

Application For Admission
Thyroid Qualification Case History

If you are reading this you have been fortunate enough to qualify for a **consultation** at no charge.
This however does NOT mean that your case has been accepted.

Your consultation today will determine if

A) You are a legitimate candidate for diagnostics and treatment and B) Your condition is serious enough to warrant your case being accepted for treatment. In the event your condition IS serious enough to warrant being considered for acceptance and the doctor is UNAVAILABLE to treat you, your case will be referred to another clinic.

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No
Employer _____ Occupation _____
Length of Employment _____ SS# _____
Marital Status S M W D Spouses Name _____

I (signature) _____ consent to allow the doctor to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for treatment and also to determine if he is willing to accept my case. It is also my understanding that BOTH the consultation AND examination (if necessary) are at no charge. Should I be accepted as a patient I will be made aware of all fees.

How Did You Hear About us? _____

1. How Serious Do You Think Your Problem Is?

What Is Your Main Problem(s)/Symptom(s) Prompting Your Request For A Consultation With The Doctor?

Would You Consider This Problem(circle one)... MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and in your own opinion what do you think the real problem is?

2. What are you hoping happens today as a result of your consultation with the Doctor?

3. When was the first time you remember having symptoms that could be related to a low thyroid condition, please describe?

4. Please list all the symptoms of low thyroid you currently have.

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

5. Are you currently taking thyroid hormones or have you taken thyroid hormones in the past?

Yes or No (Please Circle the appropriate answer)

6. Please list the symptoms of low thyroid that persisted after the prescription of thyroid hormones.

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

7. Have you always thought you had a thyroid problem, but never have had a confirmation via diagnosis from a doctor?

Yes or No (Please circle the appropriate response)

8. Please list all prescription medications, over the counter drugs, and supplements (vitamins) you are currently taking.

- 1.
- 2.
- 3.
- 4.
- 5.

9. Since your thyroid issues began what three things has it caused you to miss the most?

- 1.
- 2.
- 3.

10. Have you ever been tested for an auto-immune thyroid condition? (Hashimoto's Thyroiditis)

Yes or No (please circle the appropriate response)

11. Have you ever been diagnosed as having an auto-immune thyroid?

Yes or No (Please circle the appropriate response)

12. Is there anything you have done on your own, outside of medical advice that improved your condition?

13. If you cannot find a solution to your health problems what do you think will happen to you?

14. What are you hoping the doctor tells you today?

15. Describe what you hope or think he might be able to do for you.

16. Describe what will be different in your life if you can finally be relieved of these problems.

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.

- 1. _____ How Long Have You Had This? _____
- 2. _____ How Long Have You Had This? _____
- 3. _____ How Long Have You Had This? _____
- 4. _____ How Long Have You Had This? _____

Due to Your Main Problem.....

Have You Lost Any Time From Work? Yes No
How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Chores/Tasks At Home? Yes No
How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Family? Yes No
How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc...) Yes No
How Much Time and What Tasks Have Been Limited?

Please list your health goals in order of importance.

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

On a Scale of 0-10 (10 being the most motivation possible, 0 being No Motivation at all) Please rate your motivation to achieve the above health goals by circling the appropriate number below.

0 1 2 3 4 5 6 7 8 9 10

List ANY surgeries that you have had and the corresponding dates.

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

Have you had ANY of the following in the last 12 months or currently?
(Mark C for Current; X for in last 12 mos.)

GENERAL

Chills ___ Convulsions ___ Dizziness ___ Fainting ___ Fatigue ___ Fever ___ Headache ___
Loss of Sleep ___ Allergy ___ (to what _____) Loss of Weight ___ Nervousness ___
Wheezing ___ Bronchitis ___
Numbness in BOTH hands AND feet ___

CARDIOVASCULAR

High Blood Pressure ___ Low Blood Pressure ___ Pain over heart ___ Poor Circulation ___ Rapid
Heartbeat ___ Previous Heart Problem ___ (Describe _____) Slow Heartbeat
___ Stroke ___ TIA ___ Swollen Ankles ___ Varicose Veins ___ Aortic Aneurysm ___ Bruise
Easily ___

DISEASES/CONDITIONS

Appendicitis ___ Anemia ___ Arthritis ___ Alcoholism ___ Abdominal Surgery ___ Bleeding
Disorder ___ Blood Clot(s) ___ Breathing Difficulty ___ Cancer ___ Cholesterol High ___ Colon
Problems ___ Diabetes ___ Depression ___ Epilepsy ___ Eczema ___ Eating Disorder ___
Glaucoma ___ HIV + ___ Heart Disease ___ Hernia ___ Headaches ___ Influenza ___ Kidney
Disease ___ Liver Disease ___ Low back Pain ___ Mental Illness ___ Measles ___ Mumps ___
Pleurisy ___ Pneumonia ___ Polio ___ Prostate Problems ___ Hyperthyroid ___ Hypothyroid ___
Rectal Surgery ___

EARS/EYES/NOSE/THROAT

Asthma ___ Crossed Eyes ___ Double Vision ___ Blurred Vision ___ Difficulty Swallowing
___ Deafness ___ Hearing Loss ___ Ear Pain ___ Thyroid Problem ___ Nose Bleeds ___ Sinus
Problems ___ Sore Throats ___

GASTRO-INTESTINAL

Gas ___ Colon Trouble ___ Constipation ___ Diarrhea ___ Gallbladder Trouble ___ Hemorrhoids
___ Liver Trouble ___ Nausea ___ Stomach Ache ___ Poor Appetite ___ Poor Digestion ___
Vomiting ___ Vomiting Blood ___ Rectal Bleeding ___ Bloating ___

GENITO-URINARY

Blood in Urine ___ Frequent Urination ___ Inability to control urine ___ Kidney Infection ___ Painful
Urination ___ Prostate Trouble ___ Painful Urination ___

FOR MEN ONLY

Lump in testicles ___ Penis discharge ___

FOR WOMEN ONLY

Menstrual Cramps ___ Excessive menstrual flow ___ Hot Flashes ___ Irregular Cycle ___ Painful
periods ___ Birth Control Pills ___ Abnormal Pap Smear ___

MUSCLE/JOINT/BONE

Backache ___ Foot Trouble ___ Pain Between Shoulders ___ Painful Tailbone ___ Stiff Neck
___ Spinal Curvature ___ Swollen Joints ___

NEUROLOGIC

Seizures ___ Dizziness ___ Hand Trembling ___ Weakness ___ Difficulty with speech ___ Loss of
memory ___ Loss of coordination ___

RESPIRATORY

Chest Pain ___ Chronic Cough ___ Difficulty Breathing ___ Coughing/Spitting Blood ___