

Intake Information

THE OFFICE OF DAVID GERSTEN, M.D.

Please write clearly with a **BLACK PEN**. Do not use a pencil.

Name _____ Date _____

Phone (work) _____

Phone (home) _____

What is the latest hour you can be called at the home number? _____

Fax _____

E-Mail _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____

Place of Birth _____

Height _____

Weight _____

Current Occupation _____ Employer _____

Marital Status ___ M ___ D ___ S ___ W

Spouse's Name _____ Spouse's Occupation _____

Names and Ages of Children _____

Disability Status: Totally Disabled ___ Partially Disabled ___ Not Disabled ___

Is there a legal case pending, regarding the problem for which you are now seeking help?

No ___ Yes ___

Approximately how many health care practitioners have evaluated and/or treated you for the problem for which you are now seeking help? _____

How did you learn about Dr. Gersten? _____

Signature _____

ABOUT THIS FORM

Finding the right doctor that suits your illness and symptoms can be challenging. Approximately two-thirds of the people who contact me for consultation are appropriate. They have problems I work with and have success with. Some people are looking for an alternative therapy when conventional medicine is the appropriate choice, while others seek out conventional medicine when an alternative approach is more likely to help them. Most people who contact me have been struggling with health issues for a long time, often years. The doctor-patient relationship is one of the most important ingredients in your healing journey. It's my job to pre-screen people so that I can make a decision about whether you and I are likely to be a good fit...and whether my approach is the best one for you at this time. Thank you for taking the time to answer the questions on this form.

You may fax this form to 760-487-7737. Do not fax more than these 4 pages.

Symptom Check List

(mark "C" for current and "P" for past)

General

- Fatigue
- Exhaustion
- Exhaustion after exertion
- Physical pain
- Libido, change
- Frequent infections
- High Blood Pressure
- Malaise
- Fevers
- Allergy
- Chemical Sensitivity

Neurological

- Trouble falling asleep
- Trouble staying asleep
- Trouble waking up
- Trouble staying awake
- Tired most of the time
- Weakness
- Lack of Endurance
- Depression
- Loss of pleasure
- Crying spells
- Agitation
- Excess worry
- Phobic or fearful
- Panic attacks
- Anxiety
- Suspicious
- Irritability
- Anger
- Delusions
- Hallucinations
- Tremor
- Seizures
- Feeling Shaky
- Hyperactive
- Distractible
- Balance Problems
- Dizzy or Fainting
- Blackouts
- Concentration poor
- Memory problem
- Trouble thinking
- Indecisive
- Confusion
- Learning disability

- Speech problems
- Taste, diminished or gone
- Smell, diminished
- Vision, blurry
- Vision, double
- Hearing loss
- Ears ringing
- Poor temperature regulation
- Headache, tension
- Headache, migraine
- Numbness

Urinary System

- Frequent urination
- Burning on urination
- Hesitation to start urination
- Obstruction to urine flow
- Loss of urine with coughing, straining, or activity
- Urinary tract infections
- Bed wetting

Gastrointestinal

- Mouth ulcers, canker sores
- Mouth - tongue, raw or sore
- Heartburn
- Indigestion
- Gastritis or acid stomach
- Gastric ulcers
- Sugar cravings
- Hypoglycemia, faint feeling if meal is missed
- Nausea
- Vomiting
- Intestinal gas
- Abdominal bloating
- Constipation
- Diarrhea
- Rectal itch

- Food cravings
- Loss of appetite
- Abdominal pain
- Gas pains

Cardiovascular System

- Chest pain on exertion
- Leg pain on exertion
- Swellings of feet/legs/hands
- Cold hands and feet
- Irregular pulse
- Rapid pulse
- Slow pulse

Musculoskeletal

- Muscle soreness
- Muscles cramps
- Muscle weakness
- Muscle jerks
- Arthritis/joint pains
- Back pain
- Limited range of motion of any joint.

Skin

- Rash
- Eczema
- Dry skin
- Rough skin
- Easy bruising
- Hives
- Slow wound healing
- Excessive perspiration
- Sweaty palms and feet

Respiratory

- Nose congested
- Constantly
- Intermittently
- Nose runny
- Nose itching
- Sneezing
- Eye itching
- Eye soreness
- Eye watering

- Eye redness
- Ears sore
- Ears itching
- Ear pressure
- Sore throat
- Throat swelling
- Drainage from nose or sinuses in throat
- Hoarseness
- Swollen neck lymph nodes
- Shortness of breath
- Asthma
- Wheezing
- Smothering feeling
- Tight chest
- Chest pain
- with breathing
- with coughing
- with exertion
- Cough
- Throat infections
- Ear infections
- Sinus infections
- Bronchitis
- Pneumonia

Female

- Vaginal, soreness or burning
- Vaginal itch
- Vaginal discharge or infections
- Hair growth, face
- Irregular menstrual periods
- Menstrual cramps
- Development of symptoms during the time prior to menstruation:
- Headache
- Fluid retention
- Weight gain
- Increased appetite
- Irritability
- Angry outbursts
- Depression
- Fatigue
- Personality change

Childhood, Development, and Relationships

- I was breast-fed.
- I got along well with my mother while growing up.
- I get/got along well with my mother as an adult.
- I got along well with my father while growing up.
- I get/got along well with my father as an adult.
- I was physically abused as a child
 - Mild — Moderate Severe
- I was emotionally abused as a child.
 - Mild — Moderate Severe
- I was sexually abused as a child .
 - Mild — Moderate Severe
- I was neglected as a child
 - Mild — Moderate Severe
- I have been physically abused as an adult.
- I have been emotionally abused as an adult.
- I have been sexually abused as an adult.
- I have been attacked, beaten, or raped as an adult.
- I am currently romantically involved or married.
- My friendships are chaotic.
- My social life is complete and fulfilling.
- I give and receive as much love in my life as I need

Personal Beliefs and Practices

- I believe in God or a Higher Power.
- I feel as if I am in control of my life.
- I believe that my Main Concern (illness, problem) is in control of my life.
- I am basically lucky. Yes No Not Sure
- I usually feel grateful. Yes No Not Sure
- I attend church, temple, synagogue, mosque
 - at least once a week
 - at least once a month
- I consider myself religious.
- I consider myself spiritual.
- My spiritual beliefs relate to my healing.
- My thoughts and feelings contribute to my health.
- The religion I was raised in was _____
- My current religion or spiritual approach is _____

Purpose and Meaning

What is your passion or purpose in life?

Surgical Procedures

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

Past and Present Medical Diagnoses

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

Current Medications

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

Number of Times Using Antibiotics (past 5 years _____) (lifetime _____)

Addictions

- Alcohol Cigarettes Illegal drugs Prescription drugs Sex
- Gambling Eating Other (specify) _____