

Sanjevani Health and Lifestyle Center

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PATIENT HISTORY

PART ONE: GENERAL INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Preferred name, if different from above _____ Occupation _____

Marital status: (check)

Single _____ Married _____ Partner: _____ Divorced _____ Widow _____ Race _____ Age _____

Why are you here today? Routine Exam/Other _____

Family/Internal Medicine Physician _____ Phone Number: _____

Date Last Seen _____ Are they supportive of you using natural and dietary changes? (Circle) Yes or No

Specialist Physician (i.e. Cardiologist, Neurologist, etc): _____ Phone Number: _____

Date Last Seen: _____ Are they supportive of you using natural and dietary changes? (Circle) Yes or No

Have you had any of the following tests preformed within the last 5 Years? Circle all that apply:

Chemistry Profile/ Thyroid Testing/ Barium Enema/ Mammogram/ Cholesterol Screening/ Cholesterol Screening/HIV (AIDS)/

Sigmoidoscopy/ Colonoscopy/ Pap Smear/ Lipid Profile/ Stool Blood Test/ EKG/Blood Count/NutraEval/CDSA/Allergy Testing

Other Tests Performed _____

Abnormal Tests Results _____

PART TWO: GENERAL MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate blood relatives.

X=Yourself M=Mother F=Father B=Brother S=Sister Grandparents: Maternal=**MGM/MGF** Paternal= **PGM/PGF**

Disease/Disorder	You	Family	Disease/Disorder	You	Family
1. Allergies			18. Diabetes		
2. Allergies - Food			19. Diarrhea		
3. Alzheimer's			20. Drug/Alcohol Abuse		
4. Anemia			21. Fibromyalgia		
5. Anxiety			22. Gallbladder Disorders		
6. Arthritis			23. Glaucoma		
7. Asthma, Lung Disease			24. Hearing Problems		
8. Autoimmune Diseases (circle) MS, Lupus, Rheumatoid, Celiac			25. Heart Disease/High Cholesterol		
9. Bladder Infections			26. Hemorrhoids		
10. Blood Clots			27. Hepatitis		
11. Blood Disorders			28. High Blood Pressure		
12. Breast Cancer			29. Insomnia		
13. Colon Cancer			30. Irritable Bowel Syndrome		
14. Constipation			31. Kidney Disease		
15. Chronic Fatigue			32. Lyme Disease		
16. Crohn's Disease/Ulcerative Colitis			33. Menopausal Symptoms		
17. Depression			34. Mental Illness		

35. Migraine Headaches			43. Reflux - Heartburn		
36. Obesity			44. Seizures		
37. Osteoporosis			45. Skin Diseases		
38. Other Cancers			46. Strokes		
39. Ovarian Cancer			47. Thyroid Disorders		
40. Pregnant or Nursing			48. Tuberculosis		
41. Prostate Enlargement			49. Ulcers		
42. Prostate Cancer			50. Other Illness:		

FAMILY MEDICAL HISTORY:

Please add date of birth, any illnesses past or present (including emotional-mental). If deceased, please list cause and age of death.

Mother: _____
Date of Birth Place of Birth

History _____

Father: _____
Date of Birth Place of Birth

History _____

PART THREE: ALLERGIES

1. Do you have any known **Medication ALLERGIES** (i.e. Penicillin, sulfa, etc.)? (Check) ___ Yes or ___ No Known Drug Allergies

If yes, please list all known drug allergies: _____

2. Do you have any known **Food ALLERGIES** (i.e. wheat, soy, corn, peanuts, etc)? (Circle) Yes or No

If yes, please list all known allergies: _____

PART FOUR: PRESCRIPTION MEDICATIONS & OVER THE COUNTER MEDICATIONS

Please list **all** prescription medications you are currently taking including dose and times per day taking as well as what for that is being treated. To also including birth control, over the counter drugs (i.e. Tylenol, Advil, aspirin, etc.).

DRUG NAME	DOSAGE	FREQUENCY	WHY TAKING/TREATING CONDITION
Example: Crestor	10 mg	1 per day	High Cholesta
1.			
2.			
3.			
4.			
5.			

6.			
DRUG NAME	DOSAGE	FREQUENCY	WHY TAKING/TREATING CONDITION
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

PART FIVE: NUTRITIONAL SUPPLEMENTS

Please list any vitamins, minerals, amino acids and other supplements you are currently taking

SUPPLEMENT NAME	MANUFACTURER	DOSAGE	FORM	FREQUENCY
Example: Vitamin C	Twin Labs	500 mg	Capsules	1 Per Day
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

PART SIX: Please list all hospitalizations, surgeries, broken bones, and serious injuries below:

Year	Problem/Diagnosis	Operation	Comments
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PART SEVEN: NUTRITION, WELLNESS & FITNESS

1. What is your blood type? _____
2. What is your body type? (Circle all words that apply to describe yourself):
slim, thin, wide, athletic, husky, petite, fat, muscular, average, medium, small, large, heavy-set.
3. What is your Ayurvedic Dosha? (i.e. Vata, Pita, Kalpha, Vata-Pitta, etc)? _____ If you don't know check here _____
4. How would you describe your body's metabolism? (Circle one) very slow, slow, average, fast, very fast
5. What is your biggest meal of the day? (Circle) Breakfast, Lunch, Dinner
6. How do you feel after you eat? (Circle) light, energetic, heavy, tired, bloated, sleepy
7. How many ounces of water do you drink *daily*?
(Circle) None, <8 ounces, 8-16 ounces, 16-32 ounces, 32-48 ounces, 48-64 ounces, 64-80 ounces, 80-96 ounces, >96 ounces
8. How much refined sugar *daily* in teaspoons or grams? (1 teaspoon = 4 grams) May need to look up Nutrition Facts on package label of amount of sugar in grams you are eating?
(Circle) None, 4- 20 grams, 20-40 grams, 40-60 grams, 60-80 grams, 80-100 grams, 100-120 grams, 120-140 grams, 140-160 grams, 160-180 grams, 180-200 grams, >200 grams
9. How much fresh fruit do you eat *daily*? i.e. 1 serving = 1 cup fresh fruit or or ¼ cup dried fruit
(Circle) None, 1 serving, 2 servings, 3 servings, 4 servings, 5 servings, 6 servings, 7 servings, 8 servings, 9 servings
10. How many fresh vegetables do you consume *daily*?
(Circle) None, 1 serving, 2 servings, 3 servings, 4 servings, 5 servings, 6 servings, 7 servings, 8 servings, 9 servings

11. Do you currently smoke? (Circle) Yes or No
If Yes, how many cigarettes or packs of cigarettes a day? # cigs____ #packs_____
12. Do you use recreational drugs such as marijuana? (Circle) Yes or No
If Yes, how much and how many times *per week*? _____
13. Do you drink alcohol? (Circle) Yes or No
14. If Yes, how what kind: (Circle one or more): Beer, Wine, Liquor
15. If Beer, how many beers *per week*? (Circle) None, 1-2 beers, 3-5 beer, 6-9 beers, >10 beers
16. If Wine, how many glasses *per week* (glass=5 ounces)? (Circle) None, 1-2 glasses, 3-5 glasses, 6-9 glasses, >10 glasses
17. If liquor, how many ounces *per week*? (Circle) None, 2-4 ounces, 4-8 ounces, 8-12 ounces, 12-16 ounces, > 16 ounces
18. Is drugs or alcohol a problem for you? (Circle) Yes or No
19. Do you drink Soda? (Circle) Yes or No Diet or regular? _____
How many sodas *per week* (1 soda =12 ounces)? (Circle) None, 1-2 sodas, 3-5 sodas, 6-9 soda, >10 sodas
20. Other beverages? _____
21. What enriched/refined starches do you eat *daily*? (Check all that apply): _____White Potatoes _____French Fries
_____White Rice _____White Pasta _____Pastries/Donuts _____White Tortillas _____White Bread/rolls/bagels
22. How much fiber do you consume *daily* (i.e. in grams, teaspoons, cups, etc)? Grains _____ Nuts _____
Dried & Fresh Fruits _____ Vegetables _____ Seeds (flax, chia, hemp) _____
23. Do you eat canned foods? (Circle) Yes or No
If Yes, how many canned items *per week*? (Circle) None, 1-2 items, 3-4 items, 5-6 items, >7 items
24. Do you eat microwaved foods? (Circle) Yes or No
If Yes, how many times *per week*? (Circle) None, 1-2 times, 3-4 times, 5-6 times, >7times
25. Do you read every food label? (Circle) Yes or No
26. How many times do you eat out *per week* (i.e. fast food, restaurants, etc)? (Circle) None, 1-2 times, 3-4 times, 5-6 times, >7times
27. Do you eat a lot of fast foods? (Circle) Yes or No
28. Do you eat a lot of junk foods (i.e chips, candy bars, cookies, ice cream)? (Circle) Yes or No
29. What are your eating weaknesses? _____
30. What are your eating strengths? _____
31. Do you have a good self-image? (Circle) Yes or No
32. How often do you exercise? (Circle) None, daily, weekly, monthly
33. Are you conscious of your breathing? (Circle) Yes or No
34. Do you know how to meditate? (Circle) Yes or No
If Yes, How often and for how long do you meditate? _____
35. Do you really love yourself? (Circle) Yes or No
36. Are you hard on yourself? (Circle) Yes or No
37. Do you reward yourself with bad foods? (Circle) Yes or No

38. Do you binge if you're sad or depressed? (Circle) Yes or No

39. Do you finish things you start? (Circle) Yes or No

40. Do you need other people's approval? (Circle) Yes or No

41. What foods make you happy? _____

42. Which food tastes do you crave? (Check all that apply) ___Sweet ___Sour ___Salty ___Bitter
___Spicy/Pungent ___Astringent

43. How often do you go to the bathroom daily? #1_____ #2_____

If you do not go daily, how often do you have a bowel movement?

(Circle) Every other day, Every 3 days, Every 4 days, Every 5 days, Every 6 days, Every 7 days, Greater than 7 days

44. Do you need a strict lifestyle program? (Circle) Yes or No

What is your favorite food type/cuisine? (List nationality and/or geographic region, i.e., Italian, Spanish, Mexican, Indian, Middle Eastern, Chinese, Thai, African)?

NOTES/COMMENTS

Please share any additional information you believe would be helpful.

PART EIGHT: MENTAL HEALTH HISTORY

1. Have you ever been sexually abused? (Circle) Yes or No

2. Have you ever been physically or emotionally abused by someone important to you? (Circle) Yes or No

3. Have you received counseling for abuse issues? (Circle) Yes or No

4. Have you had a recent major stress (i.e. loss of job, loss of loved one, change in marital status)? (Circle) Yes or No

PART NINE: 5-DAY FOOD LOG

Please log everything you eat and drink over a five day period, including all liquids (particularly alcohol). If you are on a diet please specify which one, i.e.; Atkins, Paleo, South Beach, The Master Cleans, Vegan, etc.

(Please print clearly.)

Breakfast

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Morning Snack

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Lunch

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Afternoon Snack

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

5-DAY FOOD LOG (Continued from previous page)

Dinner

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Evening Snack

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT. I WILL NOT HOLD LIABLE AND HOLD HARMLESS Dr. Sunil Pai, MD, Maureen Sutton, LMT and all Sanjevani related companies, affiliates, agents and employees and Brigitte Britton, MegaWay/Cannabiseology companies, affiliates, agents and employees IN ANY WAY FOR ANY MEDICAL CONDITIONS BOTH EMOTIONAL AND PHYSICAL THAT MAY ARISE NOW OR IN THE FUTURE FROM THE USE OF ANY SUGGESSTED NUTRITIONAL PRODUCTS OR NUTRITIONAL/DIETARY PROGRAMS OR RECOMMENDATIONS. By signing this consent form I also agree to the Terms and Conditions of the Patient Consent Form that on file at Sanjevani Integrative Medicine Health & Lifestyle Center. Although clinical data and experience with use of recommended products have been established, since they are classified as "diet" and "dietary supplements", I understand that they are not approved or intended to treat, prevent or cure any disease according to the Food and Drug Administration. I AM ALSO REMINDED THAT I SHOULD CONSULT A DOCTOR BEFORE STARTING A NUTRITIONAL AND/OR EXERCISE PROGRAM.

CUSTOMER SIGNATURE: _____

TODAY'S DATE: ____/____/____