ZABRECKY INSTITUTE of Biomedicine

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Patient's Name _____Sex _____ Age _____

Height _____ Weight _____ Date _____
Please bring this in with you on your first visit; or mail it. **We would appreciate a 48 hour cancellation notice.**

Your appointment is: _____

Patient Selection

At the Zabrecky Institute of Biomedicine, we understand that many of our patients…

● Are unresponsive or are poorly responsive to the conventional standard of care.

● Have acute or chronic conditions which have not been fully explored or diagnosed with conventional approaches.

● Have conditions which can be managed, in part, by conventional medicine, but with continued progression of the disease process and deterioration in quality of life.

● Have conditions for which no conventional standard of care is currently available.

The Zabrecky Institute of Biomedicine has limitations, as do all providers of medical care. In order to provide more effective care for our patients, we strive to accept those individuals we believe can benefit the most through our integrative medicine approach. Therefore, patient selection is a critical aspect of our progress. As a result, all prospective new patients are interviewed by our staff and screened to determine if they are appropriate candidates for treatment at the Zabrecky Institute of Biomedicine.

QUESTIONNAIRE

Please circle (NO) or (YES) if you have had any of the following life changes within the last two (2) years.

1.	Death of spouse ……	NO	YES	22.	Major revision of personal habit……	NO	YES
2.	Divorce……	NO	YES	23.	Changing to a new school……..……	NO	YES
3.	Marital separation……	NO	YES	24.	Change in residence……..……....	NO	YES
4.	Death of close family member……	NO	YES	25.	Major change in recreation…….	NO	YES
5.	Marriage……	NO	YES	26.	Major change in church activities……	NO	YES
6.	Marital reconciliation……	NO	YES	27.	Major change in social activities…….	NO	YES
7.	Major change in health of family……	NO	YES	28.	Major change in sleeping habits…….	NO	YES
8.	Pregnancy……	NO	YES	29	Major change in eating habits……	NO	YES
9.	Addition of new family member……	NO	YES	30.	Vacation in the last 3 months……..	NO	YES
10.	Major change in arguments with wife/husband	NO	YES	31.	Christmas in the last 3 months……..	NO	YES
11.	Son or daughter leaving home……	NO	YES	32.	Minor violations of the law……...	NO	YES
12.	In-law troubles……	NO	YES	33.	Being fired from work……..……	NO	YES
13.	Wife/husband starting or ending work……	NO	YES	34.	Retirement from work……..……	NO	YES
14.	Major change in family get-togethers……	NO	YES	35.	Major business adjustment……..…	NO	YES
15.	Detention in jail……	NO	YES	36.	Changing to different line of work……	NO	YES
16.	Major personal injury or illness……	NO	YES	37.	Major change in work responsibility…..	NO	YES
17.	Sexual difficulties……	NO	YES	38.	Trouble with boss……..	NO	YES
18.	Death of a close friend……	NO	YES	39.	Major change in working conditions…	NO	YES
19.	Outstanding personal achievement……	NO	YES	40.	Major change in financial state……	NO	YES
20.	Start or end of formal schooling……	NO	YES	41.	Mortgage or loan over 50,000……...	NO	YES
21.	Major change of living conditions……	NO	YES	42.	Mortgage foreclosure…….....	NO	YES
				43.	Mortgage or loan less than 50,000….	NO	YES

Please circle appropriate answer.

1. If female, are you pregnant? NO YES
2. Have you had any of the following diagnosed health history problems?
   - Heart disease NO YES
   - Cancer NO YES
   - Diabetes NO YES
   - High blood pressure NO YES
   - Kidney problems NO YES
   - Obesity NO YES
   - Stroke NO YES
   - Arthritis NO YES
   - Periodontal disease (oral, gum and bone problems) NO YES
3. Have you had a family history of any of the following conditions?
   - Heart disease NO YES
   - Cancer NO YES
   - Diabetes NO YES
   - High blood pressure NO YES
   - Kidney problems NO YES
   - Obesity NO YES
   - Stroke NO YES
4. Are you now taking any of the following medications?
   - Antihypertensive (blood pressure) NO YES
   - Antidiabetic NO YES
   - Antibiotic NO YES
   - Anticancer NO YES
   - Antidepressants NO YES
   - Drugs for ulcers or stomach upsets NO YES
   - Sleeping pills or muscle relaxants NO YES
   - Oral contraceptives NO YES
5. Do you exercise at least three times per week? NO YES
6. Do you use a seatbelt when in a car? NO YES
7. Do you have a history of high blood pressure? NO YES
8. Are you currently under greater than normal amounts of stress? NO YES
9. Do you brush your teeth after meals? NO YES
10. Do you floss your teeth each day? NO YES
11. What is your average daily alcoholic drink consumption? (1 drink = 1 ounce hard liquor, 1 beer or 1 glass of wine)
    1. none 2. 1-2 drinks 3. 3-4 drinks 4. 5 or more drinks
12. How much do you smoke daily?
    1. none 2. less than 1/2 pack 3. less than 1 1/2 packs 4. greater than 1 1/2 packs
13. Please give the daily overall hours for the following (should equal 24 hours):
    Sleep: _____ Rest: _____
    Physical Activity: Vigorous _____ Moderate _____ Light _____ Sedentary _____
14. What is your daily coffee, tea or cola consumption?
    1. one cup _____ 2. two to three cups _____ 3. more than three cups _____

Please place the appropriate number of your answer in the box to the right.

1.	If female, do you have irregular menstrual periods or menstrual pain? 1. no 2. slight 3. moderate 4. significant……	
2.	If female, do you have excess hair on your face, arms or legs? 1. no 2. slight 3. moderate 4. significant……	
3.	If male, are you subject to impotence, premature ejaculation, or difficulty in maintaining an erection? 1. no 2. slight 3. moderate 4. significant……	
4.	Do you have a history of a weight problem? 1. no 2. slight 3. moderate 4. significant……	
5.	Do you have white spots under your fingernails or ridges in your nails? 1. no 2. slight 3. moderate 4. significant……	
6.	Do you feel consistently cold or have cold hands and/or feet? 1. no 2. slight 3. moderate 4. significant……	
7.	Do you have allergies, asthma, or a chronic sniffle? 1. no 2. slight 3. moderate 4. significant……	
8.	Is it difficult for you to get started in the morning? Do you feel tired? 1. no 2. slight 3. moderate 4. significant……	
9.	Do you have dryness of the hair or skin or persistent dandruff? 1. no 2. slight 3. moderate 4. significant……	
10.	Do you get frequent colds or infections? 1. no 2. slight 3. moderate 4. significant……	
11.	Are you subject to constipation? 1. no 2. slight 3. moderate 4. significant……	
12.	Do you often have bloating, gas, or abdominal pain; particularly after eating? 1. no 2. slight 3. moderate 4. significant……	
13.	Do you suffer from aching and/or stiffness of the muscles and joints? 1. no 2. slight 3. moderate 4. significant……	
14.	Do you get headaches? 1. no 2. slight 3. moderate 4. significant……	
15.	After walking, do you have chest pain, a heaviness in your legs, or feel short of breath? 1. no 2. slight 3. moderate 4. significant……	
16.	Do you have frequent bad breath or bad tastes in your mouth? 1. no 2. slight 3. moderate 4. significant……	
17.	Does your stool appear yellow or clay-colored, foul-odored, or contain undigested foods? 1. no 2. slight 3. moderate 4. significant……	
18.	Do you have a history of anemia? 1. no 2. slight 3. moderate 4. significant……	
19.	Do you have symptoms aggravated by worry and/or tension? 1. no 2. slight 3. moderate 4. significant……	
20.	Are your eyes sensitive to light or dark? 1. no 2. slight 3. moderate 4. significant……	
21.	Does your heart pound and are you easily "shaken up" or startled by an unexpected noise? 1. no 2. slight 3. moderate 4. significant……	
22.	How long can you hold your breath? 1. < 60-75 seconds 2. 76-90 seconds 3. 10-30 seconds 4. > 110……	
23.	Does your heart seem to miss beats occasionally? 1. no 2. slight 3. moderate 4. significant……	
24.	At rest, what is your heart beat per minute? 1. < 60-75 seconds 2. 76-90 3. 91-110 4. > 110……	

25. Is your tongue cracked, bluish-red in color, or very smooth (no bumps)?
    1. no 2. slight 3. moderate 4. significant……

26. Are your teeth and gums infected, loose, or subject to periodontal disease?
    1. no 2. slight 3. moderate 4. significant……

27. Have you had major surgery including hysterectomy, coronary bypass, mastectomy, or other cancer surgery?
    1. no 2. yes……

28. Do you have difficulty urinating due to pain or poor flow?
    1. no 2. slight 3. moderate 4. significant……

29. Do you have muscle weakness?
    1. no 2. slight 3. moderate 4. significant……

30. Do you have bloodshot eyes or a feeling of sand in your eyes?
    1. no 2. slight 3. moderate 4. significant……

31. Do you have redness at the corners of your nose or mouth, cracked lips, or dermatitis?
    1. no 2. slight 3. moderate 4. significant……

32 Do you often feel drowsy after eating or feel shaky before meals?
    1. no 2. slight 3. moderate 4. significant……

33. Do your ankles swell in hot weather or do you have hay fever?
    1. no 2. slight 3. moderate 4. significant……

34. Is your skin rough or bumpy, particularly on the back of your arms?
    1. no 2. slight 3. moderate 4. significant……

35. To your knowledge, have you ever passed albumin (protein) in your urine?
    1. no 2. slight 3. moderate 4. significant……

36. Do you have night thirst or night sweats or are you constantly thirsty?
    1. no 2. slight 3. moderate 4. significant……

37. Do you have a history of boils, sores that do not heal, or acne?
    1. no 2. slight 3. moderate 4. significant……

38. Do you feel lightheaded when you stand up quickly?
    1. no 2. slight 3. moderate 4. significant……

39. Do you have recurring vaginal or urinary infections?
    1. no 2. slight 3. moderate 4. significant……

40. Do you have a history of kidney stones or blood in the urine?
    1. no 2. slight 3. moderate 4. significant……

41. Any further information important to your health: