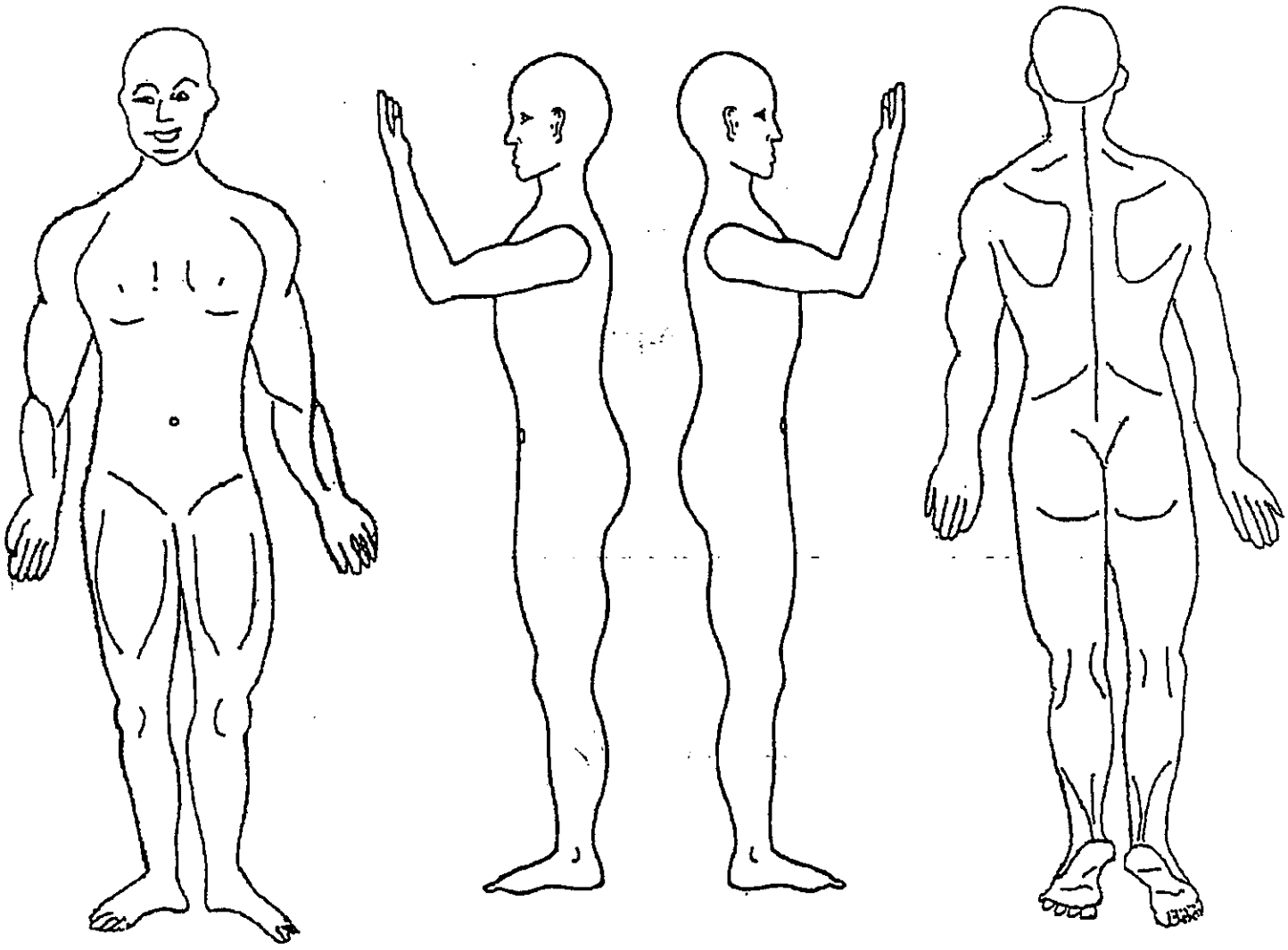
SCAR/TRAUMA CHART



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 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,

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

Men:

☐ Swollen testes ☐ Testicular pain ☐ Impotence ☐ Premature ejaculation

☐ Feeling of coldness or numbness in external genitalia ☐ Other _____

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

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 Circle each type of food you eat often.

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

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/NutraSweet (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) ____

crackers (store bought) ____

bagels (store bought) ____

buns (store bought) ____

pasta (store bought) ____

muffins (store bought) ____

cookies (store bought) ____