INSTITUTE OF PREVENTIVE MEDICINE AND NUTRITION
1342 ATWOOD ROAD
SILVER SPRING, MARYLAND 20906
(301) 460-6600 (703) 573-8181

Patient_____Birthdate _____Phone ( )_____
Last First M.I

Address_____
No. and Street City State Zip

Social Security #_____ Driver's License# _____

Responsible party_____Patient Married_____Single _____
(Patient-Spouse-Father-Guardian) Widowed_____Divorce ____

Employer_____Occupation_____
(Employer of Patient or Parent)

Employer's_____Phone ( )_____
No.Street City State Zip

Given name of Husband or wife_____
(If not shown above)

Spouse Employed by_____Phone( ) _____

Employer'_____
Address No. and Street City State Zip

In case of Emergency, notify_____ phone( )_____
(Family-Friend-Neighbor)
Address_____

Name and branch of bank- or other financial reference_____
Address_____
Medicare #_____
Insurance Co. Name_____ Policy No_____
Health Care Practitioners attended in the last three years:
Name Address Phone#
1._____
2._____
3._____
Who referred you to the Institute?_____
How did you find out about us?_____
Major health problem_____

The following conditions may be related to mineral deficiency or excess. Check those to your own condition.

____ Back pain	____ Use antacids	____ Pain on sitting
____ Ulcer	____ Bladder trouble	____ Taking vitamins and minerals
____ Diabetes	____ City dwellers	____ Stress occupation
____ Pregnancy	____ Eat meat daily	____ High blood pressure
____ weakness	____ Fish eater	____ Trouble making decisions
____ Allergies	____ Soft drink user	____ Trouble concentrating
____ Swelling	____ Take medicine	____ Skin sores, rashes
____ Arthritis	____ Hypoglycemia	____ Sleep disturbances
____ Headache	____ Kidney stone	_____ frequent infection
____ Menopause	____ Bone pain	_____ Bruises easily
____ Diarrhea	____ loose teeth	_____Hereditary illnesses
____ Hair loss	____ Bleeding gums	_____ Brittle fingernails
____ Fatigue	____ Constipation	_____ emotional disturbances
____Epilepsy	____ Hemorrhoids	_____ History of hospitalization
____Bad liver	____Weak kidney	_____ Varicose veins
____Cancer	____ Asthma	_____ Heart trouble
____Palpitation	____ Milk drinker	_____ More than one broken bone

Circle I am I am not pregnant or attempting to become pregnant.

Follicle analysis by x-ray florescent spectra is one way to get a notion about mineral excess and deficiency as well as impressions about toxic metals. The balance of nutrients as well as detoxification. Is a traditional aspect of orthomolecular preventive and holistic medicine. It differs from the concept of allopathic medicine

When a diet, vitamin minerals are recommended, it is a result of experience and history you supply. The purpose of mineral supplementation is the optimization of health and cannot be offered as a "cure" for any specific disease. I understand that supplements must be complemented with diet for optimum results, and that many people require supplements of structural minerals for many years if they are deficient. Follow up of mineral status with blood tests and later follicle analyses are desired generally at 4-6 months intervals.

I have read and understand the above and have given a copy of this form

_____ _____

Laboratory technician signed

Date_____ age_____ wt_____

Street and no_____

City and zip_____

INSTITUTE OF PREVENTIVE MEDICINE AND NUTRITION
MARYLAND – (301) 460 –6600

COMPREHENSIVE LIFE HISTORY

NAME: _____

DATE: _____

Dear patient

In order to render complete and comprehensive care. It is necessary to summarize by decades what happened in your life important to your physical mental and spiritual healing. This essential data or information will assist the therapist with her evaluation and enable your care to be as comprehensive as possible. We realize this will be time consuming and we appreciate the effort.

Example: Age 0-10- born july8: 1951, 10 lbs. 6.oz in hospital the 4th of 5 children, mother had blood pressure, no complications for me, I had eczema in preschool, hay fever started at age 6 fell out of tree fractured skull; age 7 hospitalized 6 weeks- bad case of measles age 7 with pneumonia- held back in school because of missed time – dad died age 8 – mom remarried age-9 headaches and unhappiness for 1 year and loss of weight- wore glasses- did well in school and become involved in church activities.

Try to be as complete as your memory will allow. Be concise and do not exceed space provided. If possible.

Age 0 – 10

Age 10- 20

Age 20-30

Age30-40

Age 40- 50

Age 50-60

Age 60-70

Age 70 plus

INSTITUTE OF PREVENTIVE MEDICINE AND NUTRITION

"Evaluate Yourself" Ecologic Questionnaire"

Instructions: Check each symptom accordingly:

0 = you never had this problem 1 = mild when or occurs or occurs seldom

2 = moderate or occurs once a week 3 = severe or occurs often

0	1	2	3	
				Crave food, hunger
				Sleepiness after eating
				Groggy, sleepy, lethargic
				Low self image, insecure
				Negativity or irritability before meals
				Moodiness
				Cry or would like to cry
				Boredom
				Depression, hopeless thoughts
				Suicidal thoughts
				Initiative reduced
				Dullness, lack of laughter
				Tenseness
				Headache, pressure or fullness
				Fatigue, lack of energy
				Fits of anger
				Nervousness, restlessness
				Bad dreams
				Insomnia
				Not rested after sleep
				Hyperactive, overactive
				Behavior problems, unsocial/antisocial
				Feel faint or shaky if meal delayed
				Feeling apart
				Fears, shyness, phobias
				Forgetful, memory loss
				Difficulty concentrating
				Labor over and magnify small details
				Trouble making decisions
				Worry excessively
				Anxious, trembling
				Suspiciousness
				Hallucinations, delusions

0	1	2	3	
				Perception distorted, "spaced"
				Symptoms of mental retardation
				Variable penmanship
				Aggressiveness, like to argue
				Use alcohol or tranquilizers
				Blurred vision
				Glare hurts eye
				Change of color perception
				Redness, swelling of eyelids
				Eye pain, dryness, redness
				Watery eyes
				Double vision
				Spots before eyes
				Eyelids swollen or itching
				Dizziness, light headedness
				Ringing in ears
				Intermittent hearing loss
				Ear pain
				Sensitivity to noise
				Tooth/jaw pain
				Bad breath
				Metallic taste
				Itching roof of mouth
				Bleeding gums
				Sinus complaint,obstructed nose
				Cracks at corner of mouth
				Difficulty swallowing
				Shortness or heavy breathing
				Chest pain,tightness or pressure
				Wheezing
				Coughing up phlehm
				Fast heart, palpitations
				Irregular heartbeat

0	1	2	3	
				High blood pressure
				Belching, gassiness
				Nausea, vomiting
				Churning in belly, noise
				Gallbladder colic
				Rectal bleeding or mucous
				Indigestion, heartburn
				Frequency of urination or discomfort
				Stomachache
				Rectal pain
				Diahrrea
				Constipation
				Bloated, swelling of belly
				Thirstiness off and on
				Itching or burning anus
				Hives, pimples, blotches, blisters
				dry, itchy skin, scales, rash
				Problem with fingernails/ toenails
				Excess or lack of sweat
				Dry scalp, oily scalp
				Hair loss, premature graying
				Wetting bed, unable to control bladder
				Back, spine pain
				Neck pain
				Muscle pain, spasm, cramps
				Muscle weakness
				Muscle twitching
				Aching and stiffness in the a.m.
				Joint pain
				Joint redness
				Joint swelling

0	1	2	3	
				Hiccups
				Need to void at night
				Incoordination
				Hot flashes, flushing
				Vaginal discharge
				Increased sex drive
				Decreased sex drive
				Itching or swelling of genitals
				Painful intercourse
				Irregular periods
				Prostate problem
				Swelling of feet
				Cold hands or feet

Patient's Name:_____

Date: _____