Dear NutriMedical Report Show Listener and Wellness Individual,

Please complete this intake health and wellness form to assist in providing the best Integrative Functional Medical help and teaching to help you become Dr You. You may find the NutriMedica.com Wellness Conditions and "Dr You" book helpful in selection of the right pathways for optimized wellness and restoration of your health.

Complete Wellness Consults with Health and Wellness Reviews :

1. Fill out the enclosed history form and send by word file attached to email with scanned labs, x-rays, CT, PET, EEG, to drbilldeagle@hotmail.com .
2. Dr Bill will review your history and provide starter protocols and integrate this with a phone consult. Fee for complete consults is $150 per 30 minutes for record review, phone consults and report time.

I will maintain HIPPA privacy of your records and directly consult with you and integrate with QRMA, 8D LRIS, Functional Medical and Conventional Labs, Advanced Imaging and Special Consult Recommendations for Medical, Surgical and Alternative Medical Interventions.

1. Have a copy of all recent physicals that you have had within the last 12 months and all physician consultations you have had in the last 12 years sent to you. Family History, Military Service and Special Past Medical History is important.
   Please do not send faxes, as they often are not readable.
2. Obtain copies of your lab tests, x-rays (written report, and scanned images X-Ray, CT..) and allergy and/or physicians' summary reports that been done in the last 12 years; this includes all physician consultations. **We do not accept faxes of these.**
3. Records that we receive from other physicians become our records, and we are not responsible for making copies of them in the future or returning them. Therefore, we suggest that you have all your records sent to you, make copies for your personal file, and send a copy to us along with your completed history form. In that way, you will be aware of your medical care, have a back up from which to make copies in the future, and know that we have received a copy of your records.

The purpose of the Health and Optimized Wellness Consult is to present advanced Integrative Diagnostics and Natural Pathways to Optimizing your health and restoring the ability to heal. Dr Bill will not recommend drug therapies but will instruct when information of some meds may cause harm or a natural NutriMed nutraceuticals will be more efficacious.

Integrative Functional Quantum Medicine discussed on the NutriMedical Report Shows, Dr You Book and Wellness Conditions on NutriMedical.com with your personal consult will help you make more valid health and preventive choices, truly informed with the most advanced technologies and natural solutions to your optimized wellness and health challenges.
Please send a current photograph of yourself (one with your spouse included is even better).

Sincerely,

Dr Bill Deagle MD AAEM ACAM A4M

Please enclose a current photograph

Dr Bill Deagle MD AAEM ACAM A4M

Diplomate American Board of Family Medicine ret.
Board Certified Canadian College Family Medicine ret.
American Academy of Environmental Medicine
American College for Advancement in Medicine
American Academy of AntiAging Medicine

Health and Wellness Intake Form

Referred by: _____ Date: _____

How did you hear about Dr. Bill ? _____

Name: _____ Social Security #: _____

Address:_____ How Long? _____

Phone Number: ( ) _____ Married: _____ Widowed: _____ Single: _____ Divorced: _____

Sex_____ Age_____ Date of Birth_____ Number of Children: _____

Occupation: _____ For _____ Years Employer: _____

Business Phone: ( ) _____ Previous Employment: _____

Hobbies: _____

Spouse's Name: _____ Age: _____ Health Problems: _____

Occupation: _____ For _____ Years

Employer: _____ Business Phone: ( ) _____

Hobbies: _____

Other Household Members:

Name	Age	Occupation	Hobbies

Household Pets: _____ Age: _____

In order of decreasing severity, list your symptoms starting with the worst one.

Symptoms	How Often?	How Many Years?

Symptoms that bother you	How many years?	All year? Yes or No	Every day? Yes or No	Worse outdoors? Yes or No	What else makes it worse?	Comments
Headache						
Nasal congestion						
Post nasal drip						
Earaches						
Plugged ears						
Dizziness						
Sinusitis						
Canker sores						
Constant colds						
Nasal sores						
Migraines						
Epilepsy						
Faints						
Tongue/lip swelling						
Sore throats						
Itching roof of mouth						
Hoarse voice						
Swollen throat						
Cough						
Bronchitis						
Pneumonia						
Asthma						
Wheezing						
Short of breath						
Tight chest						
Chest pain						
Acne/rosacea						
Hives						
Eczema						
Poor circulation						
Rash						
Leg ulcers						
Dermatitis						
Rectal pain						
Spastic colon						
Vomiting						
Indigestion						
Cramps						
Gas-bloating						
Abdominal pain						
Diarrhea/blood/mucus						
Fluid retention						
Contact dermatitis						
Drug reactions						
Insect sting reaction						

Symptoms that bother you	How many years?	All year? Yes or No	Every day? Yes or No	Worse outdoors? Yes or No	What else makes it worse?	Comments
Nasal polyps						
Constipation						
Arthritis/joint pain						
Leg aches						
Muscle pain						
Weakness						
Numbness/tingling						
Palpitations						
Flushing						
Chilling						
Racing heart/irregular						
Unwarranted fatigue						
Sweating spells						
Exhaustion						
Depression						
Premenstrual tension						
Vaginitis						
Hyperactivity/ADD						
Compulsive eating						
Brain fog						
Lapses of memory						
Burning eyes						
Learning disability						
Swelling eyes						
Confusion						
Tearing eyes						
Irritability						
Insomnia						
Dry eyes						
Dry mouth						
Hearing loss						
Loss of smell						
Loss of coordination						
Frequent urination						
Burning urination						
Balance problem						
Nausea						
Fingers/toes turn color						
Phlebitis						
Hallucinations						
Mood swings						
Inappropriate behavior						
Inability to sweat						
Other						

List all doctors seen for your problems in the last 12 years. Add a separate sheet if needed.

	Doctor's name and specialty	Year examined	Tests done	Medicine or treatment prescribed	Diagnosis	Did it help?
1						
2						
3						
4						
5						
6						

List your primary care physician: _____

Has everything been done that can be to rule out correctable causes? _____

What is missing? _____

Have you been told there is nothing more that can be done? _____

Have you been told you do not need tests that you think you do? Specify_____

When were you last well? _____

What moves, exposures, accidents, surgeries, dental work, infections, emotional stress, change of job, poor diet, antibiotics, new furnishings may have contributed?

_____
_____
_____
_____

Please give a history of when and how your symptoms began, and then how they progressed (feel free to add extra sheets).

_____
_____
_____
_____
_____

Have you ever had tests to measure your (circle):

Immunology Tests RBC minerals Toxins RBC/WBC Fatty acids Organic Acids Pathogens
Heavy Metals - Lead, Mercury + Stool Analysis Detox Capacity & 23andMe Other: _____

Surgeries and your age at the time:

_____
_____
_____
_____
_____

Any other hospitalizations? (circle)

Pregnancies Heart Attack Stroke Pneumonia Phlebitis Concussion
Auto Accident Other _____
Diagnostic work-up for: _____
Any drug intolerances or allergies to medicine? _____

Do you take medicine for the following (list name and number of years you've been on it):

Headache _____ Stomach _____
Prostate _____ Sinus _____
Constipation _____ Infection _____
Asthma _____ Nerves _____
Heart _____ High blood pressure _____
Contraception _____ Depression _____
Eyes _____ Fluid retention _____
Gout _____ Acne _____
Pain _____ Other _____

Serious illnesses (circle):

Hepatitis Mono Rheumatic Fever Lyme's Disease Former trauma Accidents
Other: _____
Long periods (1 month or longer) of antibiotics? Yes / No For what? _____
_____
What ages? _____

Did any of your relatives ever have:

_____ Hay fever	_____ Chronic Sinusitis	_____ Migraines
_____ Eczema	_____ Asthma	_____ Colitis
_____ Thyroid	_____ Chronic depression	_____ Allergy to medicines
_____ Schizophrenia	_____ Learning disability	_____ Allergy to bee stings
_____ Criminal actions	_____ Undiagnosed illness	_____ Bizarre behavior
_____ Hypochondriasis	_____ Cancer	_____ Heart disease
_____ Alcoholism	_____ Auto-immune disease	_____ Other

Previous symptoms (that no longer bother you) as infant or child:

_____ Colic	_____ Croup	_____ Repeated ear/throat infections
_____ Formula intolerances	_____ Eczema	_____ Wheezing
_____ Bronchitis	_____ Diarrhea	_____ Other

List vitamins you take by company, vitamin name, dose, number per day (add sheets if need):

_____

_____

_____

_____

_____

_____

Within two years of the onset of your symptoms, did you do any of the following:

Change Jobs?	Yes _____	No _____	Never _____
Renovate your office or home?	Yes _____	No _____	Never _____
Move to a new office or home?	Yes _____	No _____	Never _____
Panel any rooms?	Yes _____	No _____	Never _____
Insulate any rooms?	Yes _____	No _____	Never _____
Carpet any rooms?	Yes _____	No _____	Never _____
Buy new furniture or bed?	Yes _____	No _____	Never _____
Install drop ceilings?	Yes _____	No _____	Never _____
Paint indoors?	Yes _____	No _____	Never _____
Side the house?	Yes _____	No _____	Never _____
Change your heating system?	Yes _____	No _____	Never _____
Change your stove, clothes dryer, or water heater?	Yes _____	No _____	Never _____
Used antibiotics?	Yes _____	No _____	Never _____
Used pesticide indoors or out?	Yes _____	No _____	Never _____
Have dental work done (fillings, root canals, etc)?	Yes _____	No _____	Never _____
Have emotional distress?	Yes _____	No _____	Never _____
Do you have any gas utilities?	Yes _____	No _____	Never _____
Do you use alcohol?	Yes _____	No _____	Never _____
Do you use cigarettes?	Yes _____	No _____	Never _____
Do you drink coffee?	Yes _____	No _____	Never _____
Do you drink tea?	Yes _____	No _____	Never _____
Do you drink soft drinks?	Yes _____	No _____	Never _____
Do you pesticide your lawn or household plants?	Yes _____	No _____	Never _____
Do you wear many dry-cleaned clothes?	Yes _____	No _____	Never _____
Do you wear many polyester clothes?	Yes _____	No _____	Never _____
Have you ever worked in a new office?	Yes _____	No _____	Never _____
Have you ever lived in a pesticided home?	Yes _____	No _____	Never _____
Have you ever lived in a urea foam formaldehyde insulated (UFFI) home?	Yes _____	No _____	Never _____
Have you ever lived in a brand new home?	Yes _____	No _____	Never _____

If your symptoms have been present all your life or less, what worsens or provokes new symptoms?
_____
_____
_____

Give brand names (if able) for any of the following that you use:

Blush _____
Foundation_____
Lipstick _____
Mascara_____
Hair conditioner _____
Shampoo _____
Hairspray _____
After shave _____
Deodorant _____
Fabric softener _____
Soap _____
Other toiletries _____

House:
Is your home located near any factories, industry, grain elevators, farms, golf courses, incinerators, or heavy traffic? (circle) Yes No
If so, please indicate which ones: _____
Do you heat with (circle): Gas Oil Electric Wood Kerosene Space heaters Other_____
Heat conducted by (circle): Water pipes Radiator Gravity Forced air
Type of furnace filter _____
Type of humidifier _____
Type of air cleaner _____
Type of insulation _____

Bedroom:
What floor is it located on? _____ Number of beds? _____ Number of people? _____
Type and age of pillows used _____
Type and age of mattress _____
Type and age of rug and pad _____
Type and age of furniture _____
Type and age of drapes _____
Are there books or knick-knacks? _____
What else is in there? _____
_____
_____

Living or family room:
Located on what floor? _____
Type of rug and pad? _____Age_____
What type of furniture _____
Fireplace _____ Space heater _____ Wood stove _____ Is the room damp? _____

Basement:
Finished? _____
Type of floor? _____
Damp? _____
What symptoms do you get when there? _____
Time spent there? _____
Are your symptoms there better or worse? _____
Do you do laundry there? _____

What smokers are in the household? _____
What hobbies or projects are in the household? _____
What month of the year are your symptoms worse? _____
What day of the week are your symptoms worse? _____
Where is firewood stored? _____
Where is camping, fishing, hunting equipment stored? _____
Any place in your home where symptoms seem to be worse? _____
Are symptoms worse at home or work? _____
What type of environment do you have at work? _____

Dental history (indicate approximate age when procedure was done):
Number of silver fillings _____ Age (s) _____Number of root canals _____Age (s) _____
Number of crowns/veneers _____ Age (s) _____Number of implants _____ Age (s)_____
Number of removed teeth _____ Age (s) _____

At any time in your life were you exposed to:

Aerial spraying of pesticides?	Yes _____	No _____	Years_____
Street spraying or fogging of pesticides?	Yes _____	No _____	Years_____
Pesticides at work?	Yes _____	No _____	Years_____
Pesticides in your home?	Yes _____	No _____	Years_____

How many antibiotic courses (average 5-10 days) have you had in your life? _____
Any episodes where you had antibiotics longer than a month or by intravenous route? _____
Have you ever had worsening of symptoms after a root canal? _____
Have you ever had a tooth extraction? _____
How old were you for your first mercury filling? _____
How many meals a week do you eat out of the house? _____
What do you suspect is the cause of your symptoms? _____
_____
_____
How do your symptoms affect the rest of the family? _____
_____
_____
When was your last complete medical examination? Please include copy of it. _____
What was the conclusion – diagnosis? _____
_____
_____

What was the recommendation? _____

_____

What drugs were prescribed if any? _____

_____

_____

Do you have unresolved anger? _____

What fears plague you the most? _____

_____

_____

What ages did you smoke? _____

How often do you have alcohol? _____

Have you ever used recreational drugs?_____

Give 3 average (for you) breakfasts (include beverages for all meals and snacks below):

1)_____

2)_____

3)_____

Give 3 average (for you) mid-morning snacks:

1)_____

2)_____

3)_____

Give 3 average (for you) lunches:

1)_____

2)_____

3)_____

Give 3 average (for you) mid-afternoon snacks:

1)_____

2)_____

3)_____

Give 3 average (for you) dinners:

1)_____

2)_____

3)_____

Give 3 average (for you) bedtime snacks:

1)_____

2)_____

3)_____

What books have you read regarding health? _____

_____

_____

_____

Which health newsletters do you read? _____

_____

_____

_____

Please list major family issues, legal, financial, marital, job or other problems of past or current. _____

_____

_____

_____

_____

_____

What do you suspect is the major cause of your symptoms? _____

_____

_____

_____

What questions do you want to deal with? _____

_____

_____

_____

_____

_____

Additional comments/questions/expectations: