Caleb Gates L.Ac. LLC
1199 Main Ave. Ste. 220, Durango, CO 81301; 970-259-9488

## PATIENT INFORMATION

**LEGAL NAME: LAST_____ FIRST/MIDDLE INITIAL_____**

**NAME YOU WISH TO BE CALLED_____ REFERRED BY: _____**

**If you're satisfied with your experience at the end of treatment are you okay with me asking you for a referral? ___YES___NO**

**DATE OF BIRTH_____ MALE_____ FEMALE_____ MARITAL STATUS_____**

**PHYSICAL ADDRESS_____ CITY, STATE, ZIP_____**

**MAILING ADDRESS_____ CITY, STATE, ZIP_____**

**CELL PHONE_____ E-MAIL _____**

**WORK PHONE_____ EMPLOYER_____**

**SOCIAL SECURITY #_____ OCCUPATION_____**

**PATIENT'S PRIMARY CARE PHYSICIAN_____**

### RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN/LEGAL REPRESENTATIVE)

**LAST NAME_____ FIRST NAME_____**

**MAILING ADDRESS_____ CITY, STATE, ZIP_____**

**HOME PHONE_____ WORK PHONE_____**

**RELATIONSHIP TO PATIENT_____**

### PERSON TO NOTIFY IN CASE OF AN EMERGENCY

**LAST NAME_____ FIRST NAME_____**

**MAILING ADDRESS_____ CITY, STATE, ZIP_____**

**HOME PHONE_____ WORK PHONE_____**

**RELATIONSHIP TO PATIENT_____**

### INSURANCE INFORMATION / PERSON RESPONSIBLE FOR BILL ( PROVIDE A CURRENT INSURANCE CARD AT TIME OF SERVICE)

**INSURANCE COMPANY_____** ☐ **NO INSURANCE**

**INSURANCE ID#_____ COPAY$_____ DEDUCTIBLE$_____**

**POLICY HOLDER: LAST NAME_____ FIRST NAME_____**

**MAILING ADDRESS_____ CITY, STATE, ZIP_____**

**DATE OF BIRTH_____ RELATIONSHIP TO PATIENT_____**

**EMPLOYEER_____ WORK PHONE_____**

**By signing this form, I verify that the information listed above is accurate and current to the best of my ability:**

_____ _____
**Signed by Patient / Legal Guardian / Legal Representative** **Date**

**I authorize payment of medical benefits to undersigned Physician or supplier for these services and all future claims:**

_____ _____
**Signed by Patient / Legal Guardian / Legal Representative** **Date**

# Acupuncture Disclosure Form

The practice of Acupuncture is regulated by the Colorado Department of Regulatory Agencies (DORA); Concerns are directed to Director of Division of Registrations, Acupuncture Registration, 1560 Broadway, Suite 1545; Denver, CO 80202; 303-894-2464.
This Acupuncture Clinic complies with rules and regulations promulgated by the department of health and environment including the use of sterilized acupuncture needles, the use of disposal able needles and the sanitation of this acupuncture office.

Caleb F. Gates III, L.Ac. Diplomat of Acupuncture NCCAOM, LLC
1199 Main Ave., Ste. 220; Durango, CO 81301; 970-259-9488

Treatment Fees:
Acupuncture Initial Treatment $120, Acupuncture follow up $110, Cupping $70
Herbal Consultation $75 and Herbal Products $20- $80 each
Advanced Allergy Therapeutics: Initial Treatment $170, Follow up $120
Field Control Therapy Initial $275, FCT Follow up $200, FCT Herbal Assessment $175
Payment is due at time of services and is the responsibility of the patient if insurance does not cover treatments. Discounts may be applied at time of payment. There is a 24-hour cancellation policy. Missed Appointments will be charged full price.

State of Colorado Acupuncture Registration #967, City of Durango License #210080
Every patient is entitled to receive information about the duration and type of therapy available which includes Acupuncture, Chinese Herbal and Nutritional Therapy, Therapeutic Massage, Chinese Medical Massage, Moxibustion and Cupping. Patients may seek a second opinion from another health care professional or may terminate therapy at any time.
In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the division at DORA.

Caleb Gates is a Licensed Acupuncturist, Certified by the National Commission for the Certification of Acupuncture and Oriental Medicine. Registered Acupuncturists are certified in clean needle technique by the Council of Colleges of Acupuncture and Oriental Medicine. He is a graduate of Colorado School of Traditional Chinese Medicine, a 3.5-year program in Acupuncture and Chinese Herbal Medicine. Member: Acupuncture Association of Colorado.
Caleb Gates is trained and clinically experienced to perform acupuncture, the insertion of sterile needles into the body and the use of Chinese Herbal Remedies and nutritional therapy in the form of plant, powder or pills as defined by Traditional Oriental Medical principals of diagnosis and treatment.
Treatment is quite safe and can improve and heal existing conditions as well temporarily aggravate existing symptoms. Patients might experience temporary disorientation, dizziness, nausea, digestive disturbance, slight bruising, Moxibustion burns and other discomforts.
I fully understand that there is no implied or stated guarantee of the success or effectiveness of a specific treatment or series of treatments. I am hereby advised to consult with my primary care medical physician on medical issues and that Acupuncture, Oriental Medicine or alternative care is not substitution for appropriate medical advise and care from a medical doctor.

Patients Signature_____ Date _____.

Caleb Gates L.Ac. CMT LLC
1199 Main Ave. Ste. 220, Durango, CO 81301; 970-259-9488

# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**With my consent, Caleb Gates LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Caleb Gates LLC, Notice of Privacy Practices for a more complete description of such uses and disclosures.**

**I have the right to review the Notice of Privacy Practices prior to signing this consent. Caleb Gates LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a request to Caleb Gates LLC Privacy Officer at (1199 Main Ave., Suite 230, Durango, Co 81301).**

**With my consent, Caleb Gates LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. I have the right to have restrictions to any of the above information, which I am required to do in writing on the appropriate office forms.**

**With my consent, Caleb Gates LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.**

**By signing this form, I am consenting to Caleb Gates LLC use and disclosure of my PHI to carry out TPO.**

**I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Caleb Gates LLC may decline to provide treatment to me.**

_____
**Signature of Patient or Legal Guardian**

_____ _____
**Patient's Name** **Date**

_____
**Print name of Patient or Legal Guardian**

# DURANGO ACUPUNCTURE AND ALLERGY RELIEF

CALEB GATES, L.Ac

## PATIENT INTAKE FORM

Date: _____

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Last Name: | First: | Middle: | Date of Birth: |
| | | | |

Chief Complaint Currently: _____

**Additional Health Priorities**:

1._____ 3._____

2._____ 4._____

## SYMPTOMS

| **Symptom & Description (worst first)** | **Known triggers Worse (<) or better (>) for…** | **When Started** | **Rating: 1 → 10: 1 = hardly there 10 = extremely bad** |
|---|---|---|---|
| | | | |

| Amount/Level Of | Very Low | Low | Medium | Hight | Excessive | Erratic |
|---|---|---|---|---|---|---|
| General Energy | | | | | | |
| Sleep | | | | | | |
| General Appetite | | | | | | |
| General Thirst | | | | | | |
| Circulation/warmth/heat | | | | | | |
| Daily Exercise | | | | | | |

Exercise Routine: _____

Energy is best: ☐ a.m. ☐p.m. ☐Night ☐Between meals ☐Just after meals ☐When moving ☐ Or still

Energy is worst:☐ a.m. ☐p.m. ☐Night ☐Between meals ☐Just after meals ☐When moving ☐ Or still

**MIND & EMOTIONS**: Tick if Current: ☐Mood Swings ☐Anger/Frustration ☐Grief/Sadness ☐Racing Mind
☐Worry ☐Fear ☐Brain Fog ☐Poor Memory ☐Poor Concentration ☐Difficulty Communicating

**STRESS**: Current stress level between 1 and 10 _____ (1 = very relaxed 10 = very stressed)

Factors most contributing to your stress: Health _____ Work _____ Money_____ Family_____ Other_____

What best helps you deal with stress? _____

---

**SYSTEMS CHECK**: **Check** any current problems.

***General Symptoms***

☐ Sweat Easily
☐ Cold Limbs
☐ Recent Weight Loss
☐ Poor Sleeper
☐ Fatigue
☐ Prefer Cold Drinks
☐ Weak Immunities
☐ Hot Flashes
☐ Cold Body
☐ Overweight
☐ Normal Energy Level
☐ Prefer Warm Drinks
☐ High Metabolism
☐ Night Sweat
☐ Feel Warm Mostly
☐ Underweight
☐ Feel Thirsty Often
☐ Strong Immunities
☐ Low Metabolism
☐ Lack of Thirst

When I am active I sweat: ☐a lot ☐little ☐almost never

I usually sweat on

☐my head
☐face
☐neck
☐back
☐upper body
☐arm pit
☐lower body
☐whole body
☐palm and sole

***Sleep***

☐ Problem getting to Sleep
☐ Frequent Waking
☐ Early Waking
☐ Wake Unrefreshed
☐ Sleepiness
☐ Night Sweats
☐ Grinding Teeth
☐ Dreams
☐ Nightmares
☐ Snoring
☐ Early Waking
☐ Fall Asleep without Meds or Supplements

_____ Hours slept per night
_____ Typical Bedtime
_____ Typical Wake time

***Infections***

☐ Recurring Frequent Colds
☐ Flu
☐ Sinusitis
☐ Chest
☐ Ear
☐ Bladder
☐ Cystitis
☐ Kidney
☐ Stomach
☐ Food Poisoning
☐ Poor Immunity
☐ General 'run down'
☐ Intestinal
☐ Swollen Lymph Nodes
☐ Phlegm
☐ Fevers

***Head***

☐ Headaches
☐ Migraines
☐ Seizures
☐ Panic Attacks
☐ Poor Hearing
☐ Ringing
☐ Blurred Vision- Distance
☐ Blurred Vision- Near
☐ Visual Spots
☐ Confusion
☐ Anxiety
☐ Loss of Consciousness
☐ Bi-Polar Disorder
☐ Mental Disorders
☐ Nervousness
☐ Dizziness/Vertigo
☐ Depression
☐ Presently in Counseling
☐ Considered/Attempted Suicide
☐ ADD/ADHD

***Cardiovascular***

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Low Blood Pressure
- ☐ Low Cholesterol
- ☐ Irregular Heart Beat
- ☐ Bruise Easily
- ☐ Chest Pain/ Pressure
- ☐ Heart Attack
- ☐ Cardiovascular Disease
- ☐ Stroke
- ☐ Anemia
- ☐ Edema - (Legs/Hands/Eyes)

***Respiratory***

- ☐ Coughing
- ☐ History Sinus Infections
- ☐ Phlegm
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Tight Chest
- ☐ Allergies
- ☐ History Pneumonia
- ☐ Post Nasal Drip
- ☐ Bronchitis/Emphysema
- ☐ Sinus Congestion
- ☐ Nose Bleeds

***Urination***

- ☐ Frequent Urination
- ☐ Bladder/Kidney Stones
- ☐ Urgency to Urinate
- ☐ Urinary Incontinence
- ☐ Blood in Urine
- ☐ Difficult Urination
- ☐ Painful Urination
- ☐ Recurrent Urinary Infections
- ☐ Kidney Disease
- ☐ Cloudy/Bubbly Urine

_____ # of glasses a water a day  Is your urine clear? (If no, please describe) _____

_____# of times night urination  Do you have any urinary diseases diagnosed by an MD? _____

***Gastrointestinal***

- ☐ Bowel Habits Changed
- ☐ Bloating
- ☐ History of Candida
- ☐ Laxative Use
- ☐ Gallbladder Troubles
- ☐ Nausea
- ☐ Heartburn
- ☐ Gas
- ☐ Constipation
- ☐ Ulcers
- ☐ Blood in Stool
- ☐ History of Parasites
- ☐ Mouth Tastes Bitter/Sour
- ☐ Vomiting
- ☐ Acid Reflux
- ☐ History of Polyps
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Hemorrhoids
- ☐ Diabetes
- ☐ Bad Breath
- ☐ Stomachaches
- ☐ Belching
- ☐ Rectal Itching
- ☐ Chronic Loose Stools
- ☐ Dry Hard Stools

Do you have any digestive diseases diagnosed by an MD? _____

Bowel Movements every _____days(s)  # per day_____

When passing the bowel does it most of the time ☐feel complete or ☐uncomplete?

When passing the bowel do you ☐sit for a prolonged period ☐need to push or ☐is it excreted in a few seconds? *Stools Tend to be:* ☐ Well Formed ☐ Loose (L) ☐ Constipated (C) ☐ Alternating (L & C)

***Skin & Hair***

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Itchiness
- ☐ Dryness
- ☐ Spots
- ☐ Athlete's Foot
- ☐ Jock Itch
- ☐ Hair Loss
- ☐ Dermatitis/Warts
- ☐ Brittle Hair
- ☐ Skin Rashes
- ☐ Early Gray
- ☐ Dry Scalp
- ☐ Facial Hair
- ☐ Acne
- ☐ Hives
- ☐ Fungal Infections
- ☐ Had Shingles

Do you have any skin diseases diagnosed by an MD?_____

***Musculoskeletal***

- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Sensitivity
- ☐ Poor Mobility
- ☐ Poor Coordination
- ☐ Muscle Weakness
- ☐ Pain Back
- ☐ Pain Neck
- ☐ Pain Shoulder
- ☐ Swollen Joints
- ☐ Tendonitis
- ☐ Bone Pain
- ☐ TMJ
- ☐ Muscle Pain
- ☐ Repetitive Strain Injury
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Muscle Spasms/Cramps
- ☐ Recurring Pain _____

Mark any muscular soreness and/or pain on the picture model using the following symbols:

**+++ = Sharp Stabbing**

**ooo = Pins & Needles/Tingling**

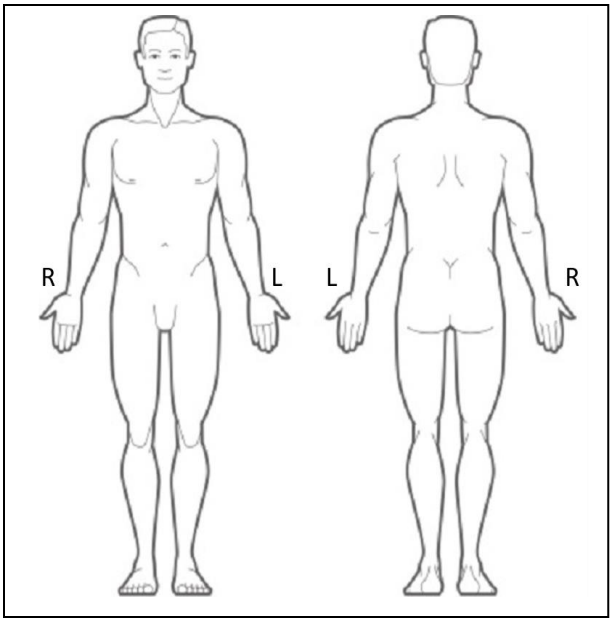
**vvv = Dull or Aching**

**lll – Numbness**

**--- = Trembling or Twitching**

Severity of pain on a scale of 1 to 10 (1 is low) _____

Is the pain fixed or does it move? _____




***Sensory***

- ☐ Eye Irritation
- ☐ Color Blindness
- ☐ Ear Congestions
- ☐ Loss of Smell
- ☐ Mouth Sores
- ☐ Spots in Vision
- ☐ Poor Hearing
- ☐ Gum/Teeth Problems
- ☐ Night Blindness
- ☐ Ear Ringing
- ☐ Nasal Discharge
- ☐ Dry Mouth & Throat
- ☐ Lumps in Throat
- ☐ Tearing Eyes

Do you have any sensory diseases diagnosed by an MD?_____

*Note: If you feel ready to be open in this area, the purpose of the following is to enable us to better assist your health.*

**<u>Men Only</u>**:

- ☐ Sexual Impotence
- ☐ Low Libido
- ☐ Genital Discharge
- ☐ Swelling
- ☐ Testicular Pain
- ☐ Infertility
- ☐ Prostate Problems
- ☐ Hepatitis (A, B, or C)
- ☐ Hernias
- ☐ Herpes
- ☐ Increased Sex Drive
- ☐ HIV Positive
- ☐ Decreased Sex Drive

**<u>Women Only</u>**: # of Children _____ # of Miscarriages _____ # of Abortions _____

Menses: ☐Late ☐Early ☐Regular ☐ Irregular ☐Absent Days of Period _____ Time Between Periods_____

The flow has been: ☐Heavy ☐Light ☐Regular ☐Dark Menses ☐PMS ☐Clotty menses ☐Cramps

Birth Control Type: _____ Dates on Birth Control Pill _____

List any symptoms which are worse ☐Before ☐During menses: _____

- ☐ Infertility/Fertility Issues
- ☐ Pregnant now
- ☐ Planning pregnancy
- ☐ Herpes
- ☐ Increased Sex Drive
- ☐ Yeast Infection
- ☐ HIV Positive
- ☐ Decreased Sex Drive
- ☐ Vaginal Discharge
- ☐ Hepatitis (A, B, or C)
- ☐ Hot Flashes/Night Sweats
- ☐ Mood Swings
- ☐ Breast Tenderness
- ☐ History of Fibroids/Cysts
- ☐ Low Libido
- ☐ Difficult birth(s) Details: _____

## DIET

| **How much do you eat/drink of the following:** | None | Very Little | Moderate | Very Much |
|---|---|---|---|---|
| Vegetables | ____ | ____ | ____ | ____ |
| Beans/legumes, nuts, seeds | ____ | ____ | ____ | ____ |
| Meat, fish (Which? _____) | ____ | ____ | ____ | ____ |
| Chicken, turkey, or eggs (not organic, even if free range) | ____ | ____ | ____ | ____ |
| Chicken, turkey, or eggs (organic) | ____ | ____ | ____ | ____ |
| Dairy Foods: milk, cheese, yogurt, etc. | ____ | ____ | ____ | ____ |
| White flour/starches: bread, pasta, potatoes, rice | ____ | ____ | ____ | ____ |
| Whole grains: whole wheat, oats, spelt, barley, rye | ____ | ____ | ____ | ____ |
| Sweets: cakes, biscuits, puddings, chocolate, soft drinks…) | ____ | ____ | ____ | ____ |
| Fruit and/or Fruit Juice | ____ | ____ | ____ | ____ |

Amount of water consumed daily (on its own): _____ Mark the type(s) of water you drink:

☐Tap ☐Filtered Tap ☐Reverse Osmosis ☐Distilled ☐Bottled What Brand? _____

Your known Allergies/ Sensitivities ☐Many ☐Few ☐Don't Know _____

_____

## MEDICAL HISTORY / PAST TREATMENTS

| | | | |
|---|---|---|---|
| ☐ Tuberculosis | ☐ Epilepsy/Seizure Disorder | ☐ Fibromyalgia | ☐ Mononucleosis |
| ☐ Scarlet Fever | ☐ Mental Illness/Depression | ☐ Hepatitis A/B/C | ☐ Cancer |
| ☐ Rheumatic Fever | ☐ Auto-Immune | ☐ Osteoporosis | ☐ Chronic Fatigue |
| ☐ Venereal Disease | | ☐ Pacemaker | ☐ Thyroid |
| | | ☐ Substance Abuse | ☐ Diabetes |

Have you ever had a negative reaction to any medications? ☐Yes ☐No

If so, which medication and what was the reaction? _____

Approximate number of course of **Antibiotics** received in your life: ☐0-10 ☐11-20 ☐21+

For what? _____When was last one received? _____

Approx. number of **X-rays** received in your life: ☐0-10 ☐11-20 ☐21+ When was last one received? _____

For what? (mammograms, injuries, dental, chest, etc)_____

***Vaccination***

Approximate number of **Vaccinations** received in your life: ☐0-10 ☐11-20 ☐21+

Which ones? _____ When was last one received? _____

Have you received any Flu Vaccinations any time in your life? ☐ Yes ☐ No When?_____

Have you ever had negative reactions to any vaccinations? ☐ Yes ☐ No Explain:_____

_____

## DENTAL HISTORY

Current number of dental amalgam fillings (these are silver or black colored): _____ Tooth Pain _____

How long since the first one was placed? _____ Total number that have been removed: _____

When removed? _____ Removed by ☐ Regular dentist or ☐ Holistic mercury-free dentist

Did your mother have amalgam fillings before your birth? ☐Yes ☐ No ☐Probably ☐No idea

Did your father and/or grandparents have amalgam fillings? ☐Yes ☐ No ☐Probably ☐No idea

Number of gold caps, root canals or other dental restorations (please indicate):_____

***Medications***

**Briefly list your previous treatment / detoxification history (including conventional or alternative medicine):**

| WHEN BEGUN | WHEN ENDED | TREATMENT | WHEN BEGUN | WHEN ENDED | TREATMENT |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## ACCIDENTS / HOSPITALIZATIONS / SURGERIES

Have you ever been knocked unconscious? _____ Any blows to the ☐head ☐spine ☐other injuries?

Details: _____

| INCIDENT | DATE | INCIDENT | DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## CURRENT TREATMENTS

List medications you currently use (prescribed or over-the-counter): **BRING A SAMPLE OF EACH TO YOUR APPT.**

| NAME | FREQUENCY | DOSAGE | SINCE WHEN | NAME | FREQUENCY | DOSAGE | SINCE WHEN |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

☐Long Term Medications(s) ☐Past ☐Present Details: _____

Any negative reactions to medication? _____

Have you had Bloodwork / X-rays / CT Scans or any other studies pertaining to your current condition(s) **done within the past year**? ☐Yes ☐ No Results:_____

List supplements / homeopathies / herbs you currently taking: **BRING SAMPLES OF THESE TOO!**

| NAME | FREQUENCY | DOSAGE | SINCE WHEN | NAME | FREQUENCY | DOSAGE | SINCE WHEN |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Is any other practitioner providing treatments/therapies for you at the present time? ☐Yes ☐No

Details: _____

## FAMILY HISTORY

| | Father | Mother | Father's Parents | Mother's Parents | Siblings |
|---|---|---|---|---|---|
| HEART DISEASE | | | | | |
| HIGH BLOOD PRESSURE | | | | | |
| STROKE | | | | | |
| TUBERCULOSIS | | | | | |
| CANCER | | | | | |
| GLAUCOMA | | | | | |
| DIABETES | | | | | |
| EPILEPSY | | | | | |
| BLEEDING DISORDER | | | | | |
| KIDNEY DISEASE | | | | | |
| THYROID DISEASE | | | | | |
| MENTAL ILLNESS | | | | | |

## TOXICITY

Do you smoke? ☐ Yes ☐ No Have you ever smoked ☐ Yes ☐ No Smokeless Tobacco ☐ Yes ☐ No

Packs/Cans daily_____ How long? _____ When stopped? _____

Have you used recreational drugs? ☐ Yes ☐ No

Please note any that apply to you now or in the past, and indicated your usage per day or week.

| | Per Day/Week | Age Started | Age Quit | History of Addiction | Family History of Addiction |
|---|---|---|---|---|---|
| Tobacco | | | | | |
| Alcohol | | | | | |
| Coffee | | | | | |
| Marijuana | | | | | |
| Cocaine | | | | | |
| Heroine | | | | | |
| Other | | | | | |

Cups (8oz) of caffeinated beverages a day: _____

Average alcohol consumption per week: _____ ☐ History of alcohol addiction

Have you ever been exposed to industrial/chemical toxins at work or home? (e.g. factory, farming…) ☐ Yes ☐ No

What chemicals/what industry/how long?_____ When stopped? _____

Have you ever used weed killer or other agricultural chemicals? ☐Yes ☐No

Do your neighbors? ☐ Yes ☐ No ☐ No Idea

Do you use a coal stove/fire (either regular or 'smokeless' coal)? ☐ Yes ☐ No

Do your neighbors? ☐ Yes ☐ No ☐ No Idea

Do you live near any of the following (i.e. within 1 – 2 miles, OR further if downwind)

☐ Nuclear Plant ☐ Crematorium ☐ Industrial Zone ☐ Polluting Factory ☐ Golf Course
☐ Agricultural Area

Have you ever been exposed to any other known major environmental toxins? ☐ Yes ☐ No ☐ No Idea

Please explain: _____

## EMFS

Your home is a ☐ House ☐Apartment Which apartment floor? _____ How many stories? _____

How far is the nearest: Mobile phone mast _____ Electricity pylon _____ High power generator _____

Describe the view from your bedroom window: _____

Do you use: ☐ Cordless phone ☐Wifi ☐Electric: blanket, shaver, toothbrush ☐Protective devices ☐Magnets

Number of ____Fluorescent lights _____ Striplights _____ Long life (mercury) lightbulbs in your Home Office

Do any direct neighbors have a cordless phone? ☐Yes ☐No ☐No idea

Number in your home: TVs _____ Computers/Laptops _____

Check specifications of each: How many are "LCD"? _____ vs. "LCD/LED"? _____

If unsure, write here all TV and Computer brand names: _____

_____

Do you use a laptop **without** an external keyboard and mouse? ☐Yes ☐No

Do you use any phones: ☐Held to ear ☐Speakerphone function

Type of heating used in home: _____ Which room do power lines enter? _____

| | Average Hours of Use per **Day** |
|---|---|
| TV | |
| Computer or Tablet | |
| Mobile phone | |
| Landline phone | |
| In a motor vehicle | |

Devices in your bedroom: ☐TV ☐Computer ☐Clock radio ☐Lamp ☐Mobile phone ☐Other appliances

## TRAVEL

Have you ever travelled to remote regions (e.g. Asia, Africa, South America) ☐ Yes ☐ No

| Date | Destination | Health Incidents There or After? | Date | Destination | Health Incidents There or After? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |