Nemechek Autonomic Medicine

Patient Information and History

Please fill out and fax to 866-480-0357 or email to Dr@autonomicmed.com prior to visit.

Name: _____ E-Mail: _____

Address, City, Zip: _____

Preferred Phone: _____ Date of Birth: _____ Gender: Male Female

Emergency Contact: Name_____ Number: _____

What are your most important health issues? _____

_____

_____

Please mark an X by any condition or diagnosis you may have or had in the past. Please provide the name of the condition as you understand it:

____ Heart Problems, _____
____ High Blood Pressure, _____
____ High Cholesterol, _____
____ Diabetes, _____
____ Stroke, _____
____ Lung Disease, _____
____ Asthma, _____
____ Heart Burn, _____
____ Low Blood Sugar, _____
____ Sleep Apnea, _____
____ Stomach Disease, _____
____ Diarrhea, _____
____ Constipation, _____
____ Liver Disease, _____
____ Kidney Disease, _____
____ Urination Problems, _____
____ Prostate Disease, _____
____ Eczema, Psoriasis, _____
____ Joint Replacement, _____
____ Spine Disorder, _____

____ Muscle Disease, _____
____ Seizure, _____
____ Frequent Headaches, _____
____ Poor Appetite, _____
____ Obesity, _____
____ Weight Loss Surgery, _____
____ Neck/Shoulder Pain , _____
____ Nerve Pain/Numbness, _____
____ Anemia/Blood Disorder, _____
____ Depression or Anxiety, _____
____ Thyroid Disease, _____
____ Cancer (past/present) , _____
____ Blood Clots, _____
____ Bleeding tendency, _____
____ Neurological Condition, _____
____ Concussion, Brain Injury, _____
____ Arthritis, _____
____ Other: _____
____ Other: _____
____ Other: _____

Common Symptom List

The following symptoms indicate altered functioning of your autonomic nervous system. The autonomic system is responsible for all organ function, blood pressure regulation, control of the immune system, production of hormone and emotions, and hunger regulation. Answering "yes" implies your brain is having difficulty regulating your body's function.

In addition, antibiotics and physical/emotional trauma can alter the balance of your intestinal bacteria. Altered intestinal bacteria are known to trigger many of these symptoms both intestinal (diarrhea, constipation, heartburn, bloating) as well as others (anxiousness/anxiety, insomnia, headaches, fatigue, arthritis, skin rashes, eczema, and autoimmune disorders). Getting to the bottom of these symptoms and fixing the underlying problem is key to disease reversal and prevention.

Circle "Yes" if you sometimes or frequently experience (without taking prescriptions or OTC medications):

Need to eat or snack all day long? – Yes
Feel better eating "Gluten Free"? – Yes
Feel better on probiotics/prebiotics? –Yes
Excessive bloating after meals? - Yes
Urge to defecate right after meals? - Yes
Are you intolerant to certain foods? - Yes
Abdominal cramping in the day? - Yes
Periods of frequent or loose stool? - Yes
Constipation? – Yes
Heartburn after certain foods? – Yes
Suffer from depression? – Yes
(Women) suffer from PMS? – Yes
(Women) suffer from cramps? – Yes
Have alopecia (round patches of hair loss) - Yes
Skin problems like eczema or rosacea? – Yes
Sour, acidy stomach if you miss meals? – Yes
Have recurrent strep throat? – Yes
Your labs are "fine" but you feel "off"? – Yes
Have a "maximum weight" that you never go over, no matter how much you eat? - Yes
Suffer from anxiety? – Yes
Have trouble sleeping? - Yes
Very sleepy shortly after dinner? – Yes
Heartburn or reflux after meals? - Yes
Get "low blood sugar" between meals? - Yes
You burp up food/fish oil/vitamin tastes? – Yes
Feel sleepy after a large meal? – Yes
Trouble seeing at night? – Yes
Lightheaded when getting out of bed? - Yes
Feel tingling sensations in neck or face? – Yes
Feel like you'll pass out when you get hot? - Yes
Crave salt or sugar during the day? – Yes
Frequent headaches or migraines? – Yes
Get unusually sleepy/anxious in the car? – Yes
Tightness or pain in your neck muscles? – Yes
Feel tingling or numbness in your hands? - Yes
You have "passed out" (not drunk either)? - Yes
Feel dizzy at times? – Yes
Must exercise to think clearly? - Yes
Have ADD/ADHD? – Yes
Family members with Autism? – Yes
Poor concentration or memory in the day? - Yes
Excessive fatigue or tiredness in the day? – Yes
Have trouble "waking up" in the AM? - Yes
Need to drink water/soda all day long? - Yes
You fidget/move around, hard to sit still? – Yes
Anxious/sleepy if you sit still very long? - Yes
Always hungry – Yes?
Can't quit drinking soda or energy drinks? - Yes
Get hungry an hour or 2 after a full meal? – Yes
Feel anxious without reason? – Yes
Sudden urge to urinate without warning? – Yes
Urinate more than once at night? - Yes
Nausea in the morning? - Yes

The physical stress of surgery, the effects of anesthesia, unintended complications and associated medications can all be triggering events for a sequence of symptoms arising over the following years.

Major Surgeries or Procedures (colonoscopies, dental, heart testing, biopsies, appendectomy, etc.):

Approximate Date: _____ Surgery/Procedure: _____

Approximate Date: _____ Surgery/Procedure: _____

Approximate Date: _____ Surgery/Procedure: _____

Approximate Date: _____ Surgery/Procedure: _____

Approximate Date: _____ Surgery/Procedure: _____

Approximate Date: _____ Surgery/Procedure: _____

Approximate Date: _____ Surgery/Procedure: _____

Physical head trauma and emotionally traumatic experiences can disrupt normal autonomic neurological functioning and may have triggered some of your symptoms or medical conditions. Please think about the next 2 sections and answer them as best as you can. All answers are strictly confidential.

Any Significant Physical Trauma to the Head (car wrecks, knocked unconscious, sports injuries, etc.):

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Dates of Any Emotionally Traumatic Experiences (relationship/financial strain, bullying, rape, molestation, death of a loved one, a fearful or near-death event):

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Approximate Year: _____ Event: _____

Antibiotics can have the unintended consequence of damaging or altering the balance of your intestinal bacterial. Altered intestinal bacteria are known to trigger many symptoms both intestinal (diarrhea, constipation, heartburn, bloating etc.) as well as other symptoms (arthritis, anxiousness, insomnia, headaches, fatigue, bladder irritability, rashes and autoimmune disorders).

Have You Ever Received Prolonged Courses of Antibiotics? If so, please list when what for.

Approximate Date: _____ Reason for Antibiotics: _____

Approximate Date: _____ Reason for Antibiotics: _____

Approximate Date: _____ Reason for Antibiotics: _____

Approximate Date: _____ Reason for Antibiotics: _____

Approximate Date: _____ Reason for Antibiotics: _____

We inherit our blend of intestinal bacteria from our mothers at the time of birth. Our intestinal bacteria are now understood to be an additional cause of some relatively common symptoms. Understanding if other family members have similar symptoms is a source of valuable information about the potential causes of your symptoms.

Please Indicate if Your Mother, Children or Any Siblings Have Any of the Following:

Have heartburn or takes medicine for heartburn? – Yes Relation:_____
Have problems with "low blood sugar"? – Yes Relation:_____
Suffer from anxiety? – Yes Relation:_____
Frequent the bathroom after meals? – Yes Relation:_____
Are intolerant to certain foods? – Yes Relation:_____
Have trouble with constipation? – Yes Relation:_____
Have trouble with diarrhea? – Yes Relation:_____
Have frequent urination? – Yes Relation:_____
Feel lightheaded when standing? – Yes Relation:_____
Suffer from chronic fatigue? – Yes Relation:_____
Have frequent headaches? – Yes Relation:_____
Crave salt or sugar? – Yes Relation:_____
Seem sleepy after bigger meals? – Yes Relation:_____
Have they ever "passed out" ? – Yes Relation:_____
Been diagnosed with ADD or ADHD ? – Yes Relation:_____
Been diagnosed with Autism or Asperger's Syndrome? – Yes Relation:_____
Anyone who feels better after eliminating gluten? – Yes Relation:_____
Struggle with Obesity ? – Yes Relation:_____
Experience Eczema or Psoriasis ? – Yes Relation:_____

Please List Your Current Medications, with Name, Dose and Frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please List Supplements (vitamins, herbs, fish oil, etc.) You Take:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please List your Allergies to Medications:

_____ Check here if none.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Personal Habits:

Do you drink caffeinated beverages (coffee, tea, soda)? Y or N, Do you drink alcoholic beverages? Y or N

Do you smoke or chew tobacco? Y or N, If no, prior tobacco use? Y or N When _____

Presently experience repetitive second-hand smoke exposure? Y or N

Use of recreational drugs? Y or N, Past or present? Names _____

Do you exercise regularly? Y or N , If so, how many times per week? Y or N

Work night or graveyard shifts? Y or N

Following is only for female patients only:

Dates and Info Regarding of Childbirth:

Date: _____ Vaginal or C-Section (circle one) Child Spent Time in ICU? Yes or No (circle one)

Date: _____ Vaginal or C-Section (circle one) Child Spent Time in ICU? Yes or No (circle one)

Date: _____ Vaginal or C-Section (circle one) Child Spent Time in ICU? Yes or No (circle one)

Date: _____ Vaginal or C-Section (circle one) Child Spent Time in ICU? Yes or No (circle one)

Date: _____ Vaginal or C-Section (circle one) Child Spent Time in ICU? Yes or No (circle one)

Date: _____ Vaginal or C-Section (circle one) Child Spent Time in ICU? Yes or No (circle one)

Family History:

Please mark an X by any condition that any first degree relative (Mom, Dad, brothers/sister or children) has been diagnosed with in the past. Please indicate which family member has of each of these specific conditions:

____ Heart Problems, _____
____ High Blood Pressure, _____
____ High Cholesterol, _____
____ Diabetes, _____
____ Stroke, _____
____ Lung Disease, _____
____ Asthma, _____
____ Heart Burn, _____
____ Low Blood Sugar, _____
____ Sleep Apnea, _____
____ Stomach Disease, _____
____ Diarrhea, _____
____ Constipation, _____
____ Liver Disease, _____
____ Kidney Disease, _____
____ Urination Problems, _____
____ Prostate Disease, _____
____ Eczema, Psoriasis, _____
____ Joint Replacement, _____
____ Spine Disorder, _____

____ Muscle Disease, _____
____ Seizure, _____
____ Frequent Headaches, _____
____ Poor Appetite, _____
____ Obesity, _____
____ Weight Loss Surgery, _____
____ Neck/Shoulder Pain , _____
____ Nerve Pain/Numbness, _____
____ Anemia/Blood Disorder, _____
____ Depression or Anxiety, _____
____ Thyroid Disease, _____
____ Cancer (past/present) , _____
____ Blood Clots, _____
____ Bleeding tendency, _____
____ Neurological Condition, _____
____ Concussion, Brain Injury, _____
____ Arthritis, _____
____ Other: _____
____ Other: _____
____ Other: _____