NEW PATIENT INTAKE FORMS

Following is the information that is critical to your care at True Life Medicine. Please complete and submit within one week of your enrollment:

Contact Info					
Full Name *		**Email Address** *		**Facebook Profile** (If you're willing to connect there)	
Appointment Date *		By checking this box, I understand that my monthly or annual payments to True Life Medicine are not for services that insurance covers, but for preventative care and non-covered benefits.*		☐	
Insurance Provider		**Insurance Provider Number**			
Your patient information is 100% private. If there are any family members or otherwise who you would like to grant access to, or give us permission to communicate with regarding your care, please list them here:					

Patient Profile	
Why are you here? What are the specific, bullet point issues you are primarily at True Life Medicine to address?	
What is the cause? Of course you may be here because you don't know what led up to your issues. Understood. But if you have some ideas of past events, circumstances, actions or anything that may have added to the ingredients of your issue, please tell us here.	
How can we best serve you? While that may seem like a big, broad question, it's very serious. Just as your health is very personal and unique and we can not address your issues with a cookie cutter approach, we want to know how you desire to be cared for. Your context may come from experiences you have had with other medical providers	
What should we know about you? To get to the root causes of your wellness, necessitates an in depth understanding of...you. This is a place to be fully know.	
What is your overall goal for yourself? Dr. James likes to reference to ends of the spectrum. Are you hoping to be in the upcoming Olympics? Or are you trying to slide into a nursing home? It's probably somewhere between those two. Where? What level of health, wellness, ability and vitality are you aiming for?	

PERSONAL INFO (not required, but helpful for context!)	
Are you married? How long?	
Do you have children? How many and ages?	
Are you employed? What is your vocation or business?	
Is your employed? What is their vocation or business?	

SLEEP	
How many hours of sleep do you get on average every night	
Do you toss and turn?	Yes ☐ / No ☐
Do you rely on an alarm to wake up in the mornings?	Yes ☐ / No ☐
Do you generally feel rested after you wake?	Yes ☐ / No ☐
Do you sleep with your mouth open to breathe?	Yes ☐ / No ☐
How would you rate the quality of your sleep? On a scale from 1-10, with 10 being the best?	
Do you remember dreams?	Yes ☐ / No ☐

NUTRITION	
How often do you eat fruits and vegetable? Do you sometimes go a day without any? Once, twice or three times per day? More? What varieties?	
How often do you eat grains?	Yes ☐ / No ☐
How often do you eat meat?	Yes ☐ / No ☐
How much water do you drink per day?	Yes ☐ / No ☐
How much coffee, tea or alcohol per day?	Yes ☐ / No ☐
How often do you eat out per week, and how much of that is fast food?	
How often per week do you eat processed (boxed or pre-prepared) food?	Yes ☐ / No ☐
How often per week do you make and eat home cooked meals?	
Do you feel you under eat or overeat?	
How well do you feel you digest foods?	

Do you take consistent vitamins or supplements? (please list)	
Are you currently taking any prescription medications?	

MOVEMENT	
How often per week do you spend with your heart rate elevated?	
What physical activities do you engage in daily/weekly?	
Do you have any physical limitations?	

WORK	
How would you rate your work environment in regards to your peace, joy and fulfillment? Harmful, neutral, or inspiring?	
Do you have a desk job or manual labor job?	☐ Desk Job ☐ Manual Labor Job
Do you feel challenged intellectually?	☐ Yes ☐ No
Do you believe in the product or service you help produce?	☐ Yes ☐ No
Do you feel respected and valued in your role?	☐ Yes ☐ No
How would you rate your stress level at work? Low, Medium, High?	☐ Low ☐ Medium ☐ High

RELATIONSHIPS	
If you are married, how would you rate your emotional well being in regards to the relationship? Bad, Average, Good, Great	☐ Bad ☐ Average ☐ Good ☐ Great
Do you feel generally supported and encouraged by your spouse, friends and family? Or discouraged?	☐ Encouraged ☐ Discouraged
Would you say your overall personal relationships are filled with positive or negative interactions?	☐ Positive ☐ Negative
Do you have less than a few close relationships? More than that? Many?	
Where do you fall in the spectrum of feeling alone, or having an overabundance of social engagement?	

MEDICAL SYMPTOMS QUESTIONNAIRE

HEAD	
Headaches	☐ 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
Faintness	☐ 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
Dizziness	☐ 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
Insomnia	☐ 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

EYES	
Watery or itchy eyes	☐ 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
Swollen, reddened or sticky eyelids	☐ 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
Bags or dark circles under eyes	☐ 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
Swollen, reddened or sticky eyelids	☐ 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

Blurred or tunnel vision (does not include near or far-sightedness)	☐ 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

EARS	
Itchy ears	☐ 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
Earaches, ear infections	☐ 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
Drainage from ear	☐ 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
Ringing in ears, hearing loss	☐ 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

NOSE	
Stuffy nose	☐ 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
Sinus problems	☐ 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
Hay fever	☐ 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
Sneezing attacks	☐ 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

Excessive mucus formation	☐ 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

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

SKIN	
Acne	☐ 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
Hives, rashes, dry skin	☐ 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
Hair loss	☐ 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

Flushing, hot flashes	☐ 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
Excessive sweating	☐ 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

MOUTH/THROAT	
Irregular or skipped heartbeat	☐ 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
Rapid or pounding heartbeat	☐ 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
Irregular or skipped heartbeat	☐ 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

LUNGS	
Chest congestion	☐ 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
Asthma, bronchitis	☐ 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
Shortness of breath	☐ 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
Difficulty breathing	☐ 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

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

JOINTS/MUSCLE	
Pain or aches in joints	☐ 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
Arthritis	☐ 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

Stiffness or limitation of movement	☐ 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
Pain or aches in muscles	☐ 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
Feeling of weakness or tiredness	☐ 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

WEIGHT	
Binge eating/drinking	☐ 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
Craving certain foods	☐ 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
Excessive weight	☐ 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
Compulsive eating	☐ 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
Water retention	☐ 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
Underweight	☐ 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

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

ENERGY/ACTIVITY	
Fatigue, sluggishness	☐ 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

Apathy, lethargy	☐ 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
Hyperactivity	☐ 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
Restlessness	☐ 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

EMOTIONS	
Mood swings	☐ 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
Anxiety, fear, nervousness	☐ 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
Anger, irritability, aggressiveness	☐ 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
Depression	☐ 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

OTHER	
Frequent illness	☐ 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
Frequent or urgent urination	☐ 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

Genital itch or discharge	☐ 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

TOXIN EXPOSURE

COMMUNITY	
Automobile Exhaust	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Farm/Industrial/Power plant or power lines	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Radio tower	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Landfill/Dump	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Hydro tower	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Visible mold	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago

HOME AND/OR WORK ENVIRONMENT	
Do you live in a:	☐ House ☐ Apartment Building ☐ Mobile Home
Do you work in a:	☐ House ☐ Office Building ☐ Factory
Bathing/Showering water source:	☐ Well ☐ Public Works ☐ Bottled
Forced air Heat	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago

Renovations (new carpets; add-ons, etc.)	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Basement cracks or dirt floor	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Damp basement or crawl space	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Wet windows or outside closet walls	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Water leaks (ceilings, walls, floors)	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Old or cracking ceiling tiles	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Old or cracking vinyl linoleum flooring	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Crumbling pipe insulation	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Crumbling wall or ceiling insulation	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Old or cracking paint	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Carpets or rugs	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Stagnant or stuffy air	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Gas or propane stove	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Coal or wood stove	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Other gas appliance (water heater, furnace)	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago

Regular contact with smokers	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago

HOBBY AND WORK ACTIVITIES	
Pesticides or herbicides	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Harsh chemicals (varnish, glue, gas, acid…)	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Welding or soldering	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Metals (Lead, Mercury, etc.)	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Paints	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Photo developing / Dark room	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Airplane travel	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago
Cleaning chemicals	☐ Yes ☐ No ☐ I don't know ☐ I had exposure to this more than 12 months ago

PERSONAL DIET		
Drinking/Cooking water source:	☐ Well ☐ Public Works ☐ Bottled ☐ Filtered	
Caffeine?	☐ Yes ☐ No	**If yes, what kind and how much?**

INGREDIENT INFO

Do you consume fish?	☐ Yes ☐ No					
Do you consume artificial sweeteners?	☐ Yes ☐ No	☐ NutraSweet	☐ Equal	☐ NutraSweet	☐ Aspartame	☐ Splenda
Do you consume Animal Products?	☐ Yes ☐ No	**How often?**		**What percentage of your animal product is organic?**		
Do you wash your produce?	☐ Yes ☐ No	**What percentage of your produce is organic?**				
Do you consume deep fried foods?	☐ Yes ☐ No					
Do you consume Sodas, juices, drinks containing High Fructose Corn Syrup?	☐ Yes ☐ No	**How many per day?**				

ADDITIONAL INFO

DO YOU HAVE:	
Allergies	☐ Yes ☐ No
Sensitivity to smells (gas, perfume, paint, etc...)	☐ Yes ☐ No
Artificial materials in the body (implants, pins, joints, etc...)	☐ Yes ☐ No
Immunizations	☐ Yes ☐ No

HAVE YOU EVER:	
Used tobacco?	☐ Yes ☐ No ☐ More than 12 months ago
Experimented with recreational drugs?	☐ Yes ☐ No ☐ More than 12 months ago
Led a high stress lifestyle?	☐ Yes ☐ No ☐ More than 12 months ago
Experienced a stressful or traumatic event?	☐ Yes ☐ No ☐ More than 12 months ago
Been under anesthesia?	☐ Yes ☐ No ☐ More than 12 months ago
Had an illness during foreign travel?	☐ Yes ☐ No ☐ More than 12 months ago
Had an illness while camping or hiking?	☐ Yes ☐ No ☐ More than 12 months ago
Had food poisoning?	☐ Yes ☐ No ☐ More than 12 months ago

DENTAL

Do you currently have amalgam fillings or caps?	☐ Yes ☐ No ☐ I'm not sure	**How many amalgam fillings do you have now?**	
Have you removed or lost dental fillings or caps?	☐ Yes ☐ No ☐ I'm not sure		
Did you have fillings as a child?	☐ Yes ☐ No ☐ I'm not sure	**How many fillings did you have?**	
Did you have your Wisdom teeth removed?	☐ Yes ☐ No ☐ I'm not sure	**At what age?**	
Any complications such as dry socket or abscesses?	☐ Yes ☐ No ☐ I'm not sure		
Do you have any root canal treated teeth?	☐ Yes ☐ No ☐ I'm not sure	**How many and when were they placed?**	
Did your mother have dental fillings prior to giving birth to you?	☐ Yes ☐ No ☐ I'm not sure	**During her pregnancy with you?**	

PRESCRIPTION MEDICATIONS

NAME OF MEDICATION	DOSE (MG, ML, IU)	HOW OFTEN DO YOU TAKE IT?	HOW LONG HAVE YOU TAKEN IT?	IF YOU HAVE SIDE EFFECTS, PLEASE SPECIFY

VITAMINS/MINERALS, HERBS, AND OTHER SUPPLEMENTS

NAME OF VITAMIN	DOSE (MG, ML, IU)	HOW OFTEN DO YOU TAKE IT?	HOW LONG HAVE YOU TAKEN IT?	IF YOU HAVE SIDE EFFECTS, PLEASE SPECIFY

DRUG ADVERSE REACTIONS

Please list ANY medication / anesthetics / immunizations you have had to stop taking because of side effects or allergic reactions:

NAME OF MEDICATION/ IMMUNIZATION	TYPE OF SIDE EFFECTS OR ALLERGIC REACTION THAT CAUSED YOU TO STOP IT	AGE	YEAR

IMPORTANT: INSURANCE & LAB PROCEDURES

INSURANCE

Traditional insurance does not cover the extensive, preventative and root cause care that True Life Medicine delivers through a Functional Medicine approach. Your monthly retainer fee pays for this.
However, Dr. James also fulfills the role of Direct Primary Care Provider for you. To ensure he can order Labs, Prescriptions and more and your insurance will cover them, he is contracted and networked with most insurance companies. Per those contracts, we are required to have your insurance information on file, bill your insurance company for appointments, and collect any appointment copays at the time of service.

LABS

Payment for labs are due at the time of service, thus it is imperative that you understand if your insurance will cover your labs.
We order labs through Quest Diagnostics. They employ a phlebotomist, Paul, who resides in our office for your convenience. The labs we initially order for new patients are much more extensive than what a traditional doctor would order, and thus, cost more, often close to $3,500 retail. We take great care so you spend as little out of pocket as necessary.

There are three options for payment:

INSURANCE:
If you know your insurance will cover the labs and your deductible will ensure you are not left with more than $600 of the cost, then simply give our phlebotomist your insurance information at the time of your lab draw and it will be taken care of between Quest, your insurance and you.

CASH PAY:
If you do not have insurance that will cover your labs and believe you will end up with $600 or more in out of pocket expense, we can run your bill as, “Client Bill”. This means Quest charges True Life Medicine directly for your labs and you receive our special, negotiated cash-pay price. To facilitate this, you must pay True Life Medicine in-full on the day of your labs. Unless Dr. James believes you require an uncommon lab test, your cost should not exceed $600 and if often less.

INSURANCE WAIT-AND-SEE:
If you do not clarify your insurance coverage and want Quest to bill your insurance company directly and wait to find out what your out of pocket expense are…and they end up exceeding $600, True Life Medicine can work with Quest to revert the bill from Insurance to Client Bill on the spot, with your payment in full to True Life Medicine at that time, plus a $75 processing fee, as we incur a substantial amount of administrative work to accommodate this.

FULL NAME **DATE**

BY SIGNING I CONFIRM MY UNDERSTANDING OF THE TRUE LIFE MEDICINE INSURANCE & LAB STRUCTURE:

(Your signature above this line)