Dr. Christopher Marzano

Treating the Individual, Not the Symptom

Patient:_____________________________________

HEALTH & WELLNESS QUESTIONNAIRE

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Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. To prevent misunderstanding or confusion, we would appreciate if you read the following steps and provide your signature at the end. This simply implies that you have read the *Patient Acceptance Policy* and understand what is expected of you. Thank you very much for your cooperation.

1. **Please complete the following forms:**
   - ❑ The Health & Wellness Questionnaire
   - ❑ The Symptom Survey
   - ❑ The Toxicity Questionnaire
   - ❑ The Metabolic Type Questionnaire
   - ❑ The 7 Day Diet Diary

   ***It is very important for you to thoroughly complete all of the forms and return them to us at least 2 days prior to your initial consultation.** Medical Records related to your current health condition must also be received at our office 2 days prior to scheduling your first consultation.

2. The cost for your initial consultation will range from between $60.00 and $150.00 depending on the amount of time required for review of prior medical records and time required for the initial consultation.

3. Based on your initial consultation and the review of your medical records additional laboratory tests or imaging may be recommended. This is not always the case and as always the choice to comply is completely up to you.

4. If you have not had a physical examination within the last two years or since the start of your most recent health problem, it is required that you either schedule additional time for a physical with Dr. Marzano or schedule with your primary medical physician for a compete physical.

5. Your case may require a report of findings separate from the initial consultation. This may occur for if extensive time is required for the history and examination, or if your case requires additional laboratory tests or imaging prior to treatment recommendations

6. Your treatment recommendations may consist of dietary, lifestyle, and environmental changes as well as prescribed natural health supplements.

7. Follow-up consultations are scheduled every 2 to 24 weeks allowing you the opportunity to discuss your progress and concerns with Dr. Marzano. Follow up consultations are also available by phone for long distance patients. Abnormal laboratory tests will need to be re-evaluated. The fee for follow-up consultations ranges between $50.00 and $75.00 depending on time and complexity.

8. Dr. Marzano does not propose to treat symptoms or disease of an organic nature. All Dr. Marzano's treatment recommendations are aimed solely at supporting normal physiological function, health, and wellness. Dr. Marzano recommends that you remain under the care of or establish yourself as a patient with a primary medical physician (we can make a referral if you do not have one). Dr. Marzano also recommends that you remain under the care your specialty medical providers.

Your signature below indicates that you have read and fully understand the Patient Acceptance Policy.

____ Date:________________

Patient Signature Is Required.

PERSONAL INFORMATION

Name____

Preferred Name____ Date _______________

Age ________ Date of Birth ____________________ Gender: female __ male___

Genetic Background: Please check appropriate box(s):

❑ African American	❑ Hispanic	❑ Mediterranean	❑ Asian
❑ Native American	❑ Caucasian	❑ Northern European	❑ Other

Married ______ Separated ______ Divorced _____ Widowed _____ Single ____ Partnership ___

With whom do you live? (Include children, parents, relatives, friends, etc)

____

____

Do you have any pets or farm animals? Yes____ No____

If yes, where do they live? Indoors_____ Outdoors _____ Both indoors and outdoors _____

Have you ever lived or travelled outside the United States? Yes ____ No ____

If so, when and where? ____

Occupation ________________________________ Hours per week ________ Retired ________

Type of Business____

Previous occupations:

____

____

Functional Health & Wellness Questionnaire

Please complete the following Health and Wellness Questionnaire to the best of your ability. Your thoroughness and accuracy in answering all appropriate questions will help me evaluate the root cause of your health concerns and determine an effective treatment program. We are very interested in so-called “minor” symptoms as well as the big ones. We know that in many doctor’s offices there is some tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. Our office are different. I am interested in them all. Please include as much information as you can on this form. Thank You!

HEALTH CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one.

Problem	Date of Onset	Frequency of Occurrence	Severity of Symptoms
1.			
2.			
3.			
4.			
5.			

What diagnosis or explanation has been given to you?

____

____

____

____

____

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 all the physicians you have seen for the above health conditions:

1.
2.
3.
4.
5.
6.

Please check all the Alternative Treatments you have tried for your condition(s)

☐ Hyperbaric O2	☐ Massage	☐ Yoga	☐ Environmental medicine
☐ Chiropractic	☐ Herbs	☐ Hypnosis	☐ Nutritional Therapy
☐ Acupuncture	☐ Reflexology	☐ Ayurveda	☐ Biological Dentistry
☐ Iridology	☐ Homeopathy	☐ Light therapy	☐ IV (chelation) therapy
☐ Colonics	☐ Biofeedback	☐ Meditation	☐ Naturopathic medicine

Please add anything additional you would like to tell us about:
____
____
____
____
____
____
____

HEALTH HISTORY

Please check all that apply to the best of your knowledge:

Check all that Apply:	YOU	Father	Mother	Brother	Sister	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Age												
Age at death												
Heart Attack												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
ADD/ADHD												
Alcoholism												
ALS or other Motor Neuron Diseases												
Alzheimer’s												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												

Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Glaucoma												
Headache												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)												
Inflammatory Bowel Disease												
Insomnia												
Irritable Bowel Syndrome												
Kidney disease												
Multiple Sclerosis												
Nervous breakdown												
Obesity												
Osteoporosis												
Other												
Parkinson’s												
Pneumonia/Bronchitis												
Psoriasis												
Psychiatric disorders												
Schizophrenia												
Sleep Apnea												
Smoking addiction												
Stroke												
Substance abuse (such as alcoholism)												
Ulcers												

INJURY & SURGERY

INJURIES	**Date**	**Comments**
SURGERIES	**Date**	**Comments**

Additional:

DIAGNOSTIC STUDIES

DIAGNOSTIC STUDIES	Date	Results and Comments

HOSPITALIZATIONS

Date	Reason and Comments

IMMUNIZATION HISTORY

Please indicate if you were vaccinated as a child: Yes___ No___ Adverse reaction: Yes___ No___

Do you receive a yearly flu shot: Yes___ NO___

Please list all other vaccines received as an adult along with the dates:
____
____

FEMALE MEDICAL HISTORY (women only)

OBSTETRICS HISTORY *Check the box if yes and provide the number of*

- ❑ Pregnancies
- ❑ Caesarean
- ❑ Vaginal deliveries
- ❑ Miscarriage
- ❑ Abortion
- ❑ Living Children
- ❑ Post partum depression
- ❑ Toxemia
- ❑ Gestational diabetes
- ❑ Baby over 8 pounds
- ❑ Breast feeding

GYNECOLOGICAL HISTORY

Age at 1st period:______ Menses Frequency: ______ Length: __________ Pain: Yes____ No ____

Clotting: Yes _____ No _____ Has your period skipped? _______ For how long? ____________________

Last Menstrual Period: ___________ Comments:____

Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?_____________________

Have you ever used hormonal contraception? Yes ____ No_____ If yes, when ___________________________

Use of hormonal contraception: ❑ Birth control pills ❑ Patch ❑ Nuva Ring

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water ❑ Yes ❑ No

Irritability (PMS)?

Last Mammogram ____________________________ Results____

Last PAP Test: _____________________________ Results____

Last Bone Density: _________________ Results: ❑ High ❑ Low ❑ Within normal range

Are you in menopause? Yes _____ No _____ Age at onset of Menopause ______________________________

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin

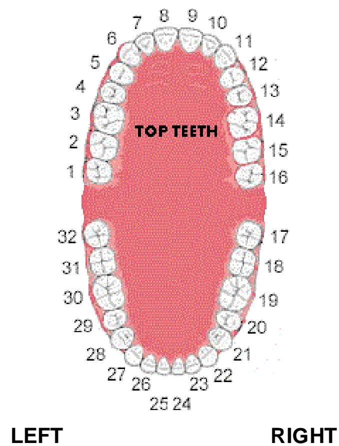
❑ Progesterone ❑ Provera Other ____

How long have you been on hormone replacement? ____

DENTAL HISTORY

- ❑ Sore gums or gingivitis
- ❑ Bleeding gums
- ❑ TMJ problems, popping or clicking jaw
- ❑ Metallic taste in mouth
- ❑ Chronic Halitosis (bad breath)
- ❑ Foul taste in mouth
- ❑ Difficulty chewing
- ❑ Dental filling(s)
- ❑ Root canal(s)

Please circle the teeth you have had problems with and state what type of problem, for example: root canal, crown, abscessed tooth, partials, etc. and indicate which teeth have fillings.



LEFT **RIGHT**

RECORD PROBLEMS:

Example: #10 root canal and crown

MEDICATIONS & SUPPLEMENTS

MEDICATIONS

Please list the medications you are taking now. Please include all non-prescription drugs.

Date started	Medication Name	Reason for taking

SUPPLEMENTS

List all vitamins, minerals and other nutritional supplements

Date started	Supplement Name	Reason for taking

How many times have you taken antibiotics in the past?

How many times have you taken oral steroids in the past?

Have your medications or supplements ever caused any unusual side effects? ____Yes ____No
If Yes, please explain:
____
____
____

ALLERGIES

Please list all known allergies and the corresponding reaction:

Medication/Supplement/Food	Reaction
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

DIET & LIFESTYLE

Height_________________________________	Weight________________________________
Usual weight range ______________________	Desired Weight ________________________
Highest adult weight_____________________	Lowest adult weight ____________________

FOOD

Do you currently follow a special diet or nutritional program? Yes____ No_____ If yes, explain:
____
____

Check all that apply to your dietary habits:

- ❑ Low fat
- ❑ Mixed food diet (animal and vegetable sources)
- ❑ High protein (or Atkin's diet)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Low sodium
- ❑ Low starch/carbohydrate
- ❑ The Blood type Diet
- ❑ Metabolic Type Diet
- ❑ The Zone Diet
- ❑ Mediterranean Diet
- ❑ Diabetic
- ❑ No dairy
- ❑ No eggs
- ❑ No corn
- ❑ No wheat
- ❑ No gluten
- ❑ No soy
- ❑ Other:

Are there any foods that you avoid because they give you symptoms? Yes____ No_____

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom(s)	Delayed or Immediate

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other________________________

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other________________________

Does skipping meals greatly affect your symptoms? Yes _____ No _____

When you purchase organic or hormone/antibiotic free foods? Yes _____ No _____

Do you read food labels and avoid additives and preservatives? Yes _____ No _____

Do you eat home cooked meals? Yes _____ No _____

How many meals do you eat out per week? 0-1_____ 1-3____ 3-5____ >5_____

Please check all that apply to your eating habits:

- ❑ Fast eater
- ❑ Erratic eating habits – skip meals
- ❑ Eat too much
- ❑ Late night eater
- ❑ Eat more than 50% of meals away from home
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Love to eat
- ❑ Eat because I have to
- ❑ Struggle with eating issues
- ❑ Emotional eater (eat when sad, lonely, depressed, bored, stressed)
- ❑ Eating in the middle of the night
- ❑ Diet often for weight control

How often do you consume the following?

ITEM	Daily	Weekly	Favorite Type
Candy			
Cheese			
Chocolate			
Cups of caffeinated coffee or tea			
Cups of decaffeinated coffee or tea			
Cups of hot chocolate			
Diet sodas			
Sodas caffeinated			
Sodas decaffeinated			
Energy Drinks			
Ice cream			
Salty foods: chips, pretzels, etc.			
White bread, rolls, bagels			

While growing up did you consume the following:

Question	Yes	No	Comment
Candy, deserts, or sugar			
Vegetables and fruits			
Soda			
White bread or pasta			
Meat: beef, pork, chicken, wild game, lamb			
Fish and seafood			
Very little meat or fish			
Vegetarian diet with milk & eggs			
Vegan diet without any animal products			

WATER

Number of 8 oz. Glasses per day_____ **Type**: City:___ Distilled:___ Bottled:___ Well:___ Filtered:___

Have you had your water tested? Yes _____ No _____ When?________________

TOBACCO

Currently using tobacco? Yes _____ No _____ How many years? _______ Packs per day: ________
If yes, what type? Cigarette _____ Chew _____ Cigar _____ Pipe _____ Patch/Gum _____
Previous smoking: How many years? _________ Packs per day: __________
Are you exposed to 2nd hand smoke? Yes____ No____

ALCOHOL

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None _____ 1-3 _____ 4-6 _____ 7-10 _____ >10 _____ *If none skip to "Other Substances"*

Previous alcohol intake? Yes ____ (Mild _____ Moderate _____ High _____)

Have you ever thought about getting help to control or stop your drinking? Yes____ No____

Does alcoholism run in the family? Yes _____ No _____ who? ___________________________________

OTHER SUBSTANCES

Are you currently using recreational drugs? Yes____ No____

If yes, what types?:____

EXERCISE

Current Exercise program:	Times per week	Minutes

SLEEP & REST

Average number of hours you sleep ❑ >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:_______________________________________

SOCIAL HISTORY

Do you feel significantly less vital than you did a year ago? Yes _____ No _____

Are you happy? Yes ____ No _____

Do you feel your life has meaning and purpose? Yes ____ No _____

Do you believe stress is presently reducing the quality of your life? Yes ____ No _____

Do you like the work you do? Yes ____ No _____

Have you experienced major losses in your life? Yes ____ No _____

Are you stressed financially? Yes ____ No _____

Would you describe your experience as a child in your family as happy and secure? Yes ____ No _____

Did you feel safe growing up? Yes _____ No _____

Have you ever been involved in abusive relationships in your life? Yes ____ No _____

Have you ever been abused, a victim of a crime? Yes ____ No _____

Was alcoholism or substance abuse present in your childhood home? Yes _____ No _____

Is alcoholism or substance abuse present in your relationships now? Yes _____ No _____

Have you ever sought counseling? Yes ____ No ____ Are you in counseling now? Yes___ No___

Do you have an excessive amount of stress in your life? Yes ____ No _____

Can you handle it? Yes___ No__

Daily stressors: *Rate on a scale of 1 – 10 (1 not stressful - 10 very stressful)*

Work________ Family_______ Social_______ Finances_____ Health______ Other_____

Do you worry about:

Do you practice relaxation techniques? Yes ____ No _____

Hobbies and leisure activities that you enjoy and help relieve stress:

____

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

ESTABLISHING HEALTH GOALS

Patient Responsibility.

The definition of insanity is to keep doing the same thing and expecting different results. Clearly, it is time for a new approach or you wouldn't be here filling out this questionnaire. Have you made the decision to change and are you willing to do what it takes to be well?

Yes☐ No☐

What are some of your lifestyle choices that you feel may be contributing to your health problems?

1.
2.
3.

What things that you have *been unable* to do as a result of your present symptoms.

1.
2.
3.

What things that you plan to do once you are feeling better.

1.
2.
3.

THANK YOU!

Thank you for taking the time to complete the Health and Wellness questionnaire. I commend you on the effort you are undertaking to better your health. I look forward to working with you**.**

Dr. Christopher Marzano