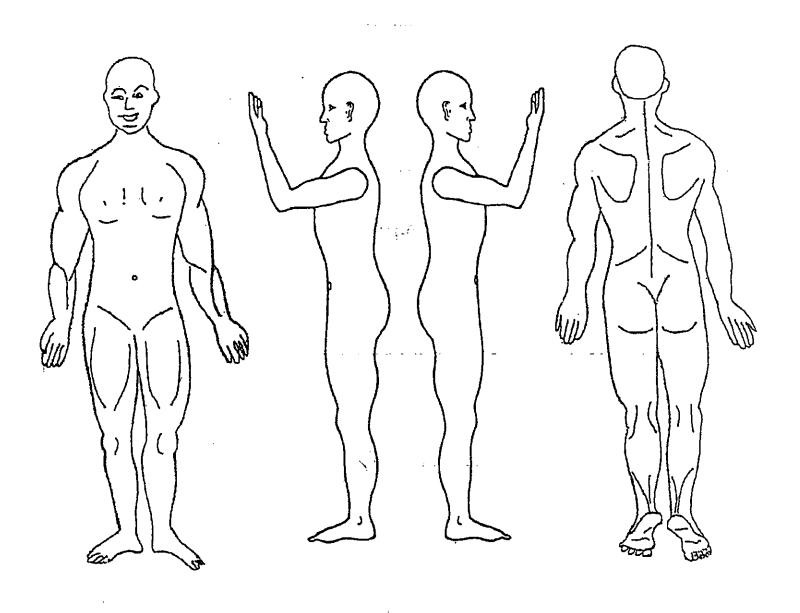
## SCAR/TRAUMA CHART



## **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?
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?
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? $\square$ Yes $\square$ N	0	Pregn	ant?	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:										
$\square$ Vaginal discharge $\square$ Bleeding beh	ween peric	ods 🗆 Me	enstrual cr	amps: 🛘	Mild 🗆	Severe				
Do you experience any of the following	pre-menst	trual syndro	mes?							
☐ Nausea ☐ Vomiting										
☐ Food cravings ☐ Headaches	☐ Headaches ☐ Migraines					☐ Breast tenderness				
☐ Depression ☐ Irritability		☐ Anxiet	у		ther emo	tions:				
$\square$ Dull pain, where? $\square$ Sharp pain w	/here?									
. Women please fill in the following mensi	trual 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)	<del>-  </del>				-					
Nausea (check if yes)			<u> </u>			}				
Other										
			-							
Men:	in	☐ impot	ence	Пр	remature	emature elaculation				
Swollen testes			erice		Other					
☐ Feeling of coldness or numbness in e			<u> </u>							
Medications: Please check the box if taking	ng and <i>list sp</i> e	ecific medica	ntions if possi							
☐ Antacids Pills ☐ Blood Thinning	ng	☐ Aspirir	ì		☐ Birth Control Pills					
☐ Antibiotics ☐ Cortisone Pill	☐ Cortisone Pills		ins		☐ Weight Reduction Pills					
☐ Hormones ☐ Blood Pressu	☐ Blood Pressure				Cough Medicine					
☐ Pain Med. ☐ Sleeping Pills	☐ Sleeping Pills		ves		☐ Insulin, Diabetic					
☐ Water Pills ☐ Tranquilizers	☐ Tranquilizers			ПТ	☐ Thyroid Medication					
Other Medications (if you have a written list	give it to the	receptionist t	o be copled	•		. <u> </u>				
•				•	<u></u>					
			_	•						
				•						
Other Comments:										
Patient Signature:			<u></u>		_ Date:					

.

. ...

Physical		ilcate test re: olesteroi	sults and da Prosto							
☐ HIV/STD	_			= 5.55 G (W.11011;)						
	_									
Test Results an	a Dale;	<del></del>		·	<del></del> -			<del></del>		
Check any yo	u baya k	and in the			<del></del>		<u> </u>	<del>-</del>		
☐ Diabetes		☐ Allergies	past:							
☐ Thyroid disorder ☐ Tuberculosis			☐ Glaucoma			□ CVA		☐ Vein condition		
Syphilis				L Emphysema			Jaundice		☐ Bleeding Tendency	
			☐ Meningitis		□ HIV		Polio			
	High Fever Hepatitis			☐ Muitiple Sclerosis		sis	☐ Migraines		☐ High Blood Pressure	
	Other lung illnesses			es 🗌 STDs			Rheumatic Fever		☐ Heart Disease	
☐ Asthma		Pneumon		☐ Gonorrhea			☐ Mumps		☐ Chicken Pox	
☐ Nervous disore	_	Mononuc	leosis	□ Epilepsy			□ Paralysis		☐ Cancer	
Other liver illn	esses [	Other hed	art illnesses	Other	<del></del>		·			
Pets										
Do you have p	ets? 🗌	Yes □ No	)							
If so, what kind	and hov	w many?_	<del></del>		<del></del>	·	·			
Is/are the pet o	illowed ii	n the hous	e? 🗌 Ye	s 🗆 No	On you	ır bed	? □ Yes □	No		
What kind of fo	od do y	ou feed yo	our pets ?	<del>-                                    </del>						
Food Choice	S Circle ed	ach type of f	ood you ea	t often.						
Pre-made foods:	e-made foods: a) canned foods			b) boxed cereals		c) frozen dinners		d) bottled of frozen juices		
Red meat:	e) take-out food Meat: a) beef			b) pork						
Chicken:	n: a) commercially grown brand			b) naturally raised brand:		c) lamb commercially grown brand; naturally raised bro				
Turkey: Fish:	a) canned	nmercially grown brand		b) naturally raised brand:						
Fresh vegetables:	getables: a) commercial (in store)			b) fresh fish b) organic (in store)		<ul><li>c) frozen fish</li><li>c) organic (direct from farm)</li></ul>		d) at restaurants		
Fresh fruit: Whole grains:	a) commercial (in store)		b) organic (in store)		c) organic (direct from farm)					
Whole beans:		ommercially grown (store bought) b) orgonommercially grown (store bought) b) orgo		<ul> <li>b) organically</li> <li>b) organically</li> </ul>	organically grown (store bought)		c) organic (direct from farmers)			
Eggs/Butter:	a) commercial eggs		<ul><li>b) organically grown (store bought)</li><li>b) organic eggs</li></ul>		c) organic (direct from farmers) c) commercial butter		d) organic butter			
Milk: Cheese:	<ul><li>a) commerce</li><li>a) commerce</li></ul>	rcial milk b) organic r		b) organic mil	rilk		c) goat's milk		o, organic buller	
Other:	a) commerc			<ul><li>b) organic ch</li><li>b) commercia</li></ul>		ought)	c) vinegar		d) announced to the con-	
Food Stressors	On the iir	ne please inc				vou ha	-		d) commercial alive all	
Stimulants		Toxic O		•			•	Links	H-st-de	
coffee (including decaf.)	coffee (including decaf.) fried foods		Commercia cow's milk			, ,		Heated Foods		
black tea, caffeine drinks fast food			yogurt				re bought)			
soft drinks (colas, etc) potato or corn chips		_	frozen yogurt				store bought)			
drinks w/NutraSweet (diet soda) roasted nuts			ice cream		_	bagels (store bought)				
alcohol (wine, beer, etc)_		mayonnaise			sour cream		į	buns (store bought)		
chocolate					cheese (co		oi)	pasta (store bought)		
candy, pastries, sweets	peanut butte	er	_		cottage cheese		muffins (store bought) cookles (store bought)			
		1		1	•			(3)		