Intake Screening 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 appropraite 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 email, or fax this form to 760-487-7737. Do not fax more than 8 pages.

MAILING ADDRESS: 1759 Oceanside Blvd Ste C-339 Oceanside, CA 92054 TEL: 760-633-3063

Main Concern (Problem, Illness, Symptom, Experience, Goal)

CURRENT SYMPTOMS

Most mportant symptom _____

Second important symptom _____

Third important symptom _____

Fourth important symptom _____

Fifth important symptom _____

History of Main Concern

In your own words, and not in medical terminology, briefly describe how and when your main concern started, how it has progressed over time, and how it is now affecting your life.

Date of Onset _____

History of Main Concern _____

Chemical Sensitivity/Reactivity to Supplements

❑ I have experienced toxic exposure that is: ❑ mild ❑ moderate ❑ severe

❑ I have been told that I have a problem with methylation.

❑ I have ❑ mild ❑ moderate ❑ severe problems tolerating nutritional suppements.

List all nutritional supplements you react to or have problems tolerating, and describe these reactions. If you react to numerous supplements, please type the details on a separate piece of paper. For each nutritional supplement you react to, state if the reaction is mild, moderate, or severe:

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
- ❑ Anxiety
- ❑ Tired most of the time
- ❑ Weakness
- ❑ Lack of Endurance
- ❑ Depression
- ❑ Loss of pleasure
- ❑ Crying spells
- ❑ Excess worry
- ❑ Phobic or fearful
- ❑ Panic attacks
- ❑ Feeling Immobilized
- ❑ Feeling Disconnected
- ❑ Suspicious
- ❑ Irritability
- ❑ Anger
- ❑ Lack of Motivation
- ❑ Hallucinations
- ❑ Suicidal Thoughts
- ❑ Suicide Attempt
- ❑ Suicidal Intent
- ❑ Tremor
- ❑ Seizures
- ❑ Feeling Shaky
- ❑ Hyperactive
- ❑ Distractible
- ❑ Balance Problems
- ❑ Dizzy or Fainting
- ❑ Emotionally Numb
- ❑ Concentration poor
- ❑ Memory problem
- ❑ Trouble thinking
- ❑ Indecisive
- ❑ Confusion
- ❑ Learning disability
- ❑ Agitation
- ❑ Speech problems
- ❑ Taste
- ❑ Smell, diminished
- ❑ Vision, blurry
- ❑ Vision, double
- ❑ Hearing loss
- ❑ Ears ringing
- ❑ Poor temperature regulation
- ❑ Headache, tension
- ❑ Headache, migraine
- ❑ Numbness, Physical

Urinary System

- ❑ Frequent urination
- ❑ Burning on urination
- ❑ Hesitation to start urination
- ❑ Obstruction to urine flow
- ❑ Loss of urine with coughing or straining
- ❑ 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

- ❑ 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

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

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)_____