The Customized Metabolic Assessment

Patient Intake Form

Patient Name:
Address:
Birthdate:

1. What vitamins/supplements are you currently taking? (Please include dosage/frequency)

2. What medications are you currently taking? (Please include dosage/frequency)

3. Are your medications well tolerated? Yes/No
   If not, please explain

4. Are you hypersensitive or allergic to any medications? Yes/No
   If yes, please explain

5. Do you have a medical condition that is currently being treated by another doctor? Yes/No
   If yes, please tell us a little bit about your condition and treatment:

6. Are you hypersensitive or allergic to any foods? Yes/No
   If yes, please explain

7. Are you hypersensitive or allergic to any environmental substances? Yes/No
   If yes, please explain

8. Are you hypersensitive or allergic to any fragrances/chemicals/cleaning products? Yes/No
   If yes, please explain

9. Have you ever had silver amalgam fillings in your mouth? Yes/No
   If yes, did you have them removed by a biological dentist? Yes/No

10. Have you ever chelated heavy metals? Yes/No
    If yes, what was your protocol & for how long?

11. Do you have a family history of male pattern baldness or hair loss? Yes/No

12. In the last ten years, approximately how many courses of antibiotics have you taken?

13. What vaccines have you received?

14. Have you reacted to a vaccine in the past? Yes/No
    If yes, please explain

15. Are you pregnant or nursing? Yes/No

16. Do you currently have or have you in the past been diagnosed with any form of cancer? Yes/No
    If yes, please explain

17. Do you have any allergies that result is severe anaphylaxis? Yes/No
    If yes, please explain