Environmental Illness and Detoxification
Initial Patient Intake Questionnaire

This form will become part of your medical record and the contents are confidential. It is very important to answer all questions as this will be most helpful in evaluating your condition.

Date____________
Name_____________________________Birthdate__________Birthplace_____________
Occupation________________________Hobbies_________________________________
List all locations in which you have lived: ______________________________________
____

Exposure History

Community

For each of the items listed below:	Did/Do you live nearby?	Where/When/How long?
Heavy traffic(excessive)	☐ no ☐ yes (please specify)	______________________
Vehicle idling area	☐ no ☐ yes (please specify)	______________________
Dump site	☐ no ☐ yes (please specify)	______________________
Farm(s)	☐ no ☐ yes (please specify)	______________________
Industrial plants	☐ no ☐ yes (please specify)	______________________
Radiation source	☐ no ☐ yes (please specify)	______________________
Polluted lake/stream	☐ no ☐ yes (please specify)	______________________
Other potential hazards	☐ no ☐ yes (please specify)	______________________

Home & Hobby

How long have you lived in your present residence?________ How old is it?__________
If more than 40 yrs old, do you have ☐ Asbestos insulation or vinyl tile ☐ Flaking paint
What type of dwelling is your residence? ☐ House ☐ Mobile home
☐ Apartment ⇒ O basement O above store O highrise⇒floor___
Does your residence have an attached or underground garage: ☐ no ☐ yes
What type of fuel is used for heating your home: ☐ Gas ☐ Oil ☐ Wood ☐ Electric ☐ Propane
Do you have carbon monoxide detectors? ☐ no ☐ yes
Have you done any painting / renovating / bought new large furniture? ☐ no ☐ yes
⇒ If so, When? _____________ What? __________________________________
____

(Home and Hobby continued)

Who smokes in your home? ________________________ Car? __________________

Do or did you use pesticides or herbicides (bug or weed killers, flea / tick sprays, collars, powders, etc.) in you home or on your pets? ☐ no ☐ yes (specify) _______________

____

⇒ On your lawn or garden? ☐ no ☐ yes (specify) _____________________

____

What is your water source for bathing? ☐ City ☐ Well ☐ Other__________________

Occupation

1. Please list the significant chemicals, solvents, heavy metals, paints, dusts, fibers, fumes, radiation, biologic agents (bacteria, molds, viruses) and phusical agents (extreme heat, cold, vibration, noise) that you have been exposed to;
Please list any protective measures taken (e.g. showering at work, laundering clothes at work, etc.) or protective equipment used (e.g. gloves, apron, mask, respirator, hearing protectors, etc.)

Past/Present Jobs and Hobbies	For how long did you do this?	Exposures	Protective measures and equipment
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

2. The following questions are about your present or most recent work environment:
Age of building: _____ Number of floors: ___ Approximate # of occupants: ____
Neighborhood: ☐ Rural ☐ Commercial ☐ Industrial

Which of the following does / did your present or most recent work environment have?

☐ laboratory
☐ cafeteria
☐ windows that open
☐ banks of computers
☐ manufacturing area
☐ central air conditioning
☐ unvented smoking areas
☐ partitions or room dividers
☐ unvented copy machines
☐ nearby parking garage
☐ carpets – *How old?* ______

3. Have any of the following occurred in your work environment over the past 12 months or the last 12 months you worked in your most recent job?

☐ use of pesticides ⇒ ☐ indoors ☐ outdoors ☐ fire, smoke ☐ flood, water leaks ☐ carpet cleaning
☐ new flooring, furniture, etc. *(specify):* ____________________ ☐ construction ☐ renovation
☐ painting ☐ chemical spill, leak *(specify):* _________________ ☐ accidents ☐ stress

Home

1. For each of the items listed below:

	Do you have in your home?	If you ever had, please write the years:
Damp, musty basement or crawl space	☐ no ☐ yes	________________
Wet windows or outside closet walls (condensation)	☐ no ☐ yes	________________
Water leaks	☐ no ☐ yes	________________
Visible mold	☐ no ☐ yes ⇒ where? ________________	
Stagnant stuffy air	☐ no ☐ yes	________________
Gas or propane stove	☐ no ☐ yes	________________
Other gas appliances	☐ no ☐ yes *(specify)*________________	
Wood stove or fireplace	☐ no ☐ yes	________________
Air Conditioning	☐ no ☐ yes	________________
	Central? Individual Rooms? ________________	
Electrostatic air cleaner/filter	☐ no ☐ yes	________________
Other air cleaner(s)/filter(s)	☐ no ☐ yes	(specify)________________
Carpets	☐ no ☐ yes ⇒ *Where?* ________________ *How Old?*________________	
Photocopier / fax machine / printer	☐ no ☐ yes ⇒ type? ________________ Location? ________________	
Pets	☐ no ☐ yes *(specify)*________________	
Do you use flea collars?	☐ no ☐ yes	
Indoor plants	☐ no ☐ yes *(how many?)*________________	
Do you use an electric blanket?	☐ no ☐ yes	

2. Do you dust (mite-proof)? Pillow covers ☐ no ☐ yes mattress covers ☐ no ☐ yes

Do you use? ☐ Central vacuum ☐ HEPA filter vacuum? ☐ Dust meter on vacuum?

3. What product(s) do you usually use:

Bathroom cleanser____________ floor / wall cleanser____________ window / mirror cleanser________________

Deodorizer________________ laundry detergent______________ fabric softener______________________

4. What hobbies do members of your household have?________________________

5. Have you personally done any of the following:

☐ furniture stripping / refinishing Years:__________

☐ home renovating Years:__________ (specify)____________________________

☐ art work *(e.g. painting, ceramics stained glass, leather work, etc.)* Years:__________ (specify)____________________________

☐ other non-occupational activities with exposure to chemicals Years:______________________

Specify:____

6. Do you:

Use mothballs? ☐ no ☐ yes Burn candles? ☐ no ☐ yes

Use potpourri or air fresheners ☐ no ☐ yes Use fabric softener: ☐ no ☐ yes

Have regular manicures? ☐ no ☐ yes Use nail polish ☐ no ☐ yes

Do you: have acrylic fingernails? ☐ no ☐ yes Have your clothes dry cleaned? ☐ no ☐ yes
Remove your shoes when entering your home? ☐ no ☐ yes

Personal

1) Synthetic Chemicals

How often do you use scented personal products (please check box)

Scented Product:	Soap	Lotion	Cosmetics	Hair permanent	Hair tint	Perfume/ Aftershave	Others?
Never	☐	☐	☐	☐	☐	☐	☐________
Occasionally	☐	☐	☐	☐	☐	☐	☐________
Daily	☐	☐	☐	☐	☐	☐	☐________

Have you ever had symptoms you linked with exposure to any synthetic (person-made) chemical at a level that did not seem to bother most people (e.g. paints, perfumes, cosmetics, engine exhaust, tar, new cars interiors, etc.?) ☐ no ☐ yes

If YES, please specify chemical(s) and symptoms (s):

("Linked" means that the symptom started or worsened within 48 hours after you were exposed to something, or the symptom improved or disappeared after you were no longer exposed to it.

"Exposure" means being near, touching, smelling, breathing, eating, drinking, swallowing or injecting something.)

Person-Made Chemical	Symptoms Linked with Low-level Exposure	Presently Affected? 1 = a little 2 = somewhat 3 = a lot	In the Past 1 = a little 2 = somewhat 3 = a lot

2) Dental Amalgams / Implants

How many silver / mercury fillings do you currently have? ______

Have you had silver / mercury fillings removed? ☐ no ☐ yes ⇒ Number removed __ When? ____

How many gold fillings / caps do you currently have ? ______

Do you have implants of silicone, teflon, etc. ☐ no ☐ yes If so, for how long? _______

3) Smoking history

Are you currently a smoker (daily or almost every day)? ☐ no ☐ yes

If YES, average number of cigarettes per day: _____ Number of years: _____

If NO, have you ever smoked tobacco (daily or almost daily)? ☐ no ☐ yes

- If YES, number of years you smoked: ____ Average number of cigarettes per day: ____
- When did you last smoked regularly? ____________

Have you ever regularly used other tobacco products? ☐ no ☐ yes

- If YES, what / how much / and when? ____

Diet and Drug History

1. Who grocery shops for you? ____

   Where? ☐ chain grocery store ☐ health food store ☐ market ☐ other ________
2. Who cooks for you? _____________________________
3. Please indicate foods and beverages most typically consumed for each of the following meals and the times at which they are most typically eaten.

Foods / Snacks	Please specify typical meals or foods	Time	Beverages	Please Specify	Time
Breakfast			Breakfast		
Mid-morning			Mid-morning		
Lunch			Lunch		
Mid-afternoon			Mid-afternoon		
Dinner			Dinner		
Evening			Evening		

4. How much of the following beverages do you consume regularly and have you linked any symptoms with drinking them?
   - Water ⇒ Number of 8 oz glasses per 24 hours ____ ☐ tap water ☐ filtered ☐ distilled
     ☐ bottled (glass) ☐ bottled (plastic) Any symptoms: ___________________________
   - Beer, ale ⇒ Number of 12 oz containers per week ____ Any symptoms: ________________
   - Wine ⇒ Number of 6 oz glasses per week ____ Any symptoms: ________________________
   - Spirits (e.g. whisky, rum) ⇒ Number of 1 ½ oz drinks per week ____ Any symptoms: _____
     ____
   - Coffee ⇒ Number of 8 oz cups or espresso shots per 24 hours ____ Any symptoms: _______
     ____
   - Tea ⇒ Number of 8 oz cups per 24 hours ____ Any symptoms: _______________________
   - Cola ⇒ Number of 12 oz drinks per 24 h ours Regular ____ Diet Any symptoms:
     ____
   - Other(s) (please specify) ______________________ Any symptoms: ___________________
5. Do you eat fish? ☐ no ☐ yes ⇒ On average how many servings (3-4 oz) per week? _________

   What are the types of fish that you eat, in order of frequency: _____________________________
6. Please list foods / beverages that do not agree with you (e.g. stuffy nose, heartburn, bloating, diarrhea, sleepiness, difficulty concentrating, etc.) or cause allergic reactions (e.g. hives, rashes, shortness of breath, wheezing, anaphylaxis, etc.):

List foods / beverages that are a problem	What problem(s) do they give you?	Approximately how often do you eat / drink these problem foods?			
		Never	Occasionally	Daily	More than daily

7. (Disagreeable foods and reactions continued)

8. Please list any foods / beverages that you crave or that help you to feel better:

List foods that you crave or that help you to feel better	What problem(s), if any, do they give you?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More than once daily