COLORADO
HEALTH
PROFESSIONALS.

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Preventive Medicine, Nutrition and Holistic Health Care

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

MEDICAL HISTORY

Please fill in all of the blanks as completely as possible. (We can give you the best care if you are the most through.)

_____ _____/_____/_____
FULL NAME (Please print) BIRTHDATE

_____ _____
ADDRESS, CITY, STATE, ZIP INSURANCE COMP.

(_____) _____ (_____) _____ (_____) _____
HOME PHONE BUSINESS PHONE EMERGENCY PHONE

E-MAIL ADDRESS: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ Male Female

Below list primary physicians who care for your health:

	NAME	SPECIALTY	LOCATION (address + zip code)
1.			
2.			
3.			
4.			

For what reason(s) are you seeking the clinic's service:

_____

_____

_____

List all symptoms you are now experiencing:

_____ _____ _____

_____ _____

_____ _____

List below all the major sicknesses and diseases you have suffered since your birth: (Please list in order)

CONDITION	DURATION	TYPE OF TREATMENT

Please list below all hospitalizations (including accidents, surgeries, fractures, psychiatric etc.)

APPROXIMATE DATE	PURPOSE FOR HOSPITALIZATION	TREATMENT RECEIVED

Please list all medications you are now taking and the amount of each:

NAME	DOSAGE	NAME	DOSAGE

X-RAYS: check if you've ever had x-rays of:

_____ Stomach (UGI)
_____ Colon (LGI)
_____ Gall Bladder
_____ Extremities or back
_____ Kidneys (IVP)
_____ Other: _____

WOMEN ONLY: Menstrual History (circle where applicable)

Age of Onset:_____ Any Clots: Yes __ No __ Regular? Yes __ No ____

Pain or Cramps? Yes ____ No ____ Flow: Heavy ____ Medium _____ Light _____

Abnormal vaginal discharge: Yes____ No _____

Date of last period _____

Date of last pelvic exam _____

Date of last pap test _____ Results: Negative___ _____ Positive _____

PREGNANCIES:

How many children born alive? _____ How many still births? _____

How many premature births? _____ How many Caesarian sections? _____

How many miscarriages? _____

Describe any complications with pregnancy (if any) _____

_____

_____

List all medical conditions you are now being treated for with by an M.D., Chiropractor …

_____

_____

Please circle the severity of your condition:

Little Discomfort	Moderately Severe	Extremely Severe
Mildly Upsetting	Very Severe	Totally Incapacitating

Has any blood relative ever had (please circle):			Who	Alive	Dead
Cancer	No	Yes	_____	_____	_____
Tuberculosis	No	Yes	_____	_____	_____
Diabetes	No	Yes	_____	_____	_____
Heart Attack	No	Yes	_____	_____	_____
High Blood Pressure	No	Yes	_____	_____	_____
Stroke	No	Yes	_____	_____	_____
Mental Disorder	No	Yes	_____	_____	_____
Suicide	No	Yes	_____		

Other (explain) _____

PERSONAL CARE:

Circle any of the following that you use on a regular basis:

Oils	Bath	Sauna	Tanning Devices
Hair Spray	Cosmetics	Steam Bath	Electric Hair Dryer

Is your clothing material mostly synthetic? _____ Cotton? Heavily Dyed?

Circle any of the following that you do on a regular basis:

Jog	Swim	Walk	Bicycle	Yoga
Breathing exercises	Meditation	Gardening	Other (list) _____	

How often and how much exercise are you getting per week?_____

Do you have trouble falling asleep?	No	Yes	
Do you sleep straight through the night?	No	Yes	
Do you have regular bedtime hours?	No	Yes	
Do you eat close to bedtime?	No	Yes	
Do you wake up feeling refreshed?	No	Yes	Tired?

Please give the average number of sleep hours you require during a 24 hours period. _____

Do you take time for rest, relaxation or meditation during the day and or before bed? No Yes

If so, how? _____

_____

LIVING ENVIRONMENT:

Do you get outdoors daily even in the winter? No Yes How often? _____

_____

Circle any of the following you routinely use at home:

Air conditioner	Ionizer	Microwave	Woodstove
Electric Blanket	Electric Heat	Gas Heat	Personal Computer

Is your environment comfortable? No Yes

Is your home well ventilated? Damp?

Circle any of the following you feel most affected by:

Sunshine	Stress	Monthly Cycle	High humidity
Cold	Heat	New Moon	Full Moon

Stools float in bowl?	No	Yes
Bloody stool (red or black streaks)	No	Yes
Indigestion ½ hour to 1 hour after meals	No	Yes
Indigestion 3-4 hours after meals	No	Yes

DRINKING WATER:

a. City Water	No	Yes
b. Well Water	No	Yes
c. Bottled spring water	No	Yes
d. Distilled water	No	Yes
e. Reverse Osmosis	No	Yes
Aluminum cookware	No	Yes
Fluoridated Toothpaste	No	Yes
Braces or other orthodontic work	No	Yes

TOBACCO USE: (Circle) List frequency:

Cigarettes Pipe Cigars Marijuana: smoke _____ edibles: _____

How often? Everyday Every 2 or 3 days Once a week Not at all

Quit – when? _____

EMPLOYMENT:

Do you enjoy your work and daily activities? No Yes

Do you work long hours just to meet expenses? No Yes

Are the environmental conditions favorable? No Yes

Circle any of the following that create stress for you at work: Noise Chemicals Exhaust

Fluorescent lighting Poor air and ventilation Relationship with co-workers Cigarette smoke

DIETARY HISTORY:

Who cooks the meal in your household? _____

What is the dining atmosphere like? _____

How often do you eat out? _____

FOOD PREPARATION EQUIPMENT

Blender Wok Pressure Cooker Electric Stove

Gas Stove Oven Juicer Microwave

How many meals do you eat a day? _____

Is your appetite: Good Fair Poor

Do you have any strong cravings for particular foods? _____

Are there any foods or mixtures of foods you avoid? _____

Are you allergic to any foods? _____

What is the percentage of raw food in your diet? _____

How was your childhood diet different from your present diet? _____

_____

Were you breast feed? _____

Underline the words that best describe how much and how often you use each of the following:

1. ALCOHOL

   One drink | 2-4 drinks | More than 4 drinks | Once in a while

   Everyday | Every other day | _____# days per week | Not at all

2. COFFEE

   1-3 cups a day | More than 6 cups | Sporadically

   4-6 cups a day | _____# days per week | Not at all

3. NON-HERVAL (Black) TEA

   1-3 cups a day | More than 6 cups | Sporadically

   4-6 cups a day | _____# days per week | Not at all

4. SUGAR (only added lumps or powder)

   1-2 teaspoons every day | More than 6 teaspoons per day | 3-6 teaspoons every day

   Sporadically | Not at all

Please fill in the following space with any heath information we have not asked for. _____

_____

_____

_____

_____

The above information is my total health picture to my best recollection

Signed (legal age only) _____

Date: _____ / _____ / _____

Client Informed Consent to Advise

I, _____, request Dr Montante to provide me with unconventional and/or alternative therapeutic recommendations as an aid to the treatment and management of my qualifying condition known as_____. Dr. Joseph Montante, or one of his professional staff members, and I have discussed in detail various conventional and unconventional alternatives for the treatment of my condition, and I have decided to proceed with a plan of action utilizing his recommendations designed to help improve my condition.

I am fully aware that these unconventional alternative treatments are considered experimental and fall outside the usual customary practice of medicine. I am also aware that these recommendations are meant to only supplement traditional methods of treatment, and that no guarantee is offered by Dr. Montante for a medical cure or beneficial outcome from their use in the care of my condition. It had also been stated, and I agree that, I shall continue to consult my PCP physician concerning traditional methods of care for my condition.

Since Dr. Montante specializes in unconventional and/or alternative natural recommendations as well as nutritional consultations, my primary care physician, _____ will provide any general medical care needs I might have. I also understand and hereby testify that Dr. Montante is not attempting in any way to engage in the practice of medicine and is currently unlicensed to do so. However, despite this, I do desire to have an established relationship with Dr. Montante and receive his nutritional recommendations to improve my health condition.

Finally, I hereby certify that this form has been fully explained to me by Dr Montante, and I am satisfied that I understand its content and significance.

Signature: _____ Date: _____

Print Name: _____

CONSULTANT'S AFFIRMATION:

I certify that I have explained the contents of this document to the person identifies above and have answered all questions at this point concerning it and the recommendations made. To the best of my knowledge, I feel this person has been adequately informed and has consented to the unconventional and/or alternative medical recommendations presented.

_____

Joseph R Montante M.D.