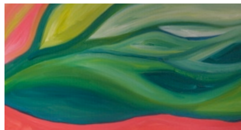
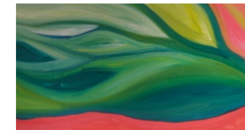


# Living Medical Arts PLLC.

Mandy Gulla ND, LM, LMP



## Client History Form

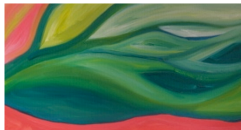
*This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.*

**Client Information** **Today's Date:**

| NAME: LAST | FIRST | MI | Date of Birth Age | **M / F** |
|---|---|---|---|---|
| Street Address | | City | State | Zip Code |
| Phone Numbers<br>Home: | Cell: | | Work: | |
| Email Address: | | | | |
| Referred By: | How did you hear about us? | | | |
| Main Reason for Visit<br>1. | | | Duration | |
| 2. | | | Duration | |
| 3. | | | Duration | |
| 4. | | | Duration | |
| Primary Care Physician:<br>Address: | | | Date of Last Physical Exam:<br>Telephone: | |
| Practitioner (if not PCP): | | | Address:<br>Telephone: | |

| **Specialists** (*If any*) | |
|---|---|
| | |
| | |

| **Past Medical History** | |
|---|---|
| Are you currently working with a doctor of conventional medicine?<br>MD DO | Name: |
| What kind of treatment have you received? | From: |
| Have you ever seen a Naturopathic Physician, Chiropractor, Acupuncturist, or other Alternative Health Practitioner for your *current problem*? | Name: |



# Living Medical Arts PLLC.

## Mandy Gulla ND, LM, LMP

| Have you ever seen a Naturopathic Physician, Chiropractor, Acupuncturist, or other Alternative Health Practitioner for *any other problems*? | Name: |
|---|---|

| **Surgeries and Hospitalizations** | |
|---|---|
| Reason/Diagnosis | Year |
| | |
| | |
| | |
| | |
| | |

| **Current Medication** | | | |
|---|---|---|---|
| Medication Name | Dose & Frequency | Approx. Start Date | Reason for Use |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **Supplements & Over-the-Counter Medications** | | | |
|---|---|---|---|
| Supplement/Medication | Dose & Frequency | Approx. Start Date | Reason for Use |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **Allergies** □ *NO KNOWN ALLERGIES* | |
|---|---|
| Do you have any allergies to any of the following: | If yes, please list the allergen(s) and the reaction(s) experienced: |
| Chemicals | |
| Drugs (over-the-counter or | |

| | |
|---|---|
| prescription) | |
| Herbs | |
| Inhalants | |
| Other | |
| Perfumes | |
| Pets | |

| **Screening** | | |
|---|---|---|
| **Basic Tests** | **Last date done** | **Results (+ or -) and state findings** |
| Blood work, incl. cholesterol | | |
| Cardiac test (EKG, echo, stress, etc.) | | |
| Colonoscopy | | |
| Dermatologist | | |
| Mammogram (women) | | |
| MRI | | |
| Ophthalmologist | | |
| PAP Smear (women) | | |
| Physical | | |
| Prostate Exam, PSA (men) | | |
| Thyroid | | |
| Ultra Sound/CT Scans | | |
| Other: | | |

**Medical & Family History-** *Please select which applies to you or your family below*

| | Self | Family | | Self | Family | | Self | Family |
|---|---|---|---|---|---|---|---|---|
| Alcohol Abuse | | | Gallbladder disease/stone | | | Migraines or Headaches | | |
| Allergies | | | Glaucoma | | | Mumps | | |
| Anemia | | | Gout | | | Obesity/Overweight | | |
| Arthritis | | | Heart Attack/ Angina | | | Osteopenia/Osteoporosis | | |
| Asthma/COPD | | | Heart Failure (CHF) | | | Other Psychiatric Illness | | |
| Cancer: (type) | | | Heart Valve Disorder | | | Palpitations | | |
| Chicken Pox | | | High Blood Pressure | | | Polio | | |
| Cholesterol | | | High Blood Sugar | | | Pulmonary HTN | | |
| Colitis | | | HIV | | | Rheumatic Fever | | |
| Constipation | | | Hyperthyroidism | | | Seizures | | |
| Dementia | | | Hypothyroidism | | | Shortness of Breath | | |
| Depression/ Anxiety | | | Insomnia | | | Sleep Apnea | | |
| Diabetes Mellitus | | | Irregular Heart beat | | | Strep/Tonsillitis | | |
| Dizziness | | | Kidney Disease/ stones | | | Stroke | | |
| Diarrhea | | | Liver Disease | | | Thyroid Disorder | | |
| Drug Abuse | | | Loss of Concentration | | | Tuberculosis | | |

| Ear Infections | | | Loss of Consciousness | | | Ulcers | | |
|---|---|---|---|---|---|---|---|---|
| Eating Disorder | | | Measles | | | Other | | |
| Eczema/Skin Issues | | | Memory Loss | | | | | |

| **Personal & Social History** | **Y** | **N** | | **Y** | **N** |
|---|---|---|---|---|---|
| Do you wear a seatbelt? | | | Do you wear a helmet when riding your bike or motorcycle? | | |
| Do you enjoy your work? | | | Do you take vacations? | | |
| Place of Birth: | | | Occupation: | | |
| What do you enjoy most in your life? | | | | | |
| What are your main hobbies and interests? | | | | | |

**REVIEW OF SYSTEMS**

| *Please check YES or No. For any YES answer, please provide brief description * Please circle applicable answers* | | | |
|---|---|---|---|
| **General** | **Y** | **N** | **Frequency/Severity** |
| Fever/Chills | | | |
| When you rise quickly from a sitting or lying position, do you ever get dizzy | | | How often |
| What do you normally feel like temperature-wise compared to others: Warmer Cooler Average | | | |
| What are the temperatures of your hands and feet generally Warm Cool Average | | | |
| How often do you suffer from colds, the flu, sore throat, or yeast infections throughout the year | | | |
| **Neurology** | **Y** | **N** | **Frequency/ Severity** |
| Numbness/tingling | | | |
| Loss or change of sensation | | | |
| Loss of reflexes | | | |
| **Cardiovascular** | **Y** | **N** | **Frequency/Severity** |
| Chest pain at rest or exercise | | | |
| Frequent bruising | | | |
| Swelling of legs | | | |
| Shortness of breath at rest or exercise | | | |
| **Head/Eyes/Nose/Ears/Mouth/ Throat** | **Y** | **N** | **Frequency/Severity** |
| Head Trauma | | | |
| Blurry vision | | | |
| Sinus problems | | | Chronic? |
| Hearing difficulty | | | |
| Ringing in ears | | | |
| Mouth sores | | | |
| Enlarged lymph nodes/glands | | | Where? |

| Gastrointestinal | Y | N | How Often/How Severe |
|---|---|---|---|
| Have you ever been told you have a hiatal hernia | | | |
| *Stool: Formed / Loose / Hard / Mucus/Black/Red/Yellow/Pale/Tar / Blood | | | Number of bowel movements per day? |
| Constipation: hard and small | | | Alternating consistency Strong odor |
| Diarrhea | | | |
| Undigested food in stool | | | |
| Do you have thin, long, narrow stools | | | |
| Hemorrhoids or fissures | | | |
| Do you ever experience rectal itching | | | |
| Acid reflux/GERD | | | |
| Nausea and or Vomiting | | | |
| * Bloating/Fullness | | | |
| * Excessive belching/flatulence | | | |
| * Do you have gas in (circle what applies): upper abdomen lower abdomen both areas | | | |
| Have you ever fasted? Juice or Water ? How long have you fasted? | | | |
| How did you feel while you were fasting? | | | |

| Genitourinary/Bladder/ Kidneys | Y | N | Frequency/Severity |
|---|---|---|---|
| * Thirst: Lack of / Too much | | | |
| Bladder Infections | | | How was it treated? |
| * Cloudy/Bloody urination | | | |
| * Difficulty / Pain / Frequency / Burning / Incontinency | | | |
| Do you get up to urinate at night | | | How often? Has this increased in recent years? |
| Do you have difficulty with flow? | | | |
| Does your urine have a strong odor? | | | |
| * Is your urine (circle one): dark yellow bright yellow cloudy pale clear | | | |

| Musculoskeletal | Y | N | Frequency/Severity |
|---|---|---|---|
| Muscle loss/weakness | | | |
| Do you see a Chiropractor | | | How Often |
| Any regular body treatments / massage | | | How Often |
| Pain: What body part Muscle Joint Scale (1-10) | | | |

| Skin/Hair | Y | N | Frequency/Severity |
|---|---|---|---|
| * Skin: Acne / Dry / Oily | | | Location: |
| Loss of collagen/firmness | | | Location: |

| | | | |
|---|---|---|---|
| Wrinkles | | | Location: |
| Pigmentation/Scarring | | | Location: |
| Cellulite | | | Location: |
| Any history of skin cancer | | | Location : Kind: Severity: |
| Do you wear sunscreen | | | Kind: When: |
| * After sun exposure do you (circle one): Always burn Sometimes Burn Rarely Burn Never Burn Tan | | | |
| * Hair: Dry / Oily | | | |
| Hair loss /Pubic hair loss | | | |
| **Emotional** | **Y** | **N** | **Frequency/Severity** |
| Do you see a counselor or psychiatrist | | | |
| Depression | | | |
| Anxiety | | | |
| Stress | | | |

**Nutrition Evaluation**

| |
|---|
| Breakfast: |
| Snack: |
| Lunch: |
| Snack: |
| Dinner: |
| Dessert: |
| Beverages: |
| Vegetable intake (please circle): < 10% 20-40% 41-60% >60% |
| Food Allergies: Food Dislikes: Foods currently avoiding: |
| Food(s) you crave: Any specific time? |

| **Nutrition (continued)** | **Y** | **N** | Notes | | **Y** | **N** | Notes |
|---|---|---|---|---|---|---|---|
| Partner or spouse overweight? | | | By ____lbs. | I cook my meals | | | |
| I eat out _____ times per week | | | | I shop for food | | | |
| I eat fast foods ___times/week | | | | I use a shopping list | | | |
| I eat when I am stressed | | | | I use sugar substitutes | | | |
| I skip meals | | | | I use butter | | | |
| I plan my meals | | | | I use margarine | | | |

| **Female Patients** | **Y** | **N** | |
|---|---|---|---|
| Any breast lumps | | | Any breast concerns |

| Are you currently sexually active | | | Are you satisfied |
|---|---|---|---|
| Do you use contraception | | | Type |
| Are you pregnant | | | |
| Are you breastfeeding | | | |
| History of physical abuse | | | If yes, at what age |
| History of sexual abuse | | | If yes, at what age |
| History of sexually transmitted infection | | | Type and Date |
| Are your cycles regular? | | | Period begins every ________ days. How long do periods last ________ |

| | |
|---|---|
| Age at first onset of period: | Date of Last Menstrual Period: |
| *What color is the blood (circle): light red dark red medium with clots | |
| Miscarriages:__________ Abortions:______ Living Children _________ Vaginal birth________ C-Section _________ | |
| *Sexual partner preference: Male Female Both<br>*Personal gender preference Male Female Both | |

| *Please select all that apply* | Y | N | | Y | N | |
|---|---|---|---|---|---|---|
| Heavy periods | | | Food cravings | | | |
| Painful periods | | | Cramps | | | |
| Water retention | | | Hot Flashes | | | |
| Breast tenderness | | | Loss of orgasm | | | |
| Vaginal Dryness | | | Loss of libido | | | |
| Mood swings | | | Irritability | | | |

| **Male Patients** | **Y** | **N** | |
|---|---|---|---|
| Any problems with impotency (getting or maintaining an erection) | | | |
| Any sores on your penis | | | |
| Any abnormal discharge from your penis | | | |
| History of sexually transmitted infection | | | |
| Any prostate problems? | | | Date of last prostate exam: |
| Are you currently sexually active | | | Are you satisfied |
| Do you use contraception | | | Type |
| Have you ever been physically abused? | | | If yes, at what age |
| Have you ever been sexually abused? | | | If yes, at what age |
| Any breast lumps | | | |

| *Please select all that apply* | Y | N | | Y | N | |
|---|---|---|---|---|---|---|
| Premature ejaculation | | | Loss of masculinity | | | |
| Loss of orgasm | | | Performance anxiety | | | |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| Loss of libido/orgasm | | | Loss of confidence | | | |
|---|---|---|---|---|---|---|
| Loss of aggressiveness | | | Other | | | |

*Partner Preference: (*Please circle*) Male Female Both
*Gender Preference: (Please circle) ) Male Female Both

| **Relational** | **Y** | **N** | |
|---|---|---|---|
| Do you feel safe in your relationship? | | | How satisfied are you in your relationship? |

*Marital Status: □ Single □ Partner □ Married □ Separated □ Divorced □ Widow(er)

*Do you have a religious or spiritual practice? YES NO Are you fulfilled? YES NO

*Do you have an advanced directive or will? YES NO

Behavior style:
___ Always calm & easygoing ___ Sometimes calm with frequent impatience
___Never calm w/overwhelming ambition ___ Usually calm & easygoing
___ Seldom calm & persistently driving for advancement ___ Hard-driving and can never relax

## Activity Level *Please select which applies to you*

□ Inactive: no regular physical activity with a sit-down job

□ Light Activity: no organized physical activity during leisure time

□ Moderate Activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling

□ Heavy Activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling, or active sports at least three times per week

□ Vigorous Activity: participation in extensive physical exercise for at least 60 minutes per session ≥ 4 times per week

| | **Y** | **N** | |
|---|---|---|---|
| Do you exercise? | | | If YES, what kind, how much and how often: |
| Do you perspire when you exercise? | | | *Lightly* *Moderately* *Heavily* |
| Do you perspire when not exercising? | | | If YES, at what times: |
| Does your perspiration have a strong odor? | | | |

| **Energy Level and Sleep** | **Y** | **N** | |
|---|---|---|---|
| Do you have problems falling or staying asleep? | | | How many hours do you sleep at night? |
| Do you wake up at night? | | | If yes, what time do you usually wake up? |
| Do you wake up feeling refreshed? | | | Do you ever nap or rest horizontally? |
| Do you ever sweat while sleeping? | | | How frequently and how much do you sweat? |

On a scale of 1-10 (1 being poor and 10 being great), how would you rate the quality of your sleep?

On a scale of 1-10 (1 being the lowest and 10 being the highest) please rate your energy level at the following times:

| | |
|---|---|
| 8:00 AM | ___________ |
| 12:00 PM (noon) | ___________ |
| 4:00 PM | ___________ |
| 10:00 PM | ___________ |

| Environmental Exposure | Y | N | (**please circle*) |
|---|---|---|---|
| Have you ever been bitten by a tick | | | If YES: any rashes, joint pain, brain fog, nerve pain |
| Have you been camping in the last 5 years | | | |
| Have you traveled outside the US in the last 5 years? | | | Where: |
| Use of Alcohol | | | How many drinks per week: |
| Use of Tobacco | | | # years total: Past use-quit date:<br>What amount per day: |
| Recreational / street drug use | | | If YES, have you ever taken street drugs with a needle? |
| Do you have any dental fillings? | | | How Many? What kind? |
| How much fish do you consume weekly | | | What kind? |
| *Have you been exposed to: chemicals pesticides insecticides herbicides volcanic ash pest control lawn service chemicals<br>Please elaborate: | | | |

| Occupational/Household |
|---|
| How long have you lived at your present address? Do you live in the city? |
| Where have you lived previously? |
| Please describe location, if old or new construction, damp or moldy conditions, etc. |
| Do you have specialized air filtration at home? Do the windows open? |
| Do you work in an office building? Do you have specialized air filtration at your work place? |
| Do you work in the presence of toxic fumes or chemicals? |
| Do any of your hobbies involve toxic materials? |
| Are you currently exposed to second hand smoke? |
| Do you eat canned food? Frequency: |
| What deodorant and perfume do you use? |
| What type of water do you use? *Bottled* *Filtered* *Tap Water* *Alkaline* |
| Any Other comments? |

| Stressful Event History |
|---|
| Please list the most significant, stressful events and scars in your life, from the most recent to the most |

distant. Are any of these situations continuing to impact your life? (insert #): ______________________________________

| | |
|---|---|
| 1. | Date: |
| 2. | Date: |
| 3. | Date: |
| 4. | Date: |
| 5. | Date: |

| **Weight Loss / Gain** | |
|---|---|
| Goal Weight: | In what time frame would you like to be at your goal weight? |
| Birth Weight: | Weight one year ago: |
| Highest Weight (non-pregnant) and when: | Lowest Adult Weight (after age 18): |
| If you wish to change your current weight, please describe the main reason: | |
| When did you begin loosing or gaining excess weight? (Give reasons, if known): | |
| Previous Diets Followed: | Approximate Date & Results of weight loss / gain: |

| **Goals** |
|---|
| Please describe your general health goals, and improvements you wish to make: |

**I have an interest in the following therapies (check all that apply):**

| | | | |
|---|---|---|---|
| Acupressure | | Intravenous Infusions | |
| Allergy Elimination | | Massage | |
| Chelation | | Nutritional Consultation | |
| Colonics | | Osseous alignment | |
| Cooking Classes | | Ozone Treatments | |
| Counseling | | Prolozone for Pain | |
| Craniosacral Therapy | | Reiki | |
| Detoxification | | Weight Loss / Gain | |
| Emotional Freedom Technique | | Weight Training | |
| Fertility or preconception care | | Women's and Men's Wellness | |
| Homeopathic Evaluation | | Yoga | |

**I have answered the above to the best of my abilities.**

______________________________________ ____________________
**Client or Guardian Signature** **Date**