



LOTUS HOLISTIC MEDICINE

Dr Sandeep Gupta MBBS FRACGP FACNEM
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Dear client,

Congratulations on making an important step towards long-term vibrant health. As you probably know, the emphasis in my practice is **on seeking the underlying causes of disease rather than focusing on symptom relief.**

This means going deeply into your diet, lifestyle and daily routine and assisting you to find the individualized health regime which will help to “switch off” the program which is driving many of your current health challenges.

This approach means that you will be able to take your health into your own hands, and learn how to stay well, track your progress and learn better to work in with your individual make-up.

In order to achieve the best possible outcome, we ask that you please have the following information available prior to the first appointment:

- Completed Charts and Checklists**
- Completed Health History Questionnaire**
- Completed Medical Consent Form**
- Completed Readiness Assessment**
- Copies of any pathology results you may have had over the last 2-3 years.**
This may mean calling some of the laboratories to request copies. You can try
 - i. Queensland Medical Laboratories (QML) on (07) 3121 4444
 - ii. Sullivan & Nicolaidis (S&N) on (07) 3377 8756
 - iii. Healthscope (previously Gribbles) on 1300 453 688
 - iv. Coastal Pathology on (07) 5456 4830
- Copies of recent medical records from your main treating practitioner, if at all possible**

These forms can be brought to your initial consultation or sent to us in advance for our review. The latter will allow us to have a familiarity with your health history before you arrive.

I look forward to being of service.

In good health,

Dr Sandeep Gupta

Health History Questionnaire

The information on this form is to help Dr Gupta to assess and treat your condition effectively. It is important that you take the time to fill this out completely to ensure the best outcome can be achieved. If you are unsure about any information you will be able to discuss it with your practitioner.

Date _____ Name _____

Address _____

Ph (H) _____ Ph (W) _____ DOB _____

Ph (M) _____ Email _____

Preferred method of contact _____

MAIN CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

What diagnoses or explanations have been given to you? _____

When was the last time you felt well? _____

What makes you feel **worse**? _____

What makes you feel **better**? _____

Please list other practitioners you have seen for the above health conditions:

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

Please check all the Complementary Medicine Treatments you have tried for your condition(s)

- | | | | |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Massage | <input type="checkbox"/> Yoga | <input type="checkbox"/> Environmental medicine |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Rolfing | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Nutritional Therapy |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Reiki | <input type="checkbox"/> Ayurveda | <input type="checkbox"/> Biological Dentistry |
| <input type="checkbox"/> Iridology | <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Light therapy | <input type="checkbox"/> IV (chelation) therapy |
| <input type="checkbox"/> Colonics | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Meditation | <input type="checkbox"/> Naturopathic medicine |
-

PAST ILLNESSES AND TESTS

Please place the date corresponding to when you started to suffer from any of the following conditions in the past.

ILLNESSES	Date	Date	Date	Comments
Chicken Pox		X	X	
German Measles		X	X	
Measles		X	X	
Mononucleosis		X	X	
Mumps		X	X	
Whooping cough		X	X	
Anaemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue Syndrome				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Glandular fever				
Pneumonia				
Rheumatic fever				
Sinusitis				
ILLNESSES	Date	Date	Date	Comments
Sleep apnoea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	Date	Date	Date	Comments
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				

DIAGNOSTIC STUDIES	Date	Date	Date	Comments
Chest X-ray				
Mammogram				
ECG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CT scan of Abdomen				
CT scan of brain				
CT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone Density Test				
Carotid Artery Ultrasound				
Blood Tests				
Other (describe)				
OPERATIONS	Date	Date	Date	Comments
Tonsillectomy		X	X	
Tubes in Ears				
Appendectomy		X	X	
Gall Bladder		X	X	
Hernia				
Hysterectomy		X	X	
Dental Surgery				
Other (describe)				

Have your medications or supplements ever caused you unusual side effects or problems?

Yes _____ No _____ If yes, please describe: _____

FAMILY HISTORY

Does anyone in your family or a near relative have any of the following? Indicate whether maternal or paternal side of the family and which relative, i.e. paternal, grandfather. Relationship (M=maternal P=paternal)									
	Yes	No	M	P		Yes	No	M	P
• allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• kidney difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• anemia or any blood diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• hereditary or congenital defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• colitis, ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• recurrent depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• abnormal fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• uncontrollable temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• diabetes/hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• thyroid deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• menstrual irregularities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REST AND RELAXATION

Do you take time to relax each day? <input type="checkbox"/>Y<input type="checkbox"/>N	
What is your present rest and relaxation pattern?	
Is it enough for you? <input type="checkbox"/>Y<input type="checkbox"/>N	
Is your life one of excess <input type="checkbox"/> or moderation<input type="checkbox"/>? Please explain:	
Do you modulate your time and energy so that you often find yourself: (check those that apply):	
Relaxed and refreshed <input type="checkbox"/> Y <input type="checkbox"/> N	Hurried <input type="checkbox"/> Y <input type="checkbox"/> N
Exhausted <input type="checkbox"/> Y <input type="checkbox"/> N	Irritable <input type="checkbox"/> Y <input type="checkbox"/> N
Centered <input type="checkbox"/> Y <input type="checkbox"/> N	Un-centered and scattered <input type="checkbox"/> Y <input type="checkbox"/> N
Bored <input type="checkbox"/> Y <input type="checkbox"/> N	Desperate <input type="checkbox"/> Y <input type="checkbox"/> N

NUTRITION

Have you made any changes in your eating habits because of your health? Yes_____ No_____

Do you currently follow a special diet or nutritional program? Yes_____ No_____

Check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Mixed food diet (animal and vegetable sources) | <input type="checkbox"/> Fat restriction | <input type="checkbox"/> Specific Program for Weight Loss/Maintenance
Type:_____ |
| <input type="checkbox"/> High protein | <input type="checkbox"/> Low starch/carbohydrate | _____ |
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> The Blood type Diet | _____ |
| <input type="checkbox"/> Vegan / raw food vegan | <input type="checkbox"/> Metabolic Typing Diet | _____ |
| <input type="checkbox"/> Gluten restricted | <input type="checkbox"/> The Zone Diet | _____ |
| <input type="checkbox"/> Low sodium | <input type="checkbox"/> Total calorie restriction | _____ |
| | <input type="checkbox"/> Diabetic | _____ |

Please check any specific food restrictions you have:

- | | |
|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Corn |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Wheat | <input type="checkbox"/> All gluten |

Anything else special about your diet?

LIFESTYLE

Have you ever smoked? If so, for how long? _____

In an average week, please detail how much and what type of the following you partake in:

Alcohol _____

Recreational drugs:_____

Exercise: _____

Relaxation or stress management? _____

Do you have any regular spiritual or religious practice? _____

If it feels appropriate for you, please tell us more about your practice: _____

How often often do you:

Walk barefoot on the earth:_____

Get away from the city and into nature: _____

Get direct sunlight for 30min/day: _____

Chew your food until it is like a liquid in your mouth: _____

Express gratitude for all you have: _____

Forgive significant people in your life: _____

Take time out to relax and turn the stress system off: _____

Go deeply into the silence within your own self: _____

WORK/HOME ENVIRONMENT

Is your home environment emotionally and spiritually uplifting ? _____

Is your work environment emotionally and spiritually uplifting ? _____

Are you regularly exposed to noise pollution, chemicals, polluted air or visual pollution?

MARKETING / FEEDBACK

How did you find out about Dr Gupta's practice?

Referral from other practitioner _____ (who?)

Website _____ (which one)

Friend/family _____

Magazine/newspaper _____ (which one)

Do you wish to receive a periodic email newsletter with recent information from the world of holistic health and clinic news (usually sent every 3-6 months). Email addresses are never sold or given away to third parties.

Yes

No

The information on this form is true and filled out in sincerity.

Signed _____ Date _____

Medical Consent Form

I, _____
(client's name)

of _____
(client's address)

understand that:

- I am seeking to consult Dr Sandeep Gupta in his capacity as a medical practitioner with a special interest in nutritional and environmental medicine.
- This means that he offers a longer consultation time, a more holistic approach to patient diagnosis and care – an approach primarily involving diet, supplementation, exercise, lifestyle and stress management.
- Dr Gupta charges a private fee for his consultations, which, in the majority of cases attract a Medicare rebate. In most cases he does not bulk bill. General fees are:
 - \$295 for a one-hour and fifteen minute consultation (usual initial consultation time)
 - \$180 for a forty minute consultation
 - \$125 for a thirty minute consultation (usual follow-up consultation time)
 - \$95 for a twenty minute consultation
 - A discount applies for health care card holders and pensioners
- The majority of diagnostic tests ordered by Dr Gupta do attract a Medicare rebate, however specific functional pathology tests may not attract a rebate.
- The costs of these tests will be discussed with me by Dr Gupta at the time of ordering.
- Dr Gupta may offer some of the recommended products for purchase from him directly. This may include a small profit margin. There is no obligation to purchase the products via this avenue, and they may be purchased from any local retailer.
- Some of the treatment suggestions (eg nutritional or digestive supplements) offered by Dr Gupta are considered to be outside the parameters of conventional medicine in Australia.
- These treatments fall under the category of complementary or alternative medicine.
- These interventions are in the majority of cases supported by research evidence, and are only prescribed with utmost care.

I am attending Dr Gupta's clinic of my own free will and consent and exercise my right to discuss and choose any useful and suitable treatment(s) made available to me.

Signed: _____

Date: / /

BASAL BODY TEMPERATURE

Date:										
37.3										
37.2										
37.1										
37.0										
36.9										
36.8										
36.7										
36.6										
36.5										
36.4										
36.3										
36.2										
36.1										
36.0										
35.9										
35.8										
35.7										
35.6										
35.5										
35.4										
35.3										
35.2										
35.1										
35.0										
34.9										
34.8										

- On waking, before getting up, place the thermometer under your armpit. It is important to make as little movement as possible. Lying and resting with your eyes closed is best.
- Wait until the thermometer beeps four times (up to 90 seconds), then remove it and record the temperature in the daily diary.
- Record the temperature for at least three mornings - preferably at the same time of day and always before getting out of bed.
- Women with a menstrual cycle must perform the test on the days between the second and ninth days after starting the period.

One Week Dietary History

Please complete a record of your meals for one week prior to your appointment

	Breakfast Time: _____	Lunch Time: _____	Dinner Time _____	Other Snacks Note Time
Sun				
Mon				
Tue				
Wed				
Thur				
Fri				
Sat				

Metal Toxicity Checklist

1) Have you had sore gums (gingivitis) often over the years?	O Y O N	
2) Have you had mental symptoms such as confusion or forgetfulness?	O Y O N	
3) Has severe depression been a problem?	O Y O N	
4) Has ringing in the ears (tinnitus) been present?	O Y O N	
5) Have TMJ (temporal mandibular joint) problems been a concern of yours?	O Y O N	
6) Have you had unusual shakiness (tremors) of your hands or arms or twitching of other muscles?	O Y O N	
7) Do you have "brown spots" or "age spots" under your eyes or elsewhere in the skin of your body?	O Y O N	
8) Have you tended to have more colds, flu, and other examples of infectious diseases than normal?	O Y O N	
9) Have you had food allergies or intolerances?	O Y O N	
10) Have you been to many doctors for your health problems and they have usually said, "There is nothing wrong"?	O Y O N	
11) Do you have numbness or burning sensations in your mouth or gums?	O Y O N	
12) Do you have numbness or unexplained tingling in your arms or legs?	O Y O N	
13) Have you developed difficulty in walking (ataxia) over the years?	O Y O N	
14) Do you have 10 or more "silver" fillings?	O Y O N	
15) Do you often have a "metallic" taste in your mouth?	O Y O N	
16) Have you ever worked as a painter or in manufacturing/chemical or pesticide/fungicide factories (fungicides with methyl mercury ingredients) or in pulp/paper mills that used mercury?	O Y O N	
17) Have you worked as a dentist, hygienist, or dental assistant?	O Y O N	
18) Have you ever had Candida-Related-Complex (CRC) or yeast infections (vagina, mouth or GI tract)?	O Y O N	
19) Do you have a lot of bad breath (halitosis) or white tongue (thrush)?	O Y O N	
20) Have you frequently had low basal body axillary temperature (below 97.4 degrees F.) over the years?	O Y O N	
21) Do you have problems with constipation?	O Y O N	
22) Do you have heart irregularities or rapid pulse (tachycardia)?	O Y O N	
23) Do you have unexplained arthritis in various joints?	O Y O N	
24) Is it common for you to have a lot of mucus in your stools?	O Y O N	
25) Do you have unidentified chest pains even after EKGs, X-ray, and heart studies are normal?	O Y O N	
26) Is your sleep poor or do you have frequent insomnia?	O Y O N	
27) Have you had frequent kidney infections or do you have significant kidney problems?	O Y O N	
28) Are you extremely fatigued much of the time and never seem to have enough energy?	O Y O N	
29) Do you have irritability or dramatic changes in behavior?	O Y O N	
30) Are you on antidepressants now or have you been in the past?	O Y O N	
TOTAL:	Y	N

Slow Oxidizer Profile

1.	Do you eat to live?	<input type="checkbox"/> Y <input type="checkbox"/> N
2.	Can you go a long time without eating?	<input type="checkbox"/> Y <input type="checkbox"/> N
3.	If you skip meals, is it easy for you to maintain energy and a sense of well being?	<input type="checkbox"/> Y <input type="checkbox"/> N
4.	Are you generally not concerned at all with eating?	<input type="checkbox"/> Y <input type="checkbox"/> N
5.	Do you have a minimal appetite for lunch?	<input type="checkbox"/> Y <input type="checkbox"/> N
6.	Do you have a minimal appetite for dinner?	<input type="checkbox"/> Y <input type="checkbox"/> N
7.	Do you love sweets and need something sweet with a meal to feel satisfied?	<input type="checkbox"/> Y <input type="checkbox"/> N
8.	Does eating before bedtime worsen sleep?	<input type="checkbox"/> Y <input type="checkbox"/> N
9.	Does eating fatty foods like lots of seeds or nut butters make you feel lethargic?	<input type="checkbox"/> Y <input type="checkbox"/> N
10.	Does eating a high protein meal drop your energy afterwards?	<input type="checkbox"/> Y <input type="checkbox"/> N
11.	Does eating sweets or fruits restore lasting energy and give you a sense of well being?	<input type="checkbox"/> Y <input type="checkbox"/> N
12.	Does apple or orange juice alone energize and satisfy you for a long time?	<input type="checkbox"/> Y <input type="checkbox"/> N
13.	Do high carbohydrate, low protein, low fat vegetarian meals (salads, fruits) make you generally feel well satisfied and energized?	<input type="checkbox"/> Y <input type="checkbox"/> N
14.	If you could eat anything you wanted (what you like) at a buffet, would you sample all the salads and leave room for the desserts?	<input type="checkbox"/> Y <input type="checkbox"/> N
15.	Do you handle juice or water fasts well?	<input type="checkbox"/> Y <input type="checkbox"/> N
16.	If you feel low energy, does eating sweets or fruits restore lasting energy?	<input type="checkbox"/> Y <input type="checkbox"/> N
17.	Are you particularly fond of potatoes?	<input type="checkbox"/> Y <input type="checkbox"/> N
18.	Do you have a sense of sustained well being after eating sweet foods?	<input type="checkbox"/> Y <input type="checkbox"/> N
19.	Do foods taste too salty?	<input type="checkbox"/> Y <input type="checkbox"/> N
20.	Does eating red meat decrease energy and well being?	<input type="checkbox"/> Y <input type="checkbox"/> N
21.	If you are a vegetarian, can you remember what happened when you used to eat red meat?	<input type="checkbox"/> Y <input type="checkbox"/> N
22.	Do you get sleepy or lethargic eating a high protein, high fat meal such as one that is high in seeds, nuts, tofu, spirulina or chorella?	<input type="checkbox"/> Y <input type="checkbox"/> N
23.	Do you particularly care for sour foods such as lemons?	<input type="checkbox"/> Y <input type="checkbox"/> N
24.	Do you rarely want snacks?	<input type="checkbox"/> Y <input type="checkbox"/> N
25.	Is it easy for you to go more than 4 hours without food?	<input type="checkbox"/> Y <input type="checkbox"/> N
26.	Is the traditional low protein, high carbohydrate diet easy and natural for you?	<input type="checkbox"/> Y <input type="checkbox"/> N
27.	Do you feel good and energetically sustained after eating grains (those which you are not allergic)?	<input type="checkbox"/> Y <input type="checkbox"/> N
28.	Has your general health and well being improved since becoming vegetarian or avoiding high protein foods?	<input type="checkbox"/> Y <input type="checkbox"/> N
29.	Did you grow up having any aversions to flesh foods?	<input type="checkbox"/> Y <input type="checkbox"/> N
30.	Did you grow up having any aversions to fatty foods?	<input type="checkbox"/> Y <input type="checkbox"/> N
31.	Does eating primarily fruits and vegetables give you a sense of emotional and mental well being?	<input type="checkbox"/> Y <input type="checkbox"/> N
TOTAL:		Y N
		<input type="checkbox"/> <input type="checkbox"/>

Fast Oxidizer Profile

1.	Do you have a strong appetite for breakfast?	<input type="checkbox"/> Y <input type="checkbox"/> N
2.	Do you have a strong appetite for lunch?	<input type="checkbox"/> Y <input type="checkbox"/> N
3.	Do you have a strong appetite for dinner?	<input type="checkbox"/> Y <input type="checkbox"/> N
4.	Do you need to snack frequently?	<input type="checkbox"/> Y <input type="checkbox"/> N
5.	Does a high carbohydrate diet with fruits/veggies/sweets make you feel worse or not satisfy you?	<input type="checkbox"/> Y <input type="checkbox"/> N
6.	Do you feel satisfied after a high protein meal like tofu, beans, spirulina, nuts, seeds, or chlorella?	<input type="checkbox"/> Y <input type="checkbox"/> N
7.	Do you feel better after a high protein meal?	<input type="checkbox"/> Y <input type="checkbox"/> N
8.	Do you crave flesh foods?	<input type="checkbox"/> Y <input type="checkbox"/> N
9.	Does a high protein meal give you a sense of increased energy and well being?	<input type="checkbox"/> Y <input type="checkbox"/> N
10.	Does going 4 hours without food make you feel jittery or weak?	<input type="checkbox"/> Y <input type="checkbox"/> N
11.	Do you need to snack often to feel okay?	<input type="checkbox"/> Y <input type="checkbox"/> N
12.	Do you live to eat?	<input type="checkbox"/> Y <input type="checkbox"/> N
13.	Do you prefer fatty foods over sweets?	<input type="checkbox"/> Y <input type="checkbox"/> N
14.	Does eating sweets throw you out of balance?	<input type="checkbox"/> Y <input type="checkbox"/> N
15.	Does eating sweets deplete your energy within an hour?	<input type="checkbox"/> Y <input type="checkbox"/> N
16.	Does eating before sleep help you sleep?	<input type="checkbox"/> Y <input type="checkbox"/> N
17.	Does eating before sleep help you to sleep through the night?	<input type="checkbox"/> Y <input type="checkbox"/> N
18.	Does having orange or apple juice alone make you feel light headed or hungry?	<input type="checkbox"/> Y <input type="checkbox"/> N
19.	Does eating a high protein or fatty meal (seeds or nuts) restore lasting energy and a feeling of well being?	<input type="checkbox"/> Y <input type="checkbox"/> N
20.	Do you like to eat potatoes?	<input type="checkbox"/> Y <input type="checkbox"/> N
21.	If you are vegetarian, can you remember if eating red meats used to give you energy?	<input type="checkbox"/> Y <input type="checkbox"/> N
22.	Does eating fruit, pastries or candy make you feel worse?	<input type="checkbox"/> Y <input type="checkbox"/> N
23.	Is it hard for you to fast on juice or water?	<input type="checkbox"/> Y <input type="checkbox"/> N
24.	Do you really not care for sweet deserts, but may enjoy something fatty or salty?	<input type="checkbox"/> Y <input type="checkbox"/> N
25.	Do you feel worse after eating grains?	<input type="checkbox"/> Y <input type="checkbox"/> N
26.	Do you like sour foods?	<input type="checkbox"/> Y <input type="checkbox"/> N
27.	Do sweet foods seem too sweet?	<input type="checkbox"/> Y <input type="checkbox"/> N
28.	Do you get a quick lift, and then suddenly drop of energy from sweet foods?	<input type="checkbox"/> Y <input type="checkbox"/> N
29.	If you skip meals, does it cause you to be weak, jittery, low energy and unbalanced?	<input type="checkbox"/> Y <input type="checkbox"/> N
30.	Do you love or crave salty foods?	<input type="checkbox"/> Y <input type="checkbox"/> N
TOTAL:		<u>Y</u> <u>N</u>



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ESTABLISHING HEALTH GOALS

Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve in your visit with us?

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

Have you made the decision to change? To do what it takes to get well?

Yes _____

No _____

I have read something interesting: ***"The definition of insanity is to keep doing the same thing and expecting different results"***.

If you keep following the same course of treatment you have been following will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination. Most people I ask tell me they're made the decision to change. But how many people have truly decided to change? Very few! Why? Because there is a big difference between deciding something and having "reasons" to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:



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Readiness Assessment

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet – 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Take several nutritional supplements each day– 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Keep a record of what you eat each day – 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Modify your lifestyle (e.g. work demands, sleep habits) 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Practice relaxation techniques – 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Engage in regular exercise – 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Have periodic pathology tests to assess progress -- 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Invest enough time into educating yourself about the first causes of health problems and how we can reverse them through lifestyle and diet – 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments: _____

Rate on a scale of: 5 (very confident) to 1 (not confident at all).

How confident are you of your ability to organize and follow through on the above health related activities? 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

Rate on a scale of: 5 (very supportive) to 1 (not supportive at all).

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? – 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments _____

Rate on a scale of: 5 (very frequent contact) to 1 (very infrequent contact).

How much ongoing support and contact (e.g. telephone consults, e-mail correspondence) from your professional staff would be helpful to you as you implement your personal health program? 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Any Other Comments?

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these medical forms will provide invaluable data. Each section builds upon the other, allowing me and other physicians the opportunity to discover “**missing keys**” that will significantly help you to manage your health problem(s).

Once all the sections of this form and the questionnaires have been filled out please return them to our office in preparation for our initial consultation. I thank you once again and look forward to helping you achieve a “**return to health and well being.**”

Sincerely,
Dr Sandeep Gupta