

ELAN VITAL MEDICAL CTR  
21 WEST STREET  
WORCESTER, MA 01609  
TEL. 508-753-0006  
FAX. 508-770-0618

### PATIENT INFORMATION

(Please print clearly)

#### WELCOME

The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide if we can assist you. If we do not believe that your condition will respond to our care, we will not accept you as a patient but will refer you to another health care provider.

Last Name \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_

Birth Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

I understand and agree that the doctor has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. I further understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that, unless other arrangements are made with your office, all services are rendered to me are charged directly to me and that I am personally responsible for payment.

Signature \_\_\_\_\_ Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PLEASE VISIT US ONLINE AT: **WWW.DRKARENWAY.COM**

Name \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

What do you think caused your problem? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Has this condition occurred before? ( ) Y ( ) N

What type(s) of therapy have you tried for this condition?

- ( ) conventional drugs      ( ) chiropractic      ( ) acupuncture  
( ) diet modification      ( ) vitamin/minerals      ( ) herbs  
( ) homeopathy      ( ) other \_\_\_\_\_

Laboratory tests performed (e.g. blood, urine, stool, hair analysis) \_\_\_\_\_

Outcome of tests \_\_\_\_\_

What diagnosis were you given? \_\_\_\_\_

Is your health currently:      ( ) getting better      ( ) getting worse      ( ) staying same

How do you know? \_\_\_\_\_

Please list any other health concerns/conditions, even if you think they may not be important. \_\_\_\_\_

Primary care physician \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Please list all medications you have taken over the past 3 months (prescription or over the counter)

Drug Name	Start Date	Stop Date	Reason For It	Results

Please list all of your medication allergies

- |    |    |    |
|----|----|----|
| 1. | 2. | 3. |
| 4. | 5. | 6. |

Please list all hospitalizations or surgeries

- |    |      |
|----|------|
| 1. | Year |
| 2. | Year |
| 3. | Year |

Have you EVER been on frequent or prolonged antibiotic therapy? ( )Y ( ) N

Any medications devices/prosthetics/implants ( )Y ( )N describe: \_\_\_\_\_

## WOMEN

Age of onset of menstruation \_\_\_\_\_

Are you pregnant? ( ) Y ( ) N

Age of onset of menopause \_\_\_\_\_

Hysterectomy ( )Y ( )N

Number of children \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

Length of menstrual cycle \_\_\_\_\_ days

Interval of time between cycles \_\_\_\_\_ days

Duration of flow \_\_\_\_\_ days

Is your flow ( )Light ( )Medium ( ) Heavy

Date last period began \_\_\_\_\_

Date of last PAP \_\_\_\_\_

Do you have:

( )irregular periods

( )cramps/pain with period

( )tension/depression before period

( )hot flashes at any time

( )pain during intercourse

( )any unusual bleeding or discharge

Do you smoke cigarettes? ( )Y ( )N

\_\_\_\_\_ packs/day How many years \_\_\_\_\_

Do you smoke cigars? ( )Y ( )N

\_\_\_\_\_ cigars/day How many years \_\_\_\_\_

Do you do illegal drugs? ( )Y ( )N

\_\_\_\_\_ amount/type \_\_\_\_\_

Do you drink alcohol? ( )Y ( )N

\_\_\_\_\_ drinks/week

Do you drink caffeine ( )Y ( )N

\_\_\_\_\_ cups/per day

How many cups of water do you drink each day? \_\_\_\_\_

Do you exercise regularly? ( )Y ( )N If yes, what kind and how often? \_\_\_\_\_

Are you on a special diet? ( )Y ( )N If yes, what kind? \_\_\_\_\_

Please list everything you eat and drink for 3 days.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

Please list all supplements/herbs/homeopathic you are currently taking.

Name/Type	Dosage	Reason For It

Please list your special interests and passions: \_\_\_\_\_

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Please check the boxes next to all illnesses you have or have had.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Atrial Fibrillation    | <input type="checkbox"/> Colon Polyps        | <input type="checkbox"/> Cancer: Colon         |
| <input type="checkbox"/> Angina Pectoris        | <input type="checkbox"/> Irritable Bowel     | <input type="checkbox"/> Cancer: Esophagus     |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Cancer: Stomach       |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Crohn's Disease     | <input type="checkbox"/> Cancer: Pancreas      |
| <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Ulcerative Colitis  | <input type="checkbox"/> Cancer: Prostate      |
| <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Liver Cirrhosis     | <input type="checkbox"/> Cancer: Breast        |
| <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Excessive Alcohol Use |
| <input type="checkbox"/> Bleeding Disorder      | <input type="checkbox"/> Gallstones          | <input type="checkbox"/> Drug Abuse            |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Pancreatitis        | <input type="checkbox"/> Anxiety               |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Diverticulosis      | <input type="checkbox"/> Suicide Attempt       |
| <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Sprue               | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Esophagitis         | <input type="checkbox"/> Migraine Headache     |
| <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Endometriosis         |
| <input type="checkbox"/> Thyroid Disorder       | <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Arthritis             |

Have you had the following immunizations:

- |   |   |
|---|---|
| <input type="checkbox"/> Polio                              | <input type="checkbox"/> tetanus booster (last 10 yr) |
| <input type="checkbox"/> DPT (diphtheria/pertussis/tetanus) | <input type="checkbox"/> Hepatitis B                  |
| <input type="checkbox"/> Measles                            | <input type="checkbox"/> HPV (human papillo virus)    |
| <input type="checkbox"/> Mumps                              | <input type="checkbox"/> Others _____                 |
| <input type="checkbox"/> Small Pox                          |   |

Please list any family members who have had any of the following problems.

Disease	Relation To You	Disease	Relation To You
Cancer: Colon		Colon Polyps	
Cancer: Breast		Colitis	
Cancer: Prostate		Bleeding Problems	
Cancer: Other		Alcohol Abuse	
Obesity		Hepatitis	
Diabetes		Osteoporosis	
Hypertension		Liver Disease	
Heart Disease		Other:	
High Cholesterol		Other:	

Please circle your answer:

Date of last colonoscopy (if over age 50)	Year:	Never – Don't know
Date of last mammogram (if female)	Year:	Never – Don't know
Date of last bone density test (for osteoporosis)	Year:	Never – Don't know

Symptoms	Yes No	Physician Comment
Lack of energy	Yes No	Constitutional
Trouble sleeping	Yes No	
Weight loss (10 lbs. in 1 yr.)	Yes No	
Weight gain (10 lbs. in 1 yr.)	Yes No	
Fevers	Yes No	
Hard or infrequent bowel movements	Yes No	GI
Loose or frequent bowel movements	Yes No	
Blood in bowel movements	Yes No	
Vomit blood	Yes No	
Heartburn/indigestion	Yes No	
Food sticks when swallowing	Yes No	
Painful swallowing	Yes No	
Yellow jaundice	Yes No	
Chest pain	Yes No	Cardiovascular
Irregular heartbeat	Yes No	
Palpitations	Yes No	
Swollen legs	Yes No	
Fainting	Yes No	
Shortness of breath	Yes No	Respiratory
Wheezing	Yes No	
Coughing up blood	Yes No	
Asthma	Yes No	
Frequent urination	Yes No	GU
Blood in urine	Yes No	
Difficulty urinating	Yes No	
Could you be pregnant	Yes No	
Painful menses	Yes No	
Joint swelling	Yes No	Musculoskeletal
Joint redness	Yes No	
Gout	Yes No	
Muscle aches	Yes No	
Breast lump	Yes No	Breast/skin
Unusual or new rash	Yes No	
Paralysis	Yes No	Neuro
Stroke	Yes No	
Seizures	Yes No	
Loss of memory	Yes No	
Depression	Yes No	Psychological
Suicide attempts	Yes No	
Anxiety	Yes No	
Diabetes	Yes No	Endocrine
Excessive thirst	Yes No	
Bleeding	Yes No	Heme
Easy bruising	Yes No	
Allergy to shellfish	Yes No	Allergy
Allergy to X-ray dye	Yes No	

Patient Signature:

Date:

## METABOLIC BIOTRANSFORMATION QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile

- Point Scale
- 0-Never or almost never have the symptoms
  - 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

### 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
- \_\_\_ Excessive sweating
- \_\_\_ Flushing, hot flashes

\_\_\_ Total

### HEART

- \_\_\_ Irregular or skipped heartbeat
- \_\_\_ Rapid or pounding heartbeat
- \_\_\_ Chest pain

\_\_\_ Total

### LUNGS

- \_\_\_ Chest congestion
- \_\_\_ Asthma, bronchitis
- \_\_\_ Shortness of breath
- \_\_\_ Difficulty breathing

\_\_\_ Total

### DIGESTIVE

- \_\_\_ Diarrhea
- \_\_\_ Constipation
- \_\_\_ Bloating feeling
- \_\_\_ Belching, passing gas
- \_\_\_ Heartburn
- \_\_\_ Intestinal/stomach pain

\_\_\_ Total

### JOINTS/MUSCLES

- \_\_\_ Pain or aches in joints
- \_\_\_ Arthritis
- \_\_\_ Stiffness or limitation of movement
- \_\_\_ Pain or aches in muscles
- \_\_\_ Feeling of weakness or tiredness

\_\_\_ Total

### WEIGHT

- \_\_\_ Binge eating/drinking
- \_\_\_ Craving certain foods
- \_\_\_ Excessive weight
- \_\_\_ Compulsive eating
- \_\_\_ Water retention
- \_\_\_ Underweight

\_\_\_ Total

### ENERGY/ACTIVITY

- \_\_\_ Fatigue, sluggishness
- \_\_\_ Apathy, lethargy
- \_\_\_ Hyperactivity
- \_\_\_ Restlessness

\_\_\_ Total

### MIND

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

\_\_\_ Total

### EMOTIONS

- \_\_\_ Mood Swings
- \_\_\_ Anxiety, fear, nervousness
- \_\_\_ Anger, irritability, aggressiveness
- \_\_\_ Depression

\_\_\_ Total

### OTHER

- \_\_\_ Frequent illness
- \_\_\_ Frequent or urgent urination
- \_\_\_ Genital itch or discharge

\_\_\_ Total

## CARBOHYDRATE TOLERANCE ASSESSMENT

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

For each of the questions, answer yes if it usually applies to you and no if it usually does not. Nevertheless, answer each question. Answer as if you were not on a diet or worrying about caloric consumption or about your weight.

PLEASE ANSWER YES OR NO TO EVERY QUESTION

- (5) \_\_\_\_\_ I have high blood pressure.
- (3) \_\_\_\_\_ I have high blood cholesterol.
- (5) \_\_\_\_\_ I have high blood triglycerides
- (3) \_\_\_\_\_ I get tired and or hungry in the mid-afternoon.
- (5) \_\_\_\_\_ I gain weight easily, especially around my waist and have difficulty losing it.
- (5) \_\_\_\_\_ An hour or two after eating a full meal that includes dessert, I want more sweets/snacks.
- (5) \_\_\_\_\_ I often experience mental confusion or brain fog.
- (3) \_\_\_\_\_ Once I start eating sweets, starches or snack food, I often have a difficult time stopping.
- (5) \_\_\_\_\_ I often experience fatigue and generalized weakness.
- (3) \_\_\_\_\_ I would rather have an ordinary meal that included dessert than a gourmet meal that did not include dessert.
- (10) \_\_\_\_\_ I have diabetes/high blood sugar/my blood sugar is not stable.
- (5) \_\_\_\_\_ I have a family history of high blood sugar/diabetes.
- (5) \_\_\_\_\_ After finishing a full meal, I sometimes feel as if I could go back and eat the whole meal again.
- (3) \_\_\_\_\_ I have a family history or obesity/overweight relatives.
- (3) \_\_\_\_\_ A meal of only meat and vegetables leaves me feeling unsatisfied.
- (3) \_\_\_\_\_ If I am feeling down, a snack of cake, cookies, or chocolate makes me feel better.
- (3) \_\_\_\_\_ If potatoes, bread, pasta or dessert are on the table, I will often skip eating vegetables or salad.
- (4) \_\_\_\_\_ I get sleepy, almost "drugged" feeling after eating a large meal containing bread or pasta or potatoes and dessert.
- (3) \_\_\_\_\_ I have a hard time going to sleep at times without a bedtime snack.
- (3) \_\_\_\_\_ At times I wake in the middle of the night and can't go back to sleep unless I eat something.
- (4) \_\_\_\_\_ I get irritable if I miss a meal of mealtime is delayed.
- (2) \_\_\_\_\_ At a restaurant I almost always eat too much bread, even before the meal is served.

### TOTAL SCORE

What your score indicates:

- |              |   |
|--------------|---|
| 10-15        | It is very unlikely that you are carbohydrate intolerant                                |
| 16-20        | There is a possibility that you are carbohydrate intolerant                             |
| 21-40        | Your symptomatology could be due to carbohydrate intolerance                            |
| 40 and Above | You are definitely carbohydrate intolerant and need to discuss further with your doctor |

# Body Type Evaluation Form

**Instructions:** For each subject below, circle the one answer that describes you best.

	<b>VATA</b>	<b>PITTA</b>	<b>KAPHA</b>
AMOUNT OF HAIR	<input type="checkbox"/> average	<input type="checkbox"/> thinning	<input type="checkbox"/> thick
TYPE OF HAIR	<input type="checkbox"/> dry	<input type="checkbox"/> medium	<input type="checkbox"/> oily
COLOR OF HAIR	<input type="checkbox"/> light brown	<input type="checkbox"/> reddish/gray	<input type="checkbox"/> dark brown, black
SKIN	<input type="checkbox"/> dry, rough	<input type="checkbox"/> soft, med. oily	<input type="checkbox"/> oily, moist
COMPLEXION	<input type="checkbox"/> darker	<input type="checkbox"/> pink to red	<input type="checkbox"/> pale, white
EYES	<input type="checkbox"/> small	<input type="checkbox"/> medium	<input type="checkbox"/> large
WHITES OF THE EYES	<input type="checkbox"/> blue or brown	<input type="checkbox"/> yellow or red	<input type="checkbox"/> white and glossy
SIZE OF TEETH	<input type="checkbox"/> very large or very small	<input type="checkbox"/> small to medium	<input type="checkbox"/> medium to large
TEETH	<input type="checkbox"/> shaded	<input type="checkbox"/> yellowish	<input type="checkbox"/> pearl white
MENTAL ACTIVITY	<input type="checkbox"/> quick mind, restless	<input type="checkbox"/> sharp intellect, aggressive	<input type="checkbox"/> calm, steady, stable
MEMORY	<input type="checkbox"/> short term is best	<input type="checkbox"/> good general memory	<input type="checkbox"/> long term is best
EXERCISE TOLERANCE	<input type="checkbox"/> low	<input type="checkbox"/> medium	<input type="checkbox"/> high
DREAMS	<input type="checkbox"/> fearful, flying, running, jumping	<input type="checkbox"/> anger, fiery, violent	<input type="checkbox"/> water, clouds, relationships, romance
WEATHER	<input type="checkbox"/> aversion to cold	<input type="checkbox"/> aversion to hot	<input type="checkbox"/> aversion to damp, cool
SLEEP	<input type="checkbox"/> interrupted, light	<input type="checkbox"/> sound, medium length	<input type="checkbox"/> sound, heavy, long
REACT TO STRESS	<input type="checkbox"/> excite very quickly	<input type="checkbox"/> anger easily, quick temper	<input type="checkbox"/> slow to get irritated
RESTING PULSE RATE (beats/min)			
WOMEN	<input type="checkbox"/> 80-100	<input type="checkbox"/> 70-80	<input type="checkbox"/> 60-70
MEN	<input type="checkbox"/> 70-90	<input type="checkbox"/> 60-70	<input type="checkbox"/> 50-60
BODY SIZE	<input type="checkbox"/> small frame	<input type="checkbox"/> medium frame	<input type="checkbox"/> large frame
WEIGHT	<input type="checkbox"/> thin, hard to gain	<input type="checkbox"/> medium weight	<input type="checkbox"/> heavy, easy to gain
ENDURANCE	<input type="checkbox"/> poor	<input type="checkbox"/> good	<input type="checkbox"/> excellent
STRENGTH	<input type="checkbox"/> poor	<input type="checkbox"/> good	<input type="checkbox"/> excellent
HUNGER	<input type="checkbox"/> irregular	<input type="checkbox"/> sharp, needs food	<input type="checkbox"/> can easily miss meals
FOOD & DRINK	<input type="checkbox"/> prefer warm	<input type="checkbox"/> prefer cold	<input type="checkbox"/> prefer dry & warm
EAT	<input type="checkbox"/> quickly	<input type="checkbox"/> med. speed	<input type="checkbox"/> slowly
FINANCIAL	<input type="checkbox"/> doesn't save, spends quickly	<input type="checkbox"/> saves but big spender	<input type="checkbox"/> saves regularly, accumulates wealth
SEX DRIVE	<input type="checkbox"/> variable, irregular	<input type="checkbox"/> moderate	<input type="checkbox"/> strong
ELIMINATION	<input type="checkbox"/> dry, hard, constipation	<input type="checkbox"/> many, soft to normal	<input type="checkbox"/> heavy, slow, thick regular
WALK	<input type="checkbox"/> fast, quickly	<input type="checkbox"/> average	<input type="checkbox"/> slow & steady
VOICE	<input type="checkbox"/> high pitch, fast	<input type="checkbox"/> medium pitch, clear	<input type="checkbox"/> low pitch, deep resonating
MOODS	<input type="checkbox"/> changes quickly	<input type="checkbox"/> slowly changing	<input type="checkbox"/> steady, non-changing

**TOTALS**

☐

**VATA**

☐

**PITTA**

☐

**KAPHA**

**PLEASE USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR HEALTH HISTORY FROM BIRTH TO PRESENT. PLEASE INCLUDE YOUR MOTHER'S PRENATAL HEALTH HISTORY. FOR EXAMPLE, WAS SHE ON MEDICATIONS, WAS SHE SICK/STRESSED DURING PREGNANCY, WAS YOUR BIRTH VAGINAL OR C-SECTION, AND WERE THERE ANY COMPLICATIONS DURING PREGNANCY OR DELIVERY.**

## **AGREEMENT CONCERNING SCOPE OF CARE**

**Dear Patient,**

You have come to us with the desire to improve your general health through Complementary and Alternative Medicine(CAM). You may or may not at the same time be under the care of another physician for primary care or for a specific ailment, it is important to understand clearly the scope and extent of CAM which we expect to render in your case. Since nutritional deficiency may or may not be associated with a specific disease, or may be the cause of that disease, or may occur as a result of that disease, our concern in your case will be with your nutritional program and your lifestyle and your ability to metabolize and utilize the nutrients you consume. If you have a specific disease and desire treatment for that specific disease entity, you should place yourself under the care of a specialist for such diagnosis and treatments as may be indicated or desired by you.

In our lifestyle changes, CAM and nutritional management of your case, we may prescribe vitamins, herbs, minerals, enzymes, and naturopathic and nutritional supplements. The purpose of these natural prescriptions is limited to:

- Improvement of your overall nutritional status
- Improvement of your metabolism
- Increasing your sense of well-being
- Normalizing your appetite
- Reducing your pain and discomfort
- Balance your mind body constitution

It is important to understand that you may not receive any of these benefits. Results do not occur predictably in every patient, and in some cases they do not occur at all.

Our viewpoint concerning Complementary and Alternative Medicine(CAM) and the diagnostic evaluation of disease is not necessarily shared by the American Medical Association, the Food and Drug Administration, the American Cancer Society, the Arthritis Foundation, the American Heart Association or similar agencies or organizations. Though significant evidence exists to consider such diagnostics and natural treatments safe and effective, the above agencies or organizations may consider them unproved, investigational or experimental. Signing below you acknowledge that, with full knowledge of these disagreements, you desire to undertake diagnostic evaluation and have prescribed in your case such nutritional supplements and natural treatments which, in our opinion, appear to be indicated in your condition.

I have read and understand the above. Under conditions indicated, I hereby place myself under your care for such diagnosis, care, treatment, prescription, and therapies that are indicated in your judgment.

**PATIENT/DATE**\_\_\_\_\_

**WITNESS**\_\_\_\_\_