegan or vegetarian for any length of time?

☐ Yes ☐ No Can you tolerate Meat?

☐ Yes ☐ No Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?

☐ Yes ☐ No Have you taken birth control or Hormone Replacement Therapy for any length of time?

☐ Yes ☐ No If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?

☐ Yes ☐ No Have been on antibiotics for any extended period of time or often as a child or adult?

☐ Yes ☐ No Were you caesarian delivered?

☐ Yes ☐ No Were you breast fed? If so, How long _____

☐ Yes ☐ No Does your gut temporarily feel better after a round of antibiotics?

How many times a day are you having a bowel movement? _____

Sleep

☐ Yes ☐ No Do you have trouble going to sleep?
☐ Yes ☐ No Do you have trouble saying asleep?
☐ Yes ☐ No If you awaken , is it to urinate?
What time do you typically awaken at night? _____
☐ Yes ☐ No Do you have trouble getting back to sleep ?
☐ Yes ☐ No Do you take medications to help you sleep?
☐ Yes ☐ No Do you feel refreshed and rested upon awakening?
If not, when during the day do you feel best?_____
What time do you go to bed? _____
What time do you get up?
Do you have a television in your bedroom?

Do you have an electric alarm clock?
☐ Yes ☐ No Do you Exercise?
☐ Yes ☐ No Do you know what Hi-Intensity Burst Training is?
If so,what type of exercise? _____
How frequently? _____

WHAT WOULD YOU SAY YOUR BIGGEST HEALTH ISSUES ARE?

- _____
- _____
- _____
- _____

_____