

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

*Dr Bill Deagle MD AAEM ACAM AAM*

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

**Please  
enclose a  
current  
photograph**

## **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:

<u>Name</u>	<u>Age</u>	<u>Occupation</u>	<u>Hobbies</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Household Pets: \_\_\_\_\_ Age: \_\_\_\_\_

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

<u>Symptoms</u>	<u>How Often?</u>	<u>How Many Years?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<b>Symptoms that bother you</b>	<b>How many years?</b>	<b>All year? Yes or No</b>	<b>Every day? Yes or No</b>	<b>Worse outdoors? Yes or No</b>	<b>What else makes it worse?</b>	<b>Comments</b>
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.

	<b>Doctor's name and specialty</b>	<b>Year examined</b>	<b>Tests done</b>	<b>Medicine or treatment prescribed</b>	<b>Diagnosis</b>	<b>Did it help?</b>
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?

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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:

<input type="checkbox"/> Hay fever	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Eczema	<input type="checkbox"/> Asthma	<input type="checkbox"/> Colitis
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Chronic depression	<input type="checkbox"/> Allergy to medicines
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Allergy to bee stings
<input type="checkbox"/> Criminal actions	<input type="checkbox"/> Undiagnosed illness	<input type="checkbox"/> Bizarre behavior
<input type="checkbox"/> Hypochondriasis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Auto-immune disease	<input type="checkbox"/> Other

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

<input type="checkbox"/> Colic	<input type="checkbox"/> Croup	<input type="checkbox"/> Repeated ear/throat infections
<input type="checkbox"/> Formula intolerances	<input type="checkbox"/> Eczema	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Other

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

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

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

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

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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Which health newsletters do you read? \_\_\_\_\_

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

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

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What questions do you want to deal with? \_\_\_\_\_

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Additional comments/questions/expectations: