TRUCARE HEALTH MEDICAL CENTER
FOR
INTEGRATIVE, FUNCTIONAL MEDICINE, & WELLNESS

PATIENT PROGRESS FORM

PATIENT PROGRESS

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the TruCare Health Team during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date:_____________

First Name:_________________________ Middle:_____________________Last:________________________

Address ___________________________________ City __________________ State _____ Zip Code______

Home Phone (____) _____-_______ Work (____) _____-_______ Cell (____) ____-_______

Email ____

Age ______ Date of Birth ____/____/_____

lease rate your level of compliance with the treatment regimen that as prescribed for you	○ **Non-Compliant** ○ **25% Compliant** ○ **50% Compliant** ○ **75% Compliant** ○ **100% Compliant**
lease list any obstacles to complying with your treatment regimen	
lease list any new health concerns	
lease add any additional comments	

List any medications that you started taking or stopped since your last office visit

Medication Name	Date started	Date stopped	Dosage

List any supplements that you started taking or stopped since your last office visit

Medication Name	Date started	Date stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:____

____

FEMALE MEDICAL HISTORY

(For women only)

GYNECOLOGICAL HISTORY

Date of last menstrual period: ____/____/______

Do you currently use contraception? Yes____ No____ If yes, what please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant.________________________________

____

____

Change in libido? Yes_____ No_____

Are you menopausal? Yes_____ No_____ If yes, age of menopause_______________________

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_______

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

❑ Other ________________________________

DIAGNOSTIC TESTING

Last PAP test: _____/_____/______ Normal:__________Abnormal____________

Last Mammogram_____/_____/_____ Breast biopsy? Date: _____/_____/______

Date of last bone density_____/_____/______ Results: High____ Low____ Within normal range____

MALE MEDICAL HISTORY

(For men only)

Do you urinate without straining? Yes _____ No _____
Do you have a good urine flow rate? Yes _____ No _____
Do you have problems with frequency during the day or night? Yes _____ No _____
Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_______
Change in libido? Yes_____ No_____

DIAGNOSTIC TESTING

Last Prostate exam _____/_____/______ Normal:____________Abnormal____________

Last PSA _____/_____/_____ Normal:_________Abnormal____________

PSA Level:
- ❑ 0 – 2
- ❑ 2 – 4
- ❑ 4 – 10
- ❑ >10

PAIN ASSESSMENT

Are you currently in pain? Yes ___ No___

Is the source of your pain due to an injury? Yes___ No___

If yes, please describe your injury and the date in which it occurred: ______________________

____

If no, please describe how long you have experienced this pain and what you believe it is attributed to: ____

Please List and Rate the severity of your pain.
(0= no pain, 10= severe pain)

Example: List Area of Pain: **Neck**

0 1 2 3 4 5 (6) 7 8 9 10

List Area of Pain________________________
1 2 3 4 5 6 7 8 9 10

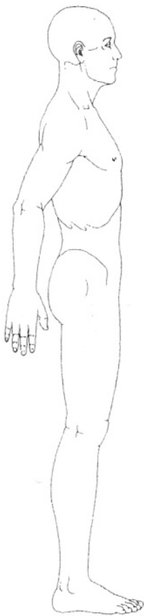
List Area of Pain. ________________________
1 2 3 4 5 6 7 8 9 10

List Area of Pain. ________________________
1 2 3 4 5 6 7 8 9 10

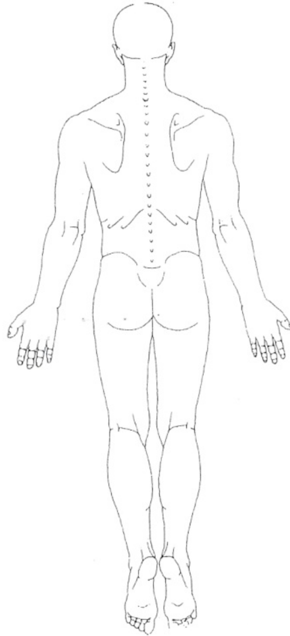
List Area of Pain. ________________________
1 2 3 4 5 6 7 8 9 10

Use the following letters provided to mark your area(s) of pain on the illustration.
Example: Place an **A** on the left shoulder to indicate an Ache you are currently experiencing

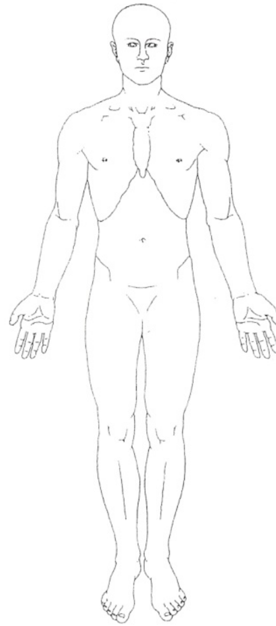
A = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting



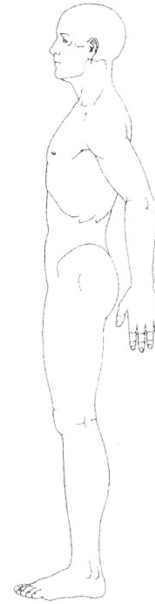
Right Side



Back



Front



Left side

DENTAL HISTORY

Have there been any changes in your Dental Health? Yes____ No_____

Please explain:

NUTRITIONAL HISTORY

FOOD DIARY

Please list your diet for the last three days and indicate estimated times

Day 1	Day 2	Day 3
❑ Breakfast / Time	❑ Breakfast / Time	❑ Breakfast / Time
❑ Lunch / Time	❑ Lunch / Time	❑ Lunch / Time
❑ Dinner / Time	❑ Dinner / Time	❑ Dinner / Time
❑ Snack / Time	❑ Snack / Time	❑ Snack / Time
❑ Snack / Time	❑ Snack / Time	❑ Snack / Time
❑ Snack / Time	❑ Snack / Time	❑ Snack / Time
❑ Beverages	❑ Beverages	❑ Beverages

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

- ❑ Ovo-lacto
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet
- ❑ Other (describe)____

Please tell us if there is anything special about your diet that we should know.________________________

____

Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc?
Yes___ No____
If yes, are these symptoms associated with any particular food or supplement?
Yes___ No____
If yes, please name the food or supplement and symptom(s). _____________________________________

____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc.? (symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_________________________

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_________________________

Does skipping meals greatly affect your symptoms? Yes _____ No _____

Please complete the following chart as it relates to your bowel movements:

Frequency	**√**	**Color**	**√**
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	**√**	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	

Often floats	
Difficult to pass	
Diarrhea	
Thin, long or narrow	
Small and hard	
Loose but not watery	
Alternating between hard and loose/watery	

Intestinal gas:

- ❑ Daily
- ❑ Occasionally
- ❑ Excessive
- ❑ Present with pain
- ❑ Foul smelling
- ❑ Little odor

LIFESTYLE HISTORY

TOBACCO HISTORY

Are you currently using tobacco? Yes ____ No _____

ALCOHOL INTAKE

- ❑ No alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

OTHER SUBSTANCES

Are you currently using recreational drugs? Yes____ No____

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?

EXERCISE HISTORY

Do you exercise regularly? Yes____ No____

If yes, please indicate:	**Times/week**				**Length of session**			
Type of exercise	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?____

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

Spouse Family Friends Religious/Spiritual Pets Other _____________

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _______________

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other

Hobbies and leisure activities:

____

____

Is there anything that you would like to discuss with the doctor that you feel you cannot indicate here?
Yes_____ No_____

Thank you for taking the time to complete this patient progress questionnaire. The information derived from these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We continue to look forward to helping you achieve lifelong health and wellbeing.

Sincerely,
Your TruCare Health TeaM