BRANDWEIN
INSTITUTE for NUTRITION & WELLNESS

PERSONAL INFORMATION

Today's Date:

Name: AGE: DOB:

Nickname or preferred name: Marital Status:

Home/Mailing Address: City: State: Zip:

Home Phone: Mobile Phone: Email:

Occupation: Employer:

In case of emergency contact: Relationship:

Home Phone: Mobile Phone:

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us?

Please check the appropriate box

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian ☐ Native American
☐ Caucasian ☐ Northern European ☐ Other

Please rank current/ongoing problems BY PRIORITY and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT	SUCCESS
Ex: Post Nasal Drip	Moderate	Elimination diet	Moderate

MEDICATIONS | Please list all medications you are currently or have recently taken (prescribed or OTC)

Medication Name	Condition	Date Started	Prescribed by

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☒ = *Past Condition* ☒ = *Ongoing Condition*

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset*

GASTROINTESTINAL

- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Inflammatory Bowel Disease
- ☐ ☐ Crohn's
- ☐ ☐ Ulcerative Colitis
- ☐ ☐ Gerd (reflux)
- ☐ ☐ Celiac Disease
- ☐ ☐ Other:

CARDIOVASCULAR

- ☐ ☐ Heart Attack
- ☐ ☐ Other Heart Disease
- ☐ ☐ Stroke
- ☐ ☐ Elevated Cholesterol
- ☐ ☐ Arrhythmia (irregular heartbeat)
- ☐ ☐ Hypertension (high blood pressure)
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Other:

METABOLIC/ENDOCRINE

- ☐ ☐ Type 1 Diabetes
- ☐ ☐ Type 2 Diabetes
- ☐ ☐ Hypoglycemia
- ☐ ☐ Metabolic Syndrome (Insulin Resistance or Pre-Diabetes)
- ☐ ☐ Hypothyroidism (low thyroid)
- ☐ ☐ Hyperthyroidism (overactive thyroid)
- ☐ ☐ Endocrine Problems
- ☐ ☐ Polycystic Ovarian Syndrome(PCOS)
- ☐ ☐ Infertility
- ☐ ☐ Weight Gain
- ☐ ☐ Weight Loss
- ☐ ☐ Frequent Weight Fluctuations
- ☐ ☐ Bulimia
- ☐ ☐ Binge Eating/Disorder
- ☐ ☐ Night Eating Syndrome
- ☐ ☐ Eating Disorder (non-specific)
- ☐ ☐ Other:

CANCER

- ☐ ☐ Lung Cancer
- ☐ ☐ Breast Cancer
- ☐ ☐ Colon Cancer
- ☐ ☐ Ovarian Cancer
- ☐ ☐ Prostate Cancer
- ☐ ☐ Skin Cancer
- ☐ ☐ Other:

GENITAL/URINARY

- ☐ ☐ Kidney Stones
- ☐ ☐ Gout
- ☐ ☐ Interstitial Cystitis
- ☐ ☐ Frequent Urinary Test
- ☐ ☐ Frequent Yeast Infections
- ☐ ☐ Erectile or Sexual Dysfunction
- ☐ ☐ Other:

MUSCLOSKELETAL/PAIN

- ☐ ☐ Osteoarthritis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Other:

INFLAMMATORY/AUTOIMMUNE

- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Autoimmune Disease
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Lupus SLE
- ☐ ☐ Immune Deficiency Disease
- ☐ ☐ Herpes-Genital
- ☐ ☐ Severe Infectious disease
- ☐ ☐ Poor Immune Function
- ☐ ☐ Food Allergies
- ☐ ☐ Environmental Allergies
- ☐ ☐ Multiple Chemical
- ☐ ☐ Latex Allergy

RESPIRATORY DISEASES

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitis
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep Apnea

SKIN DISEASES

- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Acne
- ☐ ☐ Melanoma
- ☐ ☐ Skin Cancer
- ☐ ☐ Other:

NEUROLOGIC/MOOD

- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Schizophrenia
- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ ADD/ADHD
- ☐ ☐ Autism
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Memory Problems
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ ALS
- ☐ ☐ Seizures
- ☐ ☐ Other Neurological Problems

PREVENTATIVE TESTS

- ☐ ☐ Full Physical Exam
- ☐ ☐ Bone Density
- ☐ ☐ Colonoscopy
- ☐ ☐ Cardiac Stress Test
- ☐ ☐ Full GI Series
- ☐ ☐ Migraines
- ☐ ☐ Ultrasound

INJURIES

- ☐ ☐ Back
- ☐ ☐ Head
- ☐ ☐ Neck
- ☐ ☐ Broken Bones

SURGERIES

- ☐ ☐ Appendectomy
- ☐ ☐ Hysterectomy
- ☐ ☐ Joint Replacement (Knee/Hip)
- ☐ ☐ Heart Surgery - Bypass
- ☐ ☐ Angioplasty or Stent

NUTRITIONAL SUPPLEMENTS | Please list all vitamins and nutritional supplements you are currently or have recently taken.			
Supplement	Brand & Amt. Consumed	Date Started	Prescribed by (if any)

Do you experience intestinal gas/bloating? ☐ YES ☐ NO

Do you experience heartburn or indigestion? ☐YES ☐NO ☐Occasional

Do you experience, chest pressure, or stomach pain? ☐ YES ☐ NO ☐Occasional

If yes, do you take anything for relief?

Please mark in the chart below with information about recent bowel movements:

FREQUENCY		**COLOR**		**CONSISTENCY**	
More than 3x per day	☐	Dark Brown	☐	Soft and well-formed	☐
2-3 times per day	☐	Medium Brown	☐	Often float	☐
One time per day	☐	Very Dark or black	☐	Difficult to pass	☐
4-6 times per week	☐	Greenish	☐	Diarrhea	☐
2-3 times per week	☐	Blood visible	☐	Thin, long, narrow	☐
Once or fewer per week	☐	Varies a great deal	☐	Small and hard	☐
		Greasy shiny looking	☐	Loose but not watery	☐

FOR WOMEN ONLY

Is there any chance you might be pregnant?: ☐YES ☐ NO Date of last menstrual cycle:

Are you experiencing peri-menopause? ☐YES ☐NO Post-Menopausal: ☐YES ☐ NO Symptoms: ☐YES ☐NO

Do you currently, or have you used, any of the following? (please check all that apply):

☐BIRTH CONTROL PILLS ☐HORMONE REPLACEMENT THERAPY ☐HORMONE IUD ☐COPPER IUD

☐VAGINAL RING ☐CONTRACEPTIVE PATCH ☐EMERGENCY CONTRACEPTIVE

Have you ever had an abnormal PAP?: ☐YES ☐ NO Age of menarche (period began): Age of children (if any):

# of Pregnancies (if any): # of C-Sections (if any):

FOR MEN ONLY

Have you had a PSA done? ☐YES ☐ NO PSA Level: ☐0-2 ☐2-4 ☐4-10 ☐>10 ☐Prostate Enlargement
☐Prostate Infection ☐Change in Libido ☐Impotence ☐Difficulty Obtaining/Maintaining

MEN AND WOMEN

Do you have urinary problems? ☐YES ☐ NO

If yes please specify: ☐ nightly urination ☐ frequent day time urination ☐ frequent urge to urinate ☐ hesitancy ☐ burning

DENTAL (MEN & WOMEN)

Do you have amalgam (silver, black or grey) fillings: ☐YES ☐ NO (if yes, how many):

Have you had fillings replaced? ☐YES ☐ NO how many when any problems

With whom do you live?

What is the attitude of those close to you concerning your health?
☐Supportive ☐ Not supportive ☐ Indifferent

Are you currently married, or have you ever been married? ☐YES ☐ NO

If yes, when: If yes, spouse's occupation?

Have you been separated or divorced? ☐YES ☐ NO If yes, when:

What are your hobbies and leisure activities?

Have you experienced any major losses in your life? ☐YES ☐ NO

If so, please comment:

STRESS: On a scale of 1-10 rate your stress level (10 being highest:)

Have you ever had psychotherapy counseling: ☐YES ☐ NO

If yes, what kind: when:

Additional comments

LIFESTYLE

How important is religion or spirituality to you?
☐Not at all ☐ Somewhat important ☐ Extremely important Do you meditate: ☐YES ☐ NO

What is your usual bedtime? wake time?

How well do you sleep? (check all that apply)
☐ Adequate (sleep through night) ☐ Wake up feeling well rested ☐ Trouble falling asleep
☐ Wake up still tired ☐ Trouble staying asleep

Check off your typical bedtime activities:
☐ Watch TV ☐ Read a book ☐ Listen to music ☐ Bed time snack ☐ Meditate ☐ Bathe/shower ☐ Drink alcohol ☐ Drink caffeinated beverages ☐ On comp/iPad

Other:

Do you ever take a sleep aid? ☐YES ☐ NO (if yes, which ones at what dose?):

Do you exercise regularly now? ☐YES ☐ NO If no, have you in the past? ☐YES ☐ NO

How often per week
☐ 1-2 times per week ☐ 3-4 times per week ☐ 5 or more

If so please specify types of exercise and how often
☐ Jogging ☐ Walking ☐ Weight training ☐ Water sports ☐ Aerobics/classes __

☐ Yoga ☐ Pilates ☐ Stretching ☐ Orange Theory/Crossfit/interval type exercise

ALLERGY & TOXIC POTENTIAL

Do you have any pets or farm animals?: ☐YES ☐ NO
LIST:

Do odors such as perfume, cleaning products, smoke, etc. affect you? ☐YES ☐ NO

If yes please clarify:

Have you to your knowledge been exposed to toxic metals at your job or home? ☐YES ☐ NO

☐ Lead ☐ Cadmium ☐ Arsenic ☐ Mercrury ☐ Aluminum

To your knowledge have you ever been exposed to an ongoing amount of any of the following?

☐ solvents ☐ paints ☐ pesticides ☐ petrochemicals ☐ coal ☐ hydrocarbons ☐ mold

Other

Do you now or have you recently lived in an older home (pre 1970's): ☐YES ☐ NO

If yes, how old is/was home how long have you lived/live there

Have you ever lived or worked in a water damaged building? ☐YES ☐ NO

If yes, when: how long?:

HABITS: Please include current and previous amounts

	DAILY	WEEKLY	MONTHLY	NEVER	AMOUNT
Alcohol	☐	☐	☐	☐	
Coffee	☐	☐	☐	☐	
Soda/Diet Soda	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	
Rec. Drugs	☐	☐	☐	☐	

WORK ACTIVITY

☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking/Moving ☐Driving
Do you take any other over the counter medication on an occasional basis? If so which ones:

As an adult how often do you take antibiotics?:

Were you ever on antibiotics for a prolonged period of time?:
☐YES ☐ NO If yes, please explain

DIETARY HABITS:

Are you currently following a specific diet: ☐YES ☐ NO

If yes, please explain

What time do you eat Breakfast: Usual Breakfast Foods:

What time do you eat Lunch: Usual Lunch Foods:

What time do you eat Dinner: Usual Dinner Foods:

What time do you eat Snacks: Usual Snacks:

List the 3 healthiest Foods you during the avg. week:

List the 3 worst foods you during the avg. week:

Do you have any dietary restrictions? If so, please explain:

Do you currently or typically have any symptoms **immediately after** eating?
(i.e. belching/fatigue/bloating/sneezing/hives) ☐YES ☐ NO If yes, please explain

Are these symptoms associated with any food that you're aware of? Please explain

Do you feel you have delayed symptoms after eating certain foods? ☐YES ☐ NO If yes, please explain

How much of the following do you consume on average?

FOOD	AMT per day	AMT per week
Candy		
Cheese		
Chocolate		
Cups of caffeinated coffee		
Cups of decaffeinated coffee		
Cups of hot chocolate		
Cups of tea (caffeine containing)		
Cups of tea (decaffeinated)		
Diet soda		
Regular soda		
Ice cream		
Salty snacks		
Slices white bread/rolls/bagel		
Nuts		

Are there any particular foods that make you feel WORSE when you eat them?
☐YES ☐ NO If yes, please describe:

Are there any particular foods that make you feel BETTER when you eat them?
☐YES ☐ NO If yes, please describe:

Do you ever binge or crave certain foods? ☐YES ☐ NO

Which foods, how often and comment on possible triggers:

Do you avoid certain foods for any reason? ☐YES ☐ NO If yes which foods and why:

Are you the primary cook for the household ☐YES ☐ NO if not who is?:

On a scale of 1(least)-5(most) rate to what extent you enjoy preparing/cooking food

Where do you do the bulk of your grocery shopping:

What percentage of your food intake is organic:

Do you drink bottled water:

If yes, approximately how many bottles per day:

Anything else you think we should know? This is the place where you can detail your main concerns and what you expect to get out of working with us at MBN: