DR. LAURA LARSON

BODY MIND Assurance

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PO Box 467
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(970) 300-1987 cell (970) 949-7029 work
(970) 450-4300 fax
info@bodymindassurance.com

General Information

Name *First* *Middle* *Last*

Preferred Name

Date of Birth

Age

Gender ○Male ○Female

Genetic Background ☐ African ☐ Caucasian ☐ European ☐ Native American

☐ Asian ☐ Hispanic ☐Middle Eastern ☐ _____

Highest Education Level ○High School ○Graduate ○Post-Graduate

Job Title

Nature of Business

Primary Address *Number, Street* *Apt. No.*

City *State* *Zip*

Alternate Address *Number, Street* *Apt. No.*

City *State* *Zip*

Home Phone 1

Home Phone 2

Work Phone

Cell Phone

Fax

Email

Emergency Contact *Name* *Phone Number*

Address *Apt. No.*

City *State* *Zip*

Physician *Name* *Phone Number*

Fax

Referred by

○Doctor referral ○Website ○Friend or Family Member ○Other _____

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Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? _____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Success: Good	Success: Fair
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		

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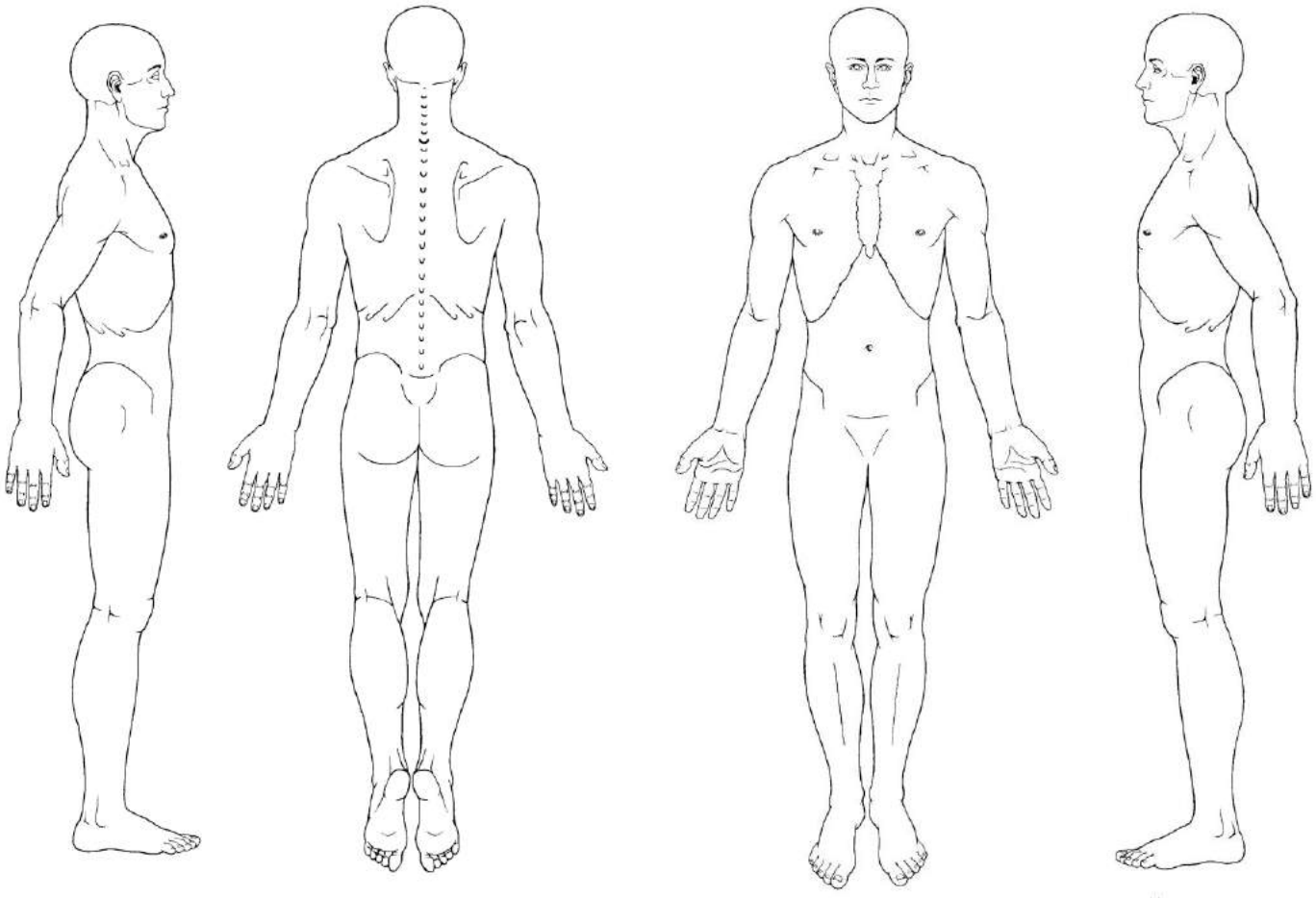

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

P - Where you experience Pain **N** - Where you experience Numbness **T** - Where you experience Tingling **B** - Where you experience Burning **C** - Where you experience Cramping

Activities that are painful to perform

❒Sitting ❒Standing ❒ Walking ❒Bending ❒ Lying Down ❒ Lifting ❒ Resting ❒ Looking Down ❒ Other_____

Type of pain:

❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting ❒ Burning ❒ Tingling ❒ Cramps ❒ Stiffness ❒ Swelling ❒ Other_____

Is your condition getting ❒ Better ❒ Worse ❒ Same?

How bad is your pain now?

0 1 2 3 4 5 6 7 8 9 10

No Pain _____Unbearable Pain

How often do you have pain? 0--10--20--30--40--50--60--70--80--90--100 (%of day)

Patient Signature _____ Date _____

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Current medications

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Previous medications: *Last 10 years*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Nutritional Supplements (Vitamins/minerals/Herbs/Homeopathy)

Supplication and Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Hospitalizations ☐ None

Date	Reason

Comments

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Medication and Supplements

Have your medications or supplements ever caused you unusual side effects or problems? ( ) Yes ( ) No
Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ○Yes ○No

Have you had prolonged or regular use of Tylenol? ○Yes ○No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ○Yes ○No Frequent antibiotics > 3 times/year ○Yes ○No Long term antibiotics ○Yes ○No

Use of steroids (prednisone, nasal allergy inhalers) in the past ○Yes ○No

Use of oral contraceptives ○Yes ○No

Food allergies

Do you have known adverse food reactions or sensitivities? ○ Yes ○ No If yes, describe symptoms _____

Do you have any food allergies or sensitivities? ○Yes List all: _____ ○No

Do you have an adverse reaction to caffeine? ○Yes ○No If Yes, do you feel: ○Irritable or Wired ○Aches & Pains

Sleep/rest

Average number of hours you sleep per night: ○>10 ○8-10 ○6-8 ○< 6

Do you have trouble falling asleep? ○Yes ○No Do you feel rested upon awakening? ○Yes ○No

Do you have problems with insomnia? ○Yes ○No Do you snore? ○Yes ○No
Do you use sleeping aids? ○Yes ○No Explain: _____

Gynecologic History *(for women only)*

Women's Menstrual and Obstetric History *Check box if yes and provide number of*

Age at first period:_____Menses Frequency:_____Length:_____ Last Menstrual Period:_____
Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?_____

Do you use contraception? ○Yes ○No ☐Condom ☐Diaphragm ☐IUD ☐Partner vasectomy

☐Pregnancies_____☐Caesarean_____☐Vaginal deliveries_____☐Miscarriage____☐Abortion____

☐ Living Children: _____ Ages and gender: _____

☐ Post Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby over 8 pounds

☐Breast Feeding For how long?_____

Women's Disorders / Hormonal imbalances

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Painful Periods ☐ Heavy periods ☐ PMS

Last Mammogram:_____☐Breast Biopsy/Date_____ LastPAP test:_____ ○Normal ○Abnormal

Date of Last Bone Density__Results: ○High ○Low ○Within Normal Range

Are you in menopause? ○Yes ○No Age at Menopause_____ Perimenopausal? ○Yes ○No

☐Hot Flashes ☐Mood Swings ☐Concentration/Memory Problems ☐Vaginal Dryness ☐Decreased Libido

☐Heavy Bleeding ☐Joint Pains ☐Headaches ☐Weight Gain ☐Loss of Control of Urine ☐Palpitations

☐ Use of hormone replacement therapy. How long?_____

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PERSONAL MEDICAL HISTORY

[ ] = Past Condition [ ] = Ongoing Condition

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset*
[ ] = Past Condition [I] = Ongoing Condition [ ] = Past Condition [I] = Ongoing Condition

Musculoskeletal/pain

☐ ☐ Osteoarthritis _____
☐ ☐ Chronic Pain / Fibromyalgia _____
☐ ☐ Other _____

Neurologic / Mood

☐ ☐ Depression _____
☐ ☐ Anxiety _____
☐ ☐ Bipolar Disorder _____
☐ ☐ Schizophrenia _____
☐ ☐ Headaches _____
☐ ☐ Migraines _____
☐ ☐ ADD/ADHD _____
☐ ☐ Autism _____
☐ ☐ Memory Problems _____
☐ ☐ Parkinson's Disease _____
☐ ☐ Multiple Sclerosis _____
☐ ☐ ALS _____
☐ ☐ Seizures _____
☐ ☐ Other Neurological Problems _____

☐ ☐ Other _____

Metabolic / Endocrine

☐ ☐ Type 1 Diabetes _____
☐ ☐ Type 2 Diabetes _____
☐ ☐ Hypoglycemia _____
☐ ☐ Metabolic Syndrome _____
(Insulin Resistance or Pre-Diabetes)
☐ ☐ Hypothyroidism (low thyroid) _____
☐ ☐ Hyperthyroidism (overactive thyroid) _____
☐ ☐ Endocrine Problems _____
☐ ☐ Polycystic Ovarian Syndrome (PCOS) _____
☐ ☐ Infertility _____
☐ ☐ Weight Gain _____
☐ ☐ Weight Loss _____
☐ ☐ Frequent Weight Fluctuations _____
☐ ☐ Bulimia _____
☐ ☐ Anorexia _____
☐ ☐ Binge Eating Disorder _____
☐ ☐ Other _____

Inflammatory / Autoimmune

☐ ☐ Chronic Fatigue Syndrome _____
☐ ☐ Rheumatoid Arthritis _____
☐ ☐ Lupus SLE _____
☐ ☐ Immune Deficiency Disease _____
☐ ☐ Herpes-Genital _____
☐ ☐ Severe Infectious Disease _____
☐ ☐ Poor Immune Function _____
(frequent infections) _____
☐ ☐ Food Allergies _____
☐ ☐ Environmental Allergies _____
☐ ☐ Multiple Chemical Sensitivities _____
☐ ☐ Latex Allergy _____
☐ ☐ Other Autoimmune Disease _____

Skin Diseases

☐ ☐ Eczema _____
☐ ☐ Psoriasis _____
☐ ☐ Acne _____
☐ ☐ Melanoma _____
☐ ☐ Skin Cancer _____

Cardiovascular

☐ ☐ Heart Attack _____
☐ ☐ Other Heart Disease _____
☐ ☐ Stroke _____
☐ ☐ Elevated Cholesterol _____
☐ ☐ Arrythmia (irregular heart rate) _____
☐ ☐ Hypertension (high blood pressure) _____
☐ ☐ Other _____

Gastrointestinal

☐ ☐ Irritable Bowel Syndrome _____
☐ ☐ Crohn's
☐ ☐ Gastritis or Peptic Ulcer Disease _____
☐ ☐ GERD (reflux) _____
☐ ☐ Celiac Disease _____
☐ ☐ Other _____

Skin Diseases

☐ ☐ Eczema _____
☐ ☐ Psoriasis _____
☐ ☐ Acne
☐ ☐ Melanoma _____
☐ ☐ Skin Cancer _____
☐ ☐ Other _____

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Respiratory Diseases

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitis
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Sleep Apnea
- ☐ ☐ Other

Genital and Urinary Systems

- ☐ ☐ Kidney Stones
- ☐ ☐ Gout
- ☐ ☐ Interstitial Cystitis
- ☐ ☐ Frequent Urinary Tract Infections
- ☐ ☐ Frequent Yeast Infections
- ☐ ☐ Erectile Dysfunction / Sexual Dysfunction
- ☐ ☐ Other

Cancer

- ☐ ☐ Type or location

Injuries

Check box if yes

- ☐ Back injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones
- ☐ Other

Surgeries

Check box if yes and provide date of surgery

- ☐ Appendectomy
- ☐ Hysterectomy +/- Ovaries
- ☐ Gall Bladder
- ☐ Hernia
- ☐ Tonsillectomy
- ☐ Dental Surgery
- ☐ Joint Replacement–Knee/Hip
- ☐ Heart Surgery–Bypass Valve
- ☐ Angioplasty or Stent
- ☐ Pacemaker
- ☐ Other
- ☐ None

Other

Comments

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Family History

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfathe	Paternal Grandmother	Paternal Grandfathe	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												