INTAKE FORM

Michael Mathieu Foundational Health

Name: _____ Date: _____

Address: _____ Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Email Address: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Age: _____ Height: _____ Weight: _____

Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Live with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Education: _____

Occupation: _____ Hours per week: _____ ☐ Retired

Employer: _____ Work Address: _____

In case of emergency, whom should we contact?

Name: _____ Relationship: _____

Address: _____ Phone: _____

How did you hear about our Wellness and Nutrition Program?

What is your major complaint. Please List when each symptom began and be as descriptive as possible

What are your current medications?

What are your current vitamins and/or supplements?

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.

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).

PATIENT HISTORY

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

MERCURY

☐ 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? Explain: _____

☐ 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?

LEAD

☐ 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.)

☐ 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 your self 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 Do you have a crawl space?

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

☐ 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?

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

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

☐ 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?

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? _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year.
If you cannot answer a question, simply leave it blank:

POINT SCALE

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

_____ Anxiety
_____ Mood swings
_____ Enraged behavior or anger for no reason
_____ Excessive shyness, timidity, social phobia (not typical to your personality)
_____ Irritability (not typical to your personality)
_____ Low body temperature (below 97.5o)
_____ Insomnia (can't get to sleep or return to sleep)
_____ Dizziness
_____ Sound in ears (ringing or hearing your heart beat)
_____ Psychological symptoms, even thoughts of suicide
_____ Sensitivity to sound
_____ Indecisiveness
_____ Feeling of being overwhelmed or fearful
_____ Metallic taste in your mouth
_____ Bad breath
_____ Bleeding gums
_____ Sensitive teeth
_____ Canker sores or other sores in the mouth
_____ Floaters, shadows or swimmers when you read or look into the sky
_____ Dyslexia or loss of place while reading, even as a child
_____ Swelling eyelids
_____ Peeling on top layer of skin (hands, feet)
_____ Dry skin
_____ Heart pain (angina) and you are under 45 years old
_____ Depression
_____ Gout (arthritic pain, especially in big toes)
_____ Pain in shoulders or upper back
_____ Twitching eyelids
_____ Anemia (low iron/hemoglobin on blood test)
_____ Wrist/ankle drop or weak extensor muscles
_____ Hair falls out (not normal male pattern baldness)

_____ Sensitivity to light

_____ Fatigue after exercising (feeling worse)

_____ Bad night vision or seeing halos around lights

_____ Shortness of breath, with very little effort

_____ Excessive thirst and/or frequent urination

_____ Red eyes or tearing

_____ Blurred vision at times

_____ Morning stiffness

_____ Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners

_____ Chronic fatigue or weakness

_____ Non-restful sleep

_____ Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)

_____ Trouble processing new information

_____ Word reversal or trouble finding words

_____ Sensitivity to touch

_____ Short-term memory loss

_____ Chronic sinus congestion

_____ Dry non-productive cough

_____ Muscle twitching

_____ Excessive sweating, especially at night

_____ Joint pain-not necessarily true arthritis-can move from joint to joint

_____ Difficulty losing weight regardless of diet or exercise

_____ Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis

_____ Frequent illness, prolonged illness or sick days

_____ Numbness or weakness in arms and legs

_____ Headaches

_____ Trouble adding or dividing numbers in your head

_____ Fluctuating constipation and diarrhea

_____ Stomach pain for no apparent reason

_____ Appetite swings

_____ Frequent muscle aches, cramps, unusual sharp sudden pains

_____ Rashes or rosacea

_____ Cold extremities (hands and feet)

_____ Total