SCAR/TRAUMA CHART

Directions

All Scars: Please draw a red line on the drawing where you have scars, even if they are very old. Don’t forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, etc.

All Trauma Areas: Please put a red “X” where you have had trauma even if it is very old. Don’t forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such as a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury: Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")
Food Habits

**Eating Out**  Do you eat out at restaurants?  ☐ Yes  ☐ No
If yes, how often?  ____________________________  Where?  ____________________________
What type of food do you eat at restaurants?  ____________________________

**Home Meals**  Do you prepare meals at home?  ☐ Yes  ☐ No
If yes, how often?  ____________________________
If yes, what type of food do you prepare?  ____________________________

**Meal Habits**  Do you (circle)  a) skip meals often  b) have irregular eating times  c) eat food past 7 pm

**MSG**  Do you avoid food/drinks that list "natural flavors" (which means hidden MSG) on the label?  ☐ Yes  ☐ No

**Water**  Do you drink tap water?  ☐ Yes  ☐ No
What brand drinking water do you use?  ____________________________
If you have a home water purifier, when was the cartridge last changed?  ____________________________

**THIS SECTION OPTIONAL**

**Typical Diet**  Please fill out your typical diet for the last few days. Please be as detailed as possible. (For example, instead of writing "chicken," identify what brand and how it was made such as "baked Foster Farms chicken." Instead of writing "salad," identify what it's made of, such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Olive Oil.") — PLEASE BE HONEST

**Breakfast** (Time eaten: __________)
________________________________________________
________________________________________________
________________________________________________

**Lunch** (Time eaten: __________)
________________________________________________
________________________________________________
________________________________________________

**Dinner** (Time eaten: __________)
________________________________________________
________________________________________________
________________________________________________

**Snacks** (Time eaten: __________)
________________________________________________
________________________________________________
________________________________________________
**Women:**

- Regular menstrual cycle?  □ Yes  □ No
- Pregnant?  □ Yes  □ No
- Number of children: ____________
- Number of pregnancies: ____________
- Age of first menstruation: ____________
- Age of menopause (if applicable): ____________
- Average number of days of flow: ____________
- Average number of days of entire cycle: ____________
- □ Vaginal discharge  □ Bleeding between periods  □ Menstrual cramps: □ Mild  □ Severe

Do you experience any of the following pre-menstrual syndromes?
- □ Nausea  □ Vomiting  □ Water retention  □ Breast swelling
- □ Food cravings  □ Headaches  □ Migraines  □ Breast tenderness
- □ Depression  □ Irritability  □ Anxiety  □ Other emotions: ____________
- □ Dull pain, where?  □ Sharp pain where?

**Women please fill in the following menstrual cycle.**

<table>
<thead>
<tr>
<th>Days of Cycle</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color (normal, bright red, pale, brown, rust, dark, purple, other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of flow (normal, heavy, light)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain / Cramps (location dull, sharp, other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clots (large, small, black, purple, red, other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting (check if yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea (check if yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Men:**

- □ Swollen testes  □ Testicular pain  □ Impotence  □ Premature ejaculation
- □ Feeling of coldness or numbness in external genitalia

**Medications:** Please check the box if taking and list specific medications if possible

- □ Antacids Pills  □ Blood Thinning  □ Aspirin  □ Birth Control Pills
- □ Antibiotics  □ Cortisone Pills  □ Vitamins  □ Weight Reduction Pills
- □ Hormones  □ Blood Pressure  □ Iron  □ Cough Medicine
- □ Pain Med.  □ Sleeping Pills  □ Laxatives  □ Insulin, Diabetic
- □ Water Pills  □ Tranquilizers  □ Digitalis  □ Thyroid Medication

Other Medications (if you have a written list give it to the receptionist to be copied)
- ______________________________________
- ______________________________________
- ______________________________________

Other Comments:
- ______________________________________
- ______________________________________
- ______________________________________

Patient Signature: ____________________________  Date: ____________
Recent tests: (please indicate test results and date below)

- Physical
- Cholesterol
- Prostate
- Blood (which?)
- HIV/STD
- Pap Smear
- Mammography
- Other:__________________

Test Results and Date: ______________________

Check any you have had in the past:

- Diabetes
- Thyroid disorder
- Syphilis
- High Fever
- Other lung illnesses
- Asthma
- Nervous disorder
- Other liver illnesses
- Allergies
- Tuberculosis
- Measles
- Hepatitis
- Other kidney illnesses
- Pneumonia
- Mononucleosis
- Other heart illnesses
- Glaucoma
- Emphysema
- Meningitis
- Multiple Sclerosis
- STDs
- Gonorrhea
- Epilepsy
- Other:
- CVA
- Jaundice
- HIV
- Migraines
- Rheumatic Fever
- Mumps
- Paralysis
- Vein condition
- Bleeding Tendency
- Polio
- High Blood Pressure
- Heart Disease
- Chicken Pox
- Cancer

Pets

Do you have pets?  ☐ Yes  ☐ No
If so, what kind and how many?

Is/are the pet allowed in the house?  ☐ Yes  ☐ No  On your bed?  ☐ Yes  ☐ No
What kind of food do you feed your pets?

Food Choices

Click each type of food you eat often.

<table>
<thead>
<tr>
<th>Pre-made foods:</th>
<th>a) canned foods</th>
<th>b) boxed cereals</th>
<th>c) frozen dinners</th>
<th>d) bottled of frozen juices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red meat:</td>
<td>a) beef</td>
<td>b) pork</td>
<td>c) lamb</td>
<td>d) at restaurants</td>
</tr>
<tr>
<td>Chicken:</td>
<td>a) commercially grown brand</td>
<td>b) naturally raised brand:</td>
<td>c) organic (direct from farm)</td>
<td>d) organic butter</td>
</tr>
<tr>
<td>Turkey:</td>
<td>a) commercially grown brand</td>
<td>b) naturally raised brand:</td>
<td>c) organic (direct from farm)</td>
<td>d) organic butter</td>
</tr>
<tr>
<td>Fish:</td>
<td>a) canned tuna</td>
<td>b) fresh fish</td>
<td>c) frozen fish</td>
<td>d) goat's milk</td>
</tr>
<tr>
<td>Fresh vegetables:</td>
<td>c) commercial (in store)</td>
<td>b) organic (in store)</td>
<td>c) organic (direct from farms)</td>
<td>d) commercial olive oil</td>
</tr>
<tr>
<td>Fresh fruit:</td>
<td>a) commercial (in store)</td>
<td>b) organic (in store)</td>
<td>c) organic (direct from farms)</td>
<td>d) organic olive oil</td>
</tr>
<tr>
<td>Whole grains:</td>
<td>a) commercially grown (store bought)</td>
<td>b) organically grown (store bought)</td>
<td>c) organic (direct from farmers)</td>
<td>d) organic olive oil</td>
</tr>
<tr>
<td>Whole beans:</td>
<td>a) commercially grown (store bought)</td>
<td>b) organically grown (store bought)</td>
<td>c) organic (direct from farmers)</td>
<td>d) organic olive oil</td>
</tr>
<tr>
<td>Eggs/Butter:</td>
<td>a) commercial eggs</td>
<td>b) organic eggs</td>
<td>c) commercial butter</td>
<td>d) at restaurants</td>
</tr>
<tr>
<td>Milk:</td>
<td>a) commercial milk</td>
<td>b) organic milk</td>
<td>c) commercial cheese</td>
<td>d) at restaurants</td>
</tr>
<tr>
<td>Cheese:</td>
<td>a) commercial cheese</td>
<td>b) commercial cheese</td>
<td>c) commercial cheese (store bought)</td>
<td>d) at restaurants</td>
</tr>
<tr>
<td>Other:</td>
<td>a) commercial ketchup</td>
<td>b) commercial mustard</td>
<td>c) vinegar</td>
<td>d) commercial olive oil</td>
</tr>
</tbody>
</table>

Food Stressors

On the line please indicate how many times per week you have each item.

Stimulants
- coffee (including decaf.)
- black tea, caffeine drinks
- soft drinks (colas, etc.)
- drinks w/NutriSweet (diet soda)
- alcohol (wine, beer, etc.)
- chocolate
- candy, pastries, sweets

Toxic Oils
- fried foods
- fast food
- potato or corn chips
- roasted nuts
- mayonnaise
- margarine
- peanut butter

Commercial Dairy
- cow's milk
- yogurt
- frozen yogurt
- ice cream
- sour cream
- cheese (commercial)
- cottage cheese

Highly Heated Foods
- bread (store bought)
- crockers (store bought)
- bagels (store bought)
- buns (store bought)
- pasta (store bought)
- muffins (store bought)
- cookies (store bought)