PATIENT INFORMATION

(Print Legibly) Please fill in all blanks.

Patient Name (Last, First, Middle)

Street Address: | City: | State: | Zip:

Home Phone: ( ) | Cell#: ( ) | Patient's Sex: Male Female | Patient's Marital Status: Married Single Other

Birth Date: | Language (Main) | Race | Ethnicity | Social Security #: - XXX-XX- | Patient's Employment Status: ( ) Employed FT/PT ( ) Retired ( ) Unemployed ( ) Student

Patient's Employer: | Employer's Phone Number (.)

Employer's Street Address: | City | State: | Zip:

Referring Physician/PCP:
Name: Phone Number:
Address:

Do you have?
Living Will Yes No
Medical Power of Attorney Yes No

Spouse:
Name: Address: Phone Number:

Emergency Contact
Name Phone Number
Address Relationship to Patient:

RESPONSIBLE PARTY INFORMATION/SECONDARY ADDRESS:

Name (Last, First, Middle)

Street Address: | City: state. | zip:

Social Security Number: XXX-XX- | Phone Number ( )

Employees Name: | Employer's Phone Number: ( )

PRIMARY INSURANCE NAME: | Policyholder's Name:

Relationship to Patient: Self Spouse Child | Policyholder's Birth Date: | Policyholder's Sex: Male Female

Policyholder's Employer: | ID # | Group #

SECONDARY INSURANCE NAME: | Policyholder's Name:

Relationship to Patient: Self Spouse Child | Policyholder's Birth Date: | Policyholder's Sex: Male Female

Policyholder's Employer: | ID# | Group #

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Dear Silver M.D. I understand that I am financially responsible for any non-covered services co-insurance. I certify that the information provided above is true and correct to the best of my knowledge. I will notify Dear Silver M. D. of any changes to this information.

Signed: _____ Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (herein after collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing by U.S. Mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Arizona Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute tight to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Revocation**: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient

Article 5: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AM) YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT.

By: _____
Physician or Duly Authorized Representative Signature (Date)

By: _____
Print or Stamp Name of Physician, Medical Group or Association Name

By _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

By _____
Print Patient's Name

By _____
Patient's Representative's Signature (Date)
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to he filed in Patient's medical records.

DEAN R. SILVER M.D.

7420 E. Pinnacle Peak Rd. Suite 126, Scottsdale AZ 85255
Phone: 480-860-2030 Fax: 480-860-0689

HEALTH QUESTIONAIRE

This form will become part of your medical record and the contents are confidential. it is very important to answer al] questions, as this will be most helpful in evaluating your condition. Please answer the questions by checking the appropriate space or by a YES or NO answer where appropriate.

DATE _____

NAME _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ WORK PHONE _____

AGE _____ PLACE OF BIRTH _____

REASONS FOR YOUR VISIT: _____

TREATMENT GOALS: _____

NAME_____

CHIEF COMPLAINT AND PRESENT ILLNESS

CHIEF COMPLAINT: _____

_____

List other complaints in order of severity:

1. _____

2. _____

3. _____

4. _____

Date or age main symptoms first began: _____

List any major illness you have or have had and the dates, if known: _____

_____

_____

Have you had a birth defect? Yes No

Have you had a brain injury? Yes No

List any present medications: _____

_____

Allergies to medications: _____

PERSONAL INFORMATION

Occupation: _____

Hobbies: _____

List work history and dates (listing possible chemical exposures/dates, if any): _____

_____

_____

_____

List all states and countries in which you have lived: _____

Education: _____

Name: _____

MEDICATIONS TAKEN IN THE PAST: Please list: _____

_____

COMMUNICABLE DISEASES: List diseases you have had (Le. measles, TB, mumps, etc):_____

_____

IMMUNIZATION: Have you ever had immunizations for: Please circle Small pox Polio Mumps Tetanus
Other _____

Difficulty with any immunizations? Yes No

If yes please explain: _____

Family: Circle any of the following illnesses that have occurred in your family

Hay fever Hives Constipation Cancer Headache High Blood Pressure
Low Blood Pressure Eczema Asthma Vertigo Tuberculosis Diabetes
Blood Disorders Arthritis Psychiatric care Kidney Disease Drug Use Depression
Emphysema Nervousness Brain Tumors Diarrhea Thyroid Emotional Problems

Other _____

If parents and/or grandparents are deceased, what was their age at the time of their death?

Parents: _____

Grandparents: _____

TREATMENT

HOSPITALIZATIONS:

Please list all hospitalizations/surgeries and dates, if known: _____

_____

_____

_____

_____

_____

Name: _____

STUDIES: List X-rays, MRI, EEG, EKG, Blood work, Sonograms, etc. done in the last 5 years: _____

_____

_____

HIV AND HEPATITIS SCREEN RESULTS IN PAST 6 MONTHS: _____

Doctors seen: Test

1. _____
2. _____
3. _____

Is there anything else you feel we should know about you that may have contributed to your illness?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dean R. Silver, M.D., P.L.L.C.
(480) 860.2030

Privacy Notice Acknowledgment and Communication Consent

Patient Name: _____ DOB: _____
Please Print Name

Name and Phone number of your family physician

_____ ( ) _____

Please list below the pharmacy you use including address or cross streets:

_____

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

Can we leave detailed or confidential messages on your home phone?
Yes ___ No ___ Home Number: _____

Can we leave detailed or confidential messages on your cell phone?
Yes ___ No ___ Cell Phone: _____

Can we mail test results to your home?
Yes ___ No ___

Exclusions/Alerts (Please note any information that you do not want released to authorized) _____

_____

We must call you at times to give you what is classified as protected. health information. Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health?

NAME	RELATIONSHIP	SECRET QUESTION (Mother's maiden name, city of birth., favorite color, optional)	ANSWER
1)			
2)			

Must Sign Below for all information given:

My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Dean R. Silver, M.D., P.L.L.C. Notice of Privacy Practices.

_____ _____
Patient Name (please print) Date

_____ _____
Patient or Person Authorized to Sign If not patient, relationship to patient (parent legal guardian, personal representative, etc.),

Dean R. Silver, M.D.
7420 E. Pinnacle Peak Rd. Suite 126, Scottsdale AZ 85255
Phone: 480-860-2030 Fax: 480-860-0689
www.deansilvermd.com / office@deansilvermd.corn

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Soc. Sec. # XXX-XX-_____

Address: _____

I hereby authorize: Practice Name: _____

Address: _____

Phone: _____

To disclose a copy of the following information to: Dean R. Silver M.D. P.L.L.C

( )By the following method ( ) Paper ( )Fax ( )CD

Covering the period(s) of health care:

FROM (date):_____ TO (date): _____

Information to be disclosed:

( ) Full access to my electronic medical record through PATIENT CARE INQUIRY (PCT)

If applicable, also give permission for the following to be disclosed (**please initial**):

____ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
____ Behavioral health services/psychiatric are
____ Treatment for alcohol and or drug abuse

This information is to be disclosed for the purpose on _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition. If I fail to specify an expiration date, event or condition, this authorization will expire in **One Year from date signed.**

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer at (480) 860-2030.

The Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized here-in.

I have requested a copy of this Release. Yes No

_____ _____ _____
Patient or Personal Representative's Signature Relationship to Patient Date

_____ _____ _____
Witness Relationship to Patient Date

Dean R Silver, M.D., P.L.L.C.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL LNFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dean R. Silver, M.D. P.L.L.C. is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office, a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient: Protected information includes demographic data and facts about your past, present or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances or sending unpaid balances to a collection agency.
3. **Health Care Operations:** We may use and disclose health information to operate our business. For example, your Health information may be used to evaluate the quality of care we provide, for state licensing or to identify you by name when you visit the office.
4. **Appointment Reminders**: We may use and disclose your information to remind you of appointments. We may also mail you *a* reminder for follow-up visits.
5. **Treatment Options**: We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.
6. **Business Associates**: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases. _
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner, or funeral director.
- For the facilitation of organ, eye, or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. TIM INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure**: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request if we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communications**: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access:** You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
   You may also request an electronic copy of your records be provided. This electronic copy may be sent using E-mail to your specified address. CD for flash drive. Please note that E-mail communications are not a secure method for transport.
4. **Record Amendment:** You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement.
5. **Accounting of Disclosures**: You have the right to receive an accounting of disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact Practice's Privacy Officer at 7420 E. Pinnacle Peak Rd #126 or (480) 860.2030. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed and protected.

Printed Patient Name _____ Name/Relationship if Signed by Individual Other than Patient _____

Signature _____ Date _____

***FOR OFFICE USE ONLY*"

We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided was Emergent

Other: _____ _____ _____

Employee Name Date

ORGAN SYSTEM	Y	N
CONSTITUTIONAL		
Cold hands or Feet		
Hot hands or Feet		
Low body Temperature		
Fever or elevated body temperature		
Pale Skin		
Brittle Nails		
Anemia		
Excessive Thirst		
Dizziness or lightheadedness		
Slow healing wounds		
Fatigue or tired		
Weight gain		
Weight Loss		
Loss of appetite		
Weakness		
Lack of thirst		
Strongly prefer hot drinks		
Strongly prefer cold drinks		
Frequent or easily faint		
Loss of libido or sexual desire		
Excessive libido		
NEURO DEVELOPMENT		
Delayed developmental milestone		
Speech or language		
Tics		
Focus or concentration		
Defiant behavior		
PHSYCHOLOGICAL / Mental / Emotional		
Anxiety		
Suicidal Thoughts		
Depression		
Irritability		
Erratic Emotional Behavior		
Excessive tension or stress		
High stress level		
Easily stressed		
Easily startled		
Eating Disorder		
Sleep Disturbances		
Poor Memory		
Mental Dullness or cloudiness		
Suicidal Thoughts		
Nervousness		
Mental or Physical abuse		
Environmental		
Multiple Chemical Sensitivity		

ORGAN SYSTEM	Y	N
ALLERGY		
Eczema or itchy eyes		
Scratchy Throat		
Chronic Hives		
Sensitivity to milk, wheat or other foods		
Nasal itching		
Food allergies		
Swelling Eyelids		
Runny nose		
Ear fullness		
Sinus Congestion		
HEAD		
Headaches		
Migraines		
Dizziness		
Head injury / Concussion		
TMJ jaw problems or clicks		
Facial Pain		
Dental cavities		
Gum Problems		
EARS		
Ringing in the Ears		
Ear pain		
Itchy eyes		
Poor hearing		
Dizziness		
Hearing loss or impaired		
EYES		
Impaired or blurred vision		
Glasses or contacts		
Night Blindness		
Double vision		
Spots or floaters in eyes		
Cataracts		
Glaucoma		
Color Blindness		
Eye pain or irritation		
Eye redness		
Tearing or discharge from eyes		
Itchy eyes		
Burning Eyes		
Swelling of eyelids		
Recurring infections to eyes		
NOSE SINUS		
Hay fever		
Head, Forehead or facial congestion/pain		
Loss of smell		
Stuffiness or breathing problems		

ORGAN SYSTEM	Y	N
Frequent nasal discharge		
Nose Bleed		
Sinus pain		
THROAT/NECK		
Dry Throat		
Hoarseness		
Laryngitis, Loss of Voice		
Frequent Sore Throat		
Change in Voice		
Enlarged Thyroid Gland		
Lumps/ Nodules/ Goiter		
Swollen Glands		
Pain/ Stiffness		
Hypothyroidism/ Low Thyroid		
RESPIRATORY		
Shortness of Breath		
Pain or Tightness in Chest		
Labored or Difficult Breathing		
Persistent Cough		
Chest Congestion/ Phlegm		
Recurring Bronchitis		
Coughing of Blood		
Wheezing		
CARDIOLOGY		
Heart Palpitations/ Flutters		
Felling as Your Heat Skips a Beat		
Dizziness Upon Standing Up		
Chest Pain		
Leg Edema(Swelling)		
Shortness of Breath		
Varicose Veins		
Angina		
High Blood Pressure		
Low Blood Pressure		
Tachycardia (fast heart beat)		
Bradycardia (slow heart beat)		
Murmur		
Congenital Heart Disease		
Leg/ Calf Pain		
DVT/ Thrombophlebitis		
Other Heart Disease		
Irregular Heart Beats		
HEMATOLOGY		
Swelling Feet and/or Ankles		
Easy Bruising		
Swollen Glands		
Blood Clots/ Easy Clotting		
Blood Clotting Difficulties		
Heavy Sensation in Limbs		

ORGAN SYSTEM	Y	N
GASTROENTEROLOGY		
Blood in Stool		
Diarrhea		
Dry Mouth or Throat		
Constipation		
Bad Breath		
Rectal Itching		
Abdominal Pain		
Heartburn		
Hemorrhoids		
Mucous in Stool		
Thick or Abnormal Tongue Coating		
Excessive Foot, Hair or Body Odor		
Vomiting		
Difficulty Eating		
Bloating, Belching or Intestinal Gas		
Dental Problems		
Bleeding Gums		
Grinding of Teeth		
Sore Lips or Tongue		
Excessive Saliva		
Strong or Abnormal Taste in Mouth		
Mouth/Tongue Sores/ Ulcer		
Strong Appetite		
Loss of Appetite		
Crave for Sweet Foods		
Crave for Salty Foods		
Crave for fatty foods		
Crave meats		
Acid Regurgitation		
Ulcers		
Gallbladder Disease		
Dark Tarry Stools		
Anal fissures/Fistulas Bleeding		
Liver disease / Flank Pain		
Worms or Parasites		
ENDOCRINOLOGY		
Inability to Lose Weight Despite Dieting		
Coarse Hair		
Faulty Memory		
Hair Loss		
Sleep Disturbance		
Loss of Sexual Desire (Libido)		
Mood Swings		
Irritability		
Poor Concentration		
Fatigue		
Polydypsia (Excessive Thirst)		
Polyuria (Excessive Urination)		
Unexplained Weight Loss		
Cold Intolerance		

ORGAN SYSTEM	Y	N
Heat Intolerance		
Diabetes		
Trouble Sleeping		
Hot Flashes		
Shaking or Irritability when hungry		
UROLOGY		
Cystitis		
Recurrent UTI		
Difficulty Urine		
Blood in Urine		
Frequent Urination		
Urinary Incontinence		
Voiding Dysfunction		
Vulvodynia (chronic vulvar pain)		
Nocturia (night urination)		
Painful urination		
Incomplete urination		
Excessive urination		
Kidney stones		
NEUROLOGY		
Headache		
Tingling or numbness		
Seizures		
Insomnia		
Memory loss		
Dizziness		
Gait abnormality		
Tics		
Tremors		
Numbness burning or tingling		
Paralysis		
MUSCULOSKELETAL		
Muscle weakness		
Leg cramps or pain		
Joint pain		
Neck pain		
Back pain		
Numbness burning or tingling		
Pain into arms or legs		
Recent injury during activities		
Muscle pains or aches		
Joint stiffness		
Joint swelling		
Low back pain		
Fracture		
Carpal tunnel		
Shoulder pain		
Arm pain		
Hip pain		
Knee pain		
Pain with activity		
Recent trauma, accidents or strenuous activities		

ORGAN SYSTEM	Y	N
DERMATOLOGY		
Psoriasis		
Dry or sensitive skin		
Hives		
Acne		
Skin cancer		
Rash		
Moles		
Lumps		
Easy sweating		
Lack of sweating		
Night sweating		
Chronic rash / eczema		
Itching		
Scars		
Ulcerations (sores)		
Fungal infections		
Dandruff		
Poor nail growth or strength		
FEMALE REPRODUCTION		
Dyspareunia (painful intercourse)		
Sexually active		
Dysmenorrhea (painful periods)		
Endometriosis or infertility		
Vaginal burning, itching or discharge		
Pelvic pain		
Nipple discharge		
Contraception		
Irregular periods		
Scanty periods		
Cramps or menstrual irregularities		
Breast pain or tenderness		
Breast lump		
Perform self-breast exams		
Regular menstrual periods		
Ovarian pain or cyst		
Annual pap		
Abnormal pap		
Vulvodynia (chronic vulvar pain)		
MALE REPRODUCTION		
Prostatitis		
Hernias (abdominal or scrotal)		
Testicular pain		
Scrotal pain		
Diminished sex drive		
Premature ejaculation		
Impotence (difficulty with erect ion)		
Diminished sex drive		
Penile discharge		
Contraception		
History of sexually transmitted diseases		

Substance use	Frequency	Amount	Duration (number of years)	No. of attempts to quit	Currently in remission	Negative consequences
Tobacco						
Alcohol						
Caffeine						
Prescriptions						
Marijuana						
Methamphetamines						
Cocaine						
Opiates						
Barbituates						

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

☐ Past month ☐ Past week ☐ Past 48 hours

Point Scale: 0—*Never or almost never* have the symptom 1—*Occasionally* have it, effect is *not severe* 2—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* 4—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **TOTAL**_____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **TOTAL**_____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **TOTAL**_____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **TOTAL**_____

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores **TOTAL**_____

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **TOTAL**_____

HEART
_____ Chest pain
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat **TOTAL**_____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **TOTAL**_____

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **TOTAL** _____

JOINTS/ MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pain or aches in muscles **TOTAL**_____

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating **TOTAL**_____

ENERGY/ ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **TOTAL**_____

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Poor concentration
_____ Poor physical coordination **TOTAL**_____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **TOTAL**_____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **TOTAL**_____

GRAND TOTAL **TOTAL**_____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

☐ Yes (1 pt.)

If yes, how many are you currently taking? ____ (1 pt. each)

☐ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?

☐ Cimetidine (2 pts.)

☐ Acetaminophen (2 pts.)

☐ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:

☐ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)

☐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)

☐ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)

☐ Experience no side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?

☐ Yes (2 pts.) ☐ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?

☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?

☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?

☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

10. Do you have a personal history of

☐ Environmental and/or chemical sensitivities (5 pts.)

☐ Chronic fatigue syndrome (5 pts.)

☐ Multiple chemical sensitivity (5 pts.)

☐ Fibromyalgia (3 pts.)

☐ Parkinson's type symptoms (3 pts.)

☐ Alcohol or chemical dependence (2 pts.)

☐ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

☐ Yes (1 pt.) ☐ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?

☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

GRAND TOTAL: _____

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?

☐ Yes ☐ No

2. Have you ever been diagnosed with a condition known as hyperkalemia?

☐ Yes ☐ No

3. Are you currently on diuretics or blood pressure medication?

☐ Yes ☐ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)

XTT SCORE _____ (High >10; moderate 5-9: Low <4)

URINARY pH _____

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 dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.