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Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: ____ / ____ / _____ Sex: M / F Marital Status: Single Married Divorced Widowed
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
Work Phone: (____) _____ - _____ Fax Number: (____) _____ - _____ (Home / Work)
Email Address: _____ @ _____

Emergency Contact Name: _____ Phone: (____) _____ - _____
Relationship: _____
Referred By (name and phone #): _____

Drug Allergies: _____

Parental Information (if patient is a minor)

Name: _____ Date of Birth: ____ / ____ / _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Fax: (____) _____ - _____
Employer Name: _____ Position: _____
Address: _____ City: _____ State: _____ Zip: _____
Work Phone: (____) _____ - _____

Financial Policy

Fees for all services and products are due at the time of service. I understand that insurance is not accepted at this office. Payment may be made in the form of cash, check or credit card. Unopened supplements may be exchanged or returned for office credit within 30 days of purchase.

Appointments

As a courtesy to other patients, please be on time for your scheduled appointment. Should you need to cancel or reschedule your appointment, please give 24 hours notice to avoid a cancellation or no show fee.

I have read the above statement and I agree to all terms and conditions.

Signature: _____ **Date:** _____ / _____ / _____



Past Medical History

Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chron's / Colitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> IBS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Fever |
| <input type="checkbox"/> Birth Trauma (your own birth) | <input type="checkbox"/> Gout | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |

List medications you are currently taking:

Medications/Supplements	Strength	How many per day	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List substances, medications and/or supplements you are allergic to:

List any major surgeries you have had:

Date	Problem
_____	_____
_____	_____
_____	_____

List significant trauma you have had (auto accident, falls, etc):

List significant family history:

Your Diet:

- Appetite: Strong / Weak Coffee (how many ___) Sugar Thirst for water: Y / N
 Soft Drinks (how many ___) Salty Foods # of glasses per day: _____

Your Lifestyle:

- Alcohol Recreational drugs Tobacco Stressful Marijuana Occupational Hazards
 Regular Exercise: Type: _____ Frequency: _____ / Type: _____ Frequency: _____

General Symptoms:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Sweats easily |
| <input type="checkbox"/> Strong appetite | <input type="checkbox"/> Restful sleep | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Vertigo / dizziness |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Bleed / bruise easily |
| <input type="checkbox"/> Recent weight loss/weight gain | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Chills | <input type="checkbox"/> Peculiar taste |
| <input type="checkbox"/> Frequently skip meals | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Night sweats | _____ |



Head, Eyes, Ears, Nose, and Throat

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Glasses / contacts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Excessive Saliva | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Grind teeth | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Color of phlegm: _____ | <input type="checkbox"/> TMJ | <input type="checkbox"/> Headaches | <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Migraines | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Other head/neck |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Thrush | <input type="checkbox"/> Itchy eyes |

Respiratory

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough: wet or dry? _____ | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Color of phlegm: _____ | | <input type="checkbox"/> Asthma/wheezing _____ | <input type="checkbox"/> Difficulty breathing when lying down | |

Cardiovascular

- | | | | | |
|--|---|--------------------------------------|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Phlebitis |

Gastrointestinal

- | | | | | |
|---|--|---|--|----------------------------------|
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Annual fissures | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Black stool | Bowel movements:
Color: _____ |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Burning anus | <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Crohn's/Colitis | Odor: _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gas | Texture/form: _____ |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Intestinal pain/cramping | <input type="checkbox"/> Itchy anus | _____ |
| <input type="checkbox"/> Laxative use | <input type="checkbox"/> Mucous stools | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Rectal pain | _____ |

Musculoskeletal

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Other (describe):
_____ |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited use | _____ |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Rib pain | | _____ |

Skin and Hair

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hair loss / excessive hair loss |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Other hair/skin problems: _____ |
| <input type="checkbox"/> Ulceration | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Eczema _____ |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infection of nails | <input type="checkbox"/> Hives _____ |

Neuropsychological

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression / seasonal depression | <input type="checkbox"/> Abuse survivor (physical/sexual) | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Considered/attempted suicide | <input type="checkbox"/> Tics | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Seeing Therapist | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Other: _____ |

Genitourinary

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Incontinent | <input type="checkbox"/> Gallstones | <input type="checkbox"/> UTI (frequent __) |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Nocturnal emission |
| | | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Other: _____ |

Gynecological

- | | | | |
|--|--|---|------------------------------|
| Age menses began: _____ | Date last period began: _____ | Date of last PAP: _____ | # of pregnancies: _____ |
| Length of cycle (day 1 to day 1)
_____ | <input type="checkbox"/> Painful period | <input type="checkbox"/> Breast lumps | # of live births: _____ |
| Duration of flow: _____ | <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Clots | # of premature births: _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> PMS | Age at menopause: _____ |
| | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Yeast infections | |



Daily Food, Exercise and Supplement Log

(Please keep a food/exercise log to further help us!)

<i>Day 1</i>	<i>Day 2</i>	<i>Day 3</i>	<i>Day 4</i>
Meal 1	Meal 1	Meal 1	Meal 1
Meal 2	Meal 2	Meal 2	Meal 2
Meal 3	Meal 3	Meal 3	Meal 3
Meal 4	Meal 4	Meal 4	Meal 4
Meal 5	Meal 5	Meal 5	Meal 5
Meal 6	Meal 6	Meal 6	Meal 6
Exercise Log and Notes:	Exercise Log and Notes:	Exercise Log and Notes:	Exercise Log and Notes:

Important: On your first visit, please bring a list of supplements and prescription medications that you are currently taking. If you desire, you may bring a copy of your blood work done within the last 12 months. Please keep this 4-day food diary of everything that you eat and drink. Do not modify any of your food intake it is necessary for you to be as candid as possible in all areas for an accurate assessment of your current nutritional status.



Disclosure of Patient Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Also, please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Phone #: (_____) _____ - _____
Name: _____ Phone #: (_____) _____ - _____

Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information if other than your home or work number (such as a cell phone number*):

(_____) _____ - _____. (* I am fully aware that a cell phone is not a secure and private line.)

Patient Name (please print): _____

Signature of Patient

Date

Acknowledgement of Review of Notice of Privacy Practices

I, _____ have reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Disclaimer

I, _____ (name) hereby attest to the following:

1. I fully understand that the Energy Health nutritionists are not medical doctors and that I am not here for medical diagnostic or treatment procedures.
2. The services performed by the Energy Health nutritionists are at all times restricted to consultation on the subject of natural health and are intended of the maintenance of the best possible state of health and do not involve the diagnosing, prognosticating, or treatment of disease.
3. I am here, on this and any subsequent visit, solely on my own behalf.

Signature of Patient

Date

We are delighted that you have chosen the path of health and wellness. It is a journey that we will make together by educating, motivating and supporting you as you begin the journey to better health and wellness.