47601 Grand River Ave Novi, MI 48374 | P (248) 308-2844 | Fax (888)540-4020

Personal History

Your Name: ____
First Middle Last

Your Address: ____
Street City/State Zip

Telephone: Home:____________________ Cell:____________________

Email Address: ____________________ Birth Date: ________________

Marital Status:____________________ Occupation:________________

Employer:______________________ Present MD:________________

Areas of Interest:
- ___ Wellness Programs
- ___ Food Allergy Testing
- ___ Hormone Therapy
- ___ Detox
- ___ Weight Loss
- ___ Disease Prevention
- ___ Testing
- Other: ____________

Main Complaints and How long have you suffered these problems?

1) ________________ ______ 2) ________________ ______
3) ________________ ______ 4) ________________ ______
5) ________________ ______ 6) ________________ ______
7) ________________ ______ 8) ________________ ______

Referred to our Centre or Seminar by: ______________________________

Medications:

1) ____ Condition:_____________________________________
2) ____ Condition:_____________________________________
3) ____ Condition:_____________________________________
4) ____ Condition:_____________________________________
5) ____ Condition:_____________________________________
6) ____ Condition:_____________________________________
7) ____ Condition:_____________________________________
8) ____ Condition:_____________________________________
9) ____ Condition:_____________________________________
10) _______________________________________ Condition:_____________________________________

Thyroid Patients Only:
How Long did you have symptoms prior to being diagnosed?______________________________
If on thyroid medication, how long have you been on? _____________________________________
Has your medications been adjusted frequently? Y / N
Do you have any symptoms of brain fog or memory difficulties? Y / N
Do you have joint inflammation? Y / N
Do you consume grains? Y / N Do these foods irritate your bowels? Y / N
Do you have heart palpitations? Y / N Do you have hot flashes or sweat attacks? Y / N
Have you been diagnosed with an autoimmune condition? Y / N
If Yes, what condition? ____

Please list any allergies to foods, dyes or other substances and type of reaction:
____
____

Would you like improvement with any of the following?

___ Digestion: Reflux, Gas, Constipation
___ Sleep: Falling asleep or staying asleep
___ Sense of Well Being
___ Energy

What have you tried doing to resolve this problem that Did Not work?
____

How does this problem interfere with the following areas in your life?
Work: ____
Family: ____
Hobbies: ____
Life: ____

Do you know how this problem may have started? __________________________________
____

How have you taken care of your health in the past?

___ Medications ___ Holistic ___ Routine medical
___ Vitamins ___ Exercise ___ Chiropractic
___ Diet and Nutrition ___ Other: _____________________________________

How did the previous methods work for you? ______________________________________
____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific ____
____

What potential barriers do you foresee that would prevent these things from happening?
____
____

What are your strengths that will enable you to accomplish your goals?
____
____

Rate on a scale of 1-10:
_______ How important is it for you to resolve your health concerns?
_______ Do you feel that you are coachable and would enjoy a mentor in helping you/
_______ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Metabolic Assessment Form Key

Please circle the appropriate number 0-3 on all questions below (0 as the least/never to 3 as the most/always)

Question	Rating
Category I: Colon	
Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relief by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard dry or small stool	0 1 2 3
Coated tongue of "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Do you use laxatives frequently?	0 1 2 3
Category II: Hypochlorydia	
Excessive belching burping or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables;	0 1 2 3
undigested foods found in stools	0 1 2 3
Category III: Hyperacidity (Ulcer)	
Stomach pain, burning or arching 1-4 hrs after eating	0 1 2 3
Do you frequently use antacids?	0 1 2 3
Feeling hungry an hour or two after eating	0 1 2 3
Heartburn when lying down bending forward	0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0 1 2 3
Category IV: Small Intestine (Pancreas)	
Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage bloated	0 1 2 3
Excessive passage of gas	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3
Category V: Biliary Insufficiency/ Statis	
Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and or bloating several hrs after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	Y es No
Category VI: Hypoglycemia	
Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep yourself going or started	0 1 2 3
Get lightheaded if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful	0 1 2 3
Blurred vision	0 1 2 3
Category VII: Insulin Resistance	
Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst & appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Symptom	Score
Category VIII: Adrenal Hypofunction	
Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3
Category IX: Adrenal Hyperfunction	
Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amounts of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hrs of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3
Category X: Hypothyroid	
Tired, sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight gain even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face or genitals or excessive falling hair	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3
Category XI: Thyroid Hyperfunction	
Heart palpations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3
Category XII: Pituitary Hypofunction	
Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without Symptoms	0 1 2 3
Category XIII: Pituitary Hyperfunction	
Increased sex drive	0 1 2 3
Tolerance to sugar reduced	0 1 2 3
"Splitting" type headaches	0 1 2 3
Category XIV (Males Only): Prostate	
Urination difficulty or dribbling	0 1 2 3
Urination frequent	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night	0 1 2 3
Category XV (Males Only): Andropause	
Decrease in libido	0 1 2 3
Decrease in spontaneous morning erections	0 1 2 3
Decrease in fullness of erections	0 1 2 3
Difficulty in maintain morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3
Category XVI (Menstruating Females only):	
Are you premenopausal?	Yes No
Alternating menstrual cycle lengths	Yes No
Extended menstrual cycle, greater than 32 days	Yes No
Shortened menses, less than every 24 days	Yes No
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne break outs	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XVII (Menopausal Females only):	**Foods: How many:**
How many years have you been menopausal?________________	alcohol beverages do you consume per week? ______
Do you ever have uterine bleeding since menopause? Yes No	caffeinated beverages do you consume per day? _______
Hot flashes 0 1 2 3	times do you eat out per week? _______
Mental fogginess 0 1 2 3	times a week do you eat fish? _______
Disinterest in sex 0 1 2 3	times a week do you workout? _______
Mood swings 0 1 2 3	Do you smoke? Y/ N If Yes, how many times ____ day___wk
Depression 0 1 2 3	Rate your stress levels on a scale of 1-10 during the average week _________
Painful intercourse 0 1 2 3	
Shrinking breasts 0 1 2 3	
Facial hair growth 0 1 2 3	
Acne 0 1 2 3	

Family Health History

Please review the conditions listed below. Write "C" under their column to indicate health problems are current and write "P" to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Children		
	Age	Age	Age	Age	Age	Age
Allergies						
Anxiety						
Asthma						
ADHD						
Back trouble						
Bed wetting						
Cancer						
Colic						
Colitis						
Constipation						
Depression						
Diabetes						
Disc problems						
Ear infections						
Emotional issues						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
Heart burn						
High blood press.						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scoliosis						
Sinus trouble						
Other						

Acknowledgement of Receipt of Notice of Privacy Practice

I, ____ have received a copy of Dr. Chellam's

Wellness Notice of Privacy Practice ____
(Signature of Patient or Guardian)

____

Section to be filled out by staff if patient's signature not obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

___ Patient refused to sign
___ Emergency situation kept us from obtaining the patient's signature
___ Language barriers kept us from obtaining the patient's signature
___ Other: ____
____

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Directions

click the map below for directions to our clinic: