

# Between the Bridges Healing Center

MR# \_\_\_\_\_

Please Print

Today's Date					
PATIENT INFORMATION					
Full Legal Name (First) (Middle) (Last)				Name Normally Used (Nickname)	
Address (Number)		(Street)		(Apt. No.)	
City		State	Zip	Social Security No.	Home Phone
Date of Birth		Age	Sex	Marital Status	Occupation
Employer Name		Employer Street Address		City	State Zip
Business Phone (Including Extension)			Cell Phone	E-mail address(optional)	May We Leave a Msg? Y N
Other Physicians You See					
How Did You Hear About Us?					
SPOUSE'S INFORMATION					
Full Legal Name (First) (Middle) (Last)				Date of Birth	
Address (If Different From Above)		City		State	Zip Home Phone
Employer Name	Street Address		City	State	Zip Business Phone (Ext)
INSURANCE INFORMATION					
Primary Insurance Company Name			Group No.	ID/Certificate No.	
Subscriber Name			Subscriber's DOB and SS#		
Secondary Insurance Company Name			Group No.	ID/Certificate No.	
Subscriber Name					
Other Insurance Information					
EMERGENCY INFORMATION					
Person to Notify in Case of Emergency				Relationship	
Address (Number)		(Street)		(Apt. No.)	
City			State	Zip	Home Phone
INFORMATION FOR THE PATIENT					
<ol style="list-style-type: none"> <li>1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.</li> <li>2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.</li> <li>3. If you have any questions we will, of course, be happy to assist you.</li> </ol>					

# HEALTH HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

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

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit: \_\_\_\_\_ Date began: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name and phone number \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):  
\_\_\_\_\_  
\_\_\_\_\_

Outcome \_\_\_\_\_

What types of therapy have you tried for this problem(s):

- diet modification  fasting  vitamins/minerals  herbs  homeopathy  chiropractic  acupuncture  conventional drugs  
 other \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_  
\_\_\_\_\_

Current medications (prescription or over-the-counter): \_\_\_\_\_  
\_\_\_\_\_

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): \_\_\_\_\_

Do you consider yourself:  underweight  overweight  just right Your weight today \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

- Corrective lenses  Dentures  Hearing aid  Medical devices/prosthetics/implants, describe: \_\_\_\_\_

Recent changes in your ability to:  see  hear  taste  smell  feel hot/cold sensations

- move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors:  sour  bitter  sweet  rich/fatty  spicy/pungent  salty

Strong dislike for any one of the following flavors:  sour  bitter  sweet  rich/fatty  spicy/pungent  salty

Do you:  Prefer warmth (i.e., food, drinks, weather, etc.)  Prefer cold (i.e., food, drinks, weather, etc.)  No preference

Is your sleep disturbed at the same time each night? \_\_\_\_\_ If yes, what time? \_\_\_\_\_

Time of day you feel the most energy or the least symptoms:

Time of day you feel the worst or your symptoms are aggravated:

- 7 a.m. - 9 a.m.  9 a.m. - 11 a.m.  11 a.m. - 1 p.m.  
 1 p.m. - 3 p.m.  3 p.m. - 5 p.m.  5 p.m. - 7 p.m.  
 7 p.m. - 9 p.m.  9 p.m. - 11 p.m.  11 p.m. - 1 a.m.  
 1 a.m. - 3 a.m.  3 a.m. - 5 a.m.  5 a.m. - 7 a.m.

- 7 a.m. - 9 a.m.  9 a.m. - 11 a.m.  11 a.m. - 1 p.m.  
 1 p.m. - 3 p.m.  3 p.m. - 5 p.m.  5 p.m. - 7 p.m.  
 7 p.m. - 9 p.m.  9 p.m. - 11 p.m.  11 p.m. - 1 a.m.  
 1 a.m. - 3 a.m.  3 a.m. - 5 a.m.  5 a.m. - 7 a.m.

## Do you experience any of these general symptoms EVERY DAY?

- Debilitating fatigue  Shortness of breath  Insomnia  Constipation  Chronic pain/inflammation  
 Depression  Panic attacks  Nausea  Fecal incontinence  Bleeding  
 Disinterest in sex  Headaches  Vomiting  Urinary incontinence  Discharge  
 Disinterest in eating  Dizziness  Diarrhea  Low grade fever  Itching/rash

## Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

## Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

## Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Surgical menopause
- Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_

## Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

## Health Habits

- Tobacco:  
Cigarettes: #/day \_\_\_\_\_
- Cigars: #/day \_\_\_\_\_
- Alcohol:  
Wine: #glasses/d or wk \_\_\_\_\_
- Liquor: #ounces/d or wk \_\_\_\_\_
- Beer: #glasses/d or wk \_\_\_\_\_
- Caffeine:  
Coffee: #6 oz cups/d \_\_\_\_\_
- Tea: #6 oz cups/d \_\_\_\_\_
- Soda w/caffeine: #cans/d \_\_\_\_\_
- Other sources \_\_\_\_\_
- Water: #glasses/d \_\_\_\_\_

## Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

## Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:  
 dairy  wheat  eggs  
 soy  corn  all gluten
- Other \_\_\_\_\_

## Food Frequency

- Servings per day:  
Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

## Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

## Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

## Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)



## II. Xenobiotic Tolerability Test (XTT)

<p>1. Are you presently using prescription drugs?  <input type="checkbox"/> Yes (1 pt.)                  If yes, how many are you currently taking? ____ (1 pt. each)  <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>2. Are you presently taking one or more of the following over-the-counter drugs?  <input type="checkbox"/> Cimetidine (2 pts.)  <input type="checkbox"/> Acetaminophen (2 pts.)  <input type="checkbox"/> Estradiol (2 pts.)</p> <hr/> <p>3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:  <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)  <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)  <input type="checkbox"/> Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)  <input type="checkbox"/> Experience <i>no</i> side effects, drug(s) is (are) usually efficacious (0 pt.)</p> <hr/> <p>4. Do you currently use or within the last 6 months had you regularly used tobacco products?  <input type="checkbox"/> Yes (2 pts.) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>5. Do you have strong negative reactions to caffeine or caffeine containing products?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p>	<p>6. Do you commonly experience "brain fog," fatigue, or drowsiness?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <hr/> <p>8. Do you feel ill after you consume even small amounts of alcohol?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <hr/> <p>10. Do you have a personal history of  <input type="checkbox"/> Environmental and/or chemical sensitivities (5 pts.)  <input type="checkbox"/> Chronic fatigue syndrome (5 pts.)  <input type="checkbox"/> Multiple chemical sensitivity (5 pts.)  <input type="checkbox"/> Fibromyalgia (3 pts.)  <input type="checkbox"/> Parkinson's type symptoms (3 pts.)  <input type="checkbox"/> Alcohol or chemical dependence (2 pts.)  <input type="checkbox"/> Asthma (1 pt.)</p> <hr/> <p>11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <p><b>GRAND TOTAL:</b> _____</p>
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*For Practitioner Use Only:*

OVERALL SCORE TABULATION					
Recommended protocols based on new detoxification questionnaire (MSQ and XTT)					
		MSQ SCORE _____ (High >50; moderate 15-49; Low <14)			
		XTT SCORE _____ (High >10; moderate 5-9; Low <4)			
MSQ Score	XTT Score	Description	Functional Medicine Protocol		
			Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance
Additional Symptom-Specific Support					
Symptom	Nutraceutical Support				
Water retention and/or frequent or urgent urination	Kidney support nutraceuticals				
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals				
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics				

**Note:** Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.