Patient Medical History

Name________________________________ Age_____ Sex____ Height________ Weight________

Present complaint:_________________________________
____

First noticed?_________________________________
Occupation:_________________________________
No. of children___________
Religion (optional):__________________________
Have you been exposed to toxic chemicals?______
If yes, which ones?__________________________
____
____

Other health care providers you are seeing, and their specialties:
____
____
____
____
____
____
What diagnosis(s) were you given?____________
____
____
____

Women only (next two lines):
Age at onset of menstruation:________________
No. of miscarriages/c-sections:________________
Number of children:__________________________
Age at onset of menopause:__________________

How was your health as a child? (circle one): excellent good fair poor

Were there any complications with your delivery? Please explain:_________________________________

Were you breast fed?__________ How long?____

Did you have any serious emotional or mental traumas as a child? Please explain:____________________

Check diseases for which you have been immunized:

☐ measles ☐ mumps ☐ rubella ☐ small pox ☐ influenza ☐ tetanus ☐ diphtheria ☐ other__________

What is your blood type? (circle one): **A** **B** **AB** **O** **don't know**

Serious Illnesses / Injuries / Surgeries	Date	Outcome

	Allergies / Sensitivities (Please Specify)	Typical Reaction
	Animal hair/dander:	
	Chemicals:	
	Drugs, medications:	
	Dust, molds:	
	Food:	
	Grasses, weeds, pollen:	
	Others:	

Tests History

Please list the date of your most recent procedures. Circle any tests that were abnormal:

Test	Year	Test	Year	Test	Year	Test	Year
☐ Chest x-ray		☐ TB Test		☐ Pap Smear		☐ Others:	
☐ Kidney x-ray		☐ EKG		☐ Mammogram			
☐ G.I. Series		☐ MRI		☐ Sigmoidoscopy			
☐ Colon x-ray		☐ CAT Scan		☐ Rectal Exam			
☐ Spine x-ray		☐ Cardiac Stress Test		☐ PSA			
☐ Blood Tests		☐ Cholesterol		☐ Complete Physical Exam			

Health Habits (Please print clearly)

Please list all supplements / herbs / homeopathics you are currently taking (attach a separate sheet if necessary):

Type (include brand name)	**Dosage**

Please circle any of the following medications you are currently taking or have taken within last 3 months:

Allergy medication
Antacids
Anti-inflammatory
Antibiotic /Anti-fungal
Antidepressants
Anti-diabetic/insulin
Aspirin/Tylenol / Advil

Chemotherapy
Cortisone
Heart Medications
High Blood Pressure
Hormones
Laxatives
Lithium

Oral Contraceptives
Pain Medication
Radiation
"Recreational" Drugs
Relaxants
Sleeping Pills
Thyroid

Ulcer Medication
Other ________________
____
____
____
____

Do you:
(Circle day or week, as appropriate):

☐ Use tobacco ______packs per day/week How Many Years?________
☐ Drink coffee ______cups per day/week
☐ Drink black tea ______cups per day/week
☐ Drink alcohol ______cups per day/week
☐ Drink sodas ______cups per day/week
☐ Use artificial sweeteners ______packets per day/week
☐ Use margarine ______pats per day/week

How many times a week do you eat in a restaurant? Breakfast______ Lunch______ Dinner________

What types of restaurants?____

What are your favorite foods: ____

Do you crave sweets?_____ At what time?:___________ Do you salt your food at the table?__________

Are there other foods you crave? (Please Circle) Bread Pasta Dairy Meat Other: ______________

What foods do you really dislike: ____

Are you on any specific diet? If so, please specify: ____

Would you like to increase or decrease your weight? If so, by how much: __________________________

When did you last have a significant (more than 10 pounds) change in weight?______________________

What exercise do you do and how often? ____

How many hours of sleep do you get each night? _______ Do you wake rested?____________________

Are you presently sexually active? _______ Any difficulties? _______ Method of B.C.? _______________

Rate your current stress level from 1-10: _________ How much does this affect you (1-10)? ___________

What are the major stress factors in your life now? ____

Rate your current emotional health (circle): excellent good fair poor unstable crisis

Are you currently in psychotherapy?_________ Do you have a good support network/team? __________

Does your home environment have a supportive effect on your health? ____________________________

How many hours of relaxation (not including sleep) do you give yourself during the work week?_________

During weekends? _______ Favorite recreational activities? ____________________________________

When was your last eye exam?___________ Do you wear contacts?_______ Hard or soft? __________

Do you drink purified or bottled water? ______If so, what brand do you use?________________________

Do you have an air purifier in the room you sleep in?______ What brand?__________________________

Do you have amalgam (silver) fillings?______ Any other dental problems?__________________________

Do you make an effort to eat organically grown foods?______ What % of your diet?__________________

Are you on a restricted diet? Please explain:____

Are you considering any elective surgery or medical procedures in the near future? __________________

Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check (x) if your blood relatives have/had:	Disease	Relationship
Father						Arthritis, gout	
Mother						Asthma, hay fever	
Brothers						Cancer	
						Chemical dependency	
						Diabetes	
						Heart disease, stroke	
Sisters						High blood pressure	
						Syphilis, gonorrhea	
						Tuberculosis	
						Other	

Diet Survey

Please list everything you eat and drink for 2-3 days:

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

Health and Lifestyle Overview

Please tell me what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach a sheet if more space is required).

Is your health currently getting better, worse, or staying the same. How do you know?

What have you tried to do to improve your state of health (e.g. other doctors, treatments, etc)?

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

a.

b.

c.

d.

e.

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

STILLPOINT

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NOTICE TO GAIL GREGORY'S PATIENTS:

BELOW IS AN EXPLANATION ABOUT HOW YOUR REMEDIES ARE SHIPPED. PLEASE READ THIS CAREFULLY. FOR THOSE WHO HAVE RECEIVED SOMETHING LIKE THIS BEFORE, PLEASE NOTE THIS IS THE MOST CURRENT, REVISED VERSION. (July 2008).

Please be sure to note change in my email address.

When you have finished reading this, please send me your email address as soon as possible, even if you think I have it already.

My name is Susanna; I am a retired acupuncturist and long time friend and associate of Gail's. I agreed to handle distribution of remedies for Gail many years ago. I have used most of these products in my practice and am familiar with most of them. This letter is by way of explaining how the distribution system works and to help avoid pitfalls.

HOW AND WHEN ORDERS ARE PLACED BY ME:

- **After Gail tests you she sends me information about what remedies you need. You can also email me an order for refills or extras that I carry. I will generally place your order within a day or two after I receive them from you. Gail sends me your order shortly after she tests you, so be sure to give her any refills you need when she is testing you as I may process that order shortly after you are tested..**
- **Exceptions:** Sometimes my workday schedule varies, due to vacations or other scheduling situations. I am not available on a full time basis but I generally check my email 1-2 times daily. If I am away from my office for an extended period of time, Yvonne Trostli covers for me. Her email is yvonne@wholelifeorganizing.com. Often I process your order the day I get it, so ***be aware of your inventory on hand before Gail tests you in case you need refills..***
- If you call or email me with **additions to an order after I have processed your order**, there will be an additional $5 charge. This is to offset the time it takes to make an invoice, run your cc, and print a shipping label if I am shipping from here.

CONTACTING ME:

- I am available to take orders other than the ones that Gail has placed for you (refills, you caught a cold and need remedies for it, etc.). However, because this is not a full time business I am not always available by phone. **The best way to place an order is by email.** This way I have a written record of your order. Also, sometimes messages on my voice mail are unclear, or the information is inaccurate or incomplete. I check my email often. If you need to order by phone, please call during business hours weekdays 10-5 Eastern Time. If you email an order to me, I will reply to you that I have received it. If you do not hear back from me, resend, or call. Sometimes emails get lost in cyberspace, or the internet may not be available to me temporarily (system breakdowns, power outages, traveling interludes, etc.)

ACCURACY:

- When you do place an order on your own, please be sure you have the accurate name of the product, and please specify how many of each you need. If there are any questions about the accuracy, I will need to contact you before I order, and sometimes it may take days to connect, thereby delaying your order.

METHOD OF PAYMENT:

- All of your remedies will be charged to your credit card. I am not set up to take checks. **Please be sure to let Gail know when there are changes in your credit card information**, **particularly expiration dates**. Any changes that I do not know about will only delay your order. I keep your numbers here in a secure database. Be sure that your credit card can handle charges. If your card habitually declines, I will apply a service charge of $5.00.

SHIPPING COSTS:

- Orders with 1-3 items will cost $10. Orders of over 3 items will cost $15 to ship. Cost of shipping continues to increase because of gas prices, but so far we have been able to keep our shipping rates stable. Generally I will be shipping via USPS first class or priority mail, depending on the weight. If you live in a high density area such as NYC, I may use FedEx or UPS. It will generally take 2-5 business days for your package to arrive once it leaves the source, depending on your location. Most items will be shipped directly from one or more of my vendors, so you may receive more than one package. This is called a “drop ship.”
- If you need your order expedited with 2nd or 3rd day service, there will be additional fees according to distance and weight of package. Additional charges will be incurred for remedies from multiple sources. Overnight and international shipping is calculated on a case by case basis. Often the handling fees are higher because of all the detail work required for customs.

METHOD OF SHIPMENT:

- Most of your packages will arrive by USPS priority or first class mail. If you feel your package is taking too long to reach you, please contact me!

NO SIGNATURE REQUIRED:

- To avoid other delivery delays, unless I hear to the contrary, I will send all packages “no signature required for delivery.” If you need security around your delivery, it will be your responsibility to inform us **each time you order.**

INVOICING:

- Once your credit card has been processed, your invoice will be emailed to you marked as paid. I will authorize your cc charges before I ship; this holds your funds, but often I deposit a batch of credit card charges together, so you will not necessarily receive your invoice at the time of shipment.

DON’T WAIT TO REORDER! :

- To minimize some of your shipping costs, I encourage you to be aware of your supplies as they diminish. **Consider a possible one to two week turn around time to replace your reserves**

RETURNS:

- If you wish to return a product, it must of course be unopened, the seal intact. I need to charge a 25% restocking fee. I will send you a check, credit your credit card, or apply your refund to your next order, depending on the circumstances. Special orders, i.e. products that I do not sometimes stock (in most cases, herbal formulas), cannot be returned. **To be sure, check with me (not Gail) before you ship.**

ERRORS:

- If there are errors in your shipment, please notify me directly and immediately! If you contact Gail, who in turn needs to contact me, it will only take longer for me to set it right.

EMAIL:

- **Please send me your email address!** Having this information can be very useful to communicate information. I am now also able to email invoices, and I of course need your email address to do that.

HOLIDAYS:

- FedEx/USPS does not deliver on Christmas, New Years, Memorial Day, July 4th, Labor Day, and Thanksgiving. If you are counting the days it takes to deliver, please count only business days (M-F) and non-holiday days.

Susanna Stewart July 2008