



Renee Hartman Ph.D., IMD

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NEW PATIENT HISTORY AND LIFESTYLE INTAKE

In order for Dr. Hartman to completely evaluate your health status, please fill out the following pages. Be as *thorough* as possible. Fill out all sections; even ones that you do not think apply to you (except if specifically for male/female). This allows me to assess your metabolic, neurological, emotional, and structural imbalances.

HEALTH HISTORY

Name: _____ **DOB:** _____ **Date:** _____

Phone: _____ **Cell:** _____ **Email:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Gender:** Male Female

Occupation: _____ **Hours per week:** _____

Are you: _____ Married _____ Separated _____ Divorced
_____ Single _____ Widowed

Live with:
_____ Spouse _____ Parents _____ Alone
_____ Children _____ Partner _____ Friend(s)

Children's Ages: _____

Emergency Contact: (Name and Relation) _____

Contact's Phone Number: _____ 2nd Emg. Contact: _____ # _____

How did you hear about my clinic: _____

Would you like to receive emails? Y N Free Newsletters twice a year? Y N

Medical History:

What are your MOST important Health Challenges? List as many as you can

Have you consulted any other physicians or health practitioner? When and for what? _____

Diagnoses

List any diagnosis you have had (Example: high blood pressure, hypo or hyper thyroid, high cholesterol, diabetes, sleep apnea, cancer, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

List all doctors currently seeing: (If you have more than three physicians, please list the top three seeing)



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Primary doctor: _____ Phone #: _____

For what condition(s) are you seeing him/her? _____

Doctor #2: _____ Phone #: _____

For what condition(s) are you seeing him/her? _____

Doctor #3: _____ Phone #: _____

For what condition(s) are you seeing him/her? _____

Have you ever had any of the following tests?

- CAT Scan Date(s) _____ Area(s) _____ Reason _____
- MRI Date(s) _____ Area(s) _____ Reason _____
- Bone scan Date(s) _____ Area(s) _____ Reason _____
- X-Rays Date(s) _____ Area(s) _____ Reason _____
- Ultrasound Date(s) _____ Area(s) _____ Reason _____
- Bone density Date(s) _____ Area(s) _____ Reason _____
- EKG Date(s) _____ Area(s) _____ Reason _____
- Stress EKG Date(s) _____ Area(s) _____ Reason _____
- Other Test Type: _____ Date(s) _____ Area(s) _____ Reason _____
- Other Test Type: _____ Date(s) _____ Area(s) _____ Reason _____
- Other Test Type: _____ Date(s) _____ Area(s) _____ Reason _____

Date of your last blood work? _____ What Lab(s) did you get? _____

Have you had any Micronutrient testing, Cellular Micronutrient assay (CMA) etc.? Y N

Have you had any Cellular Nutrient Assay (CNA) done? Y N

Have you had any ALCAT, Food Sensitive Test, GI-Mapping, etc.? Y N

Have you ever had a stool test Y N Urine Test Y N or Saliva Test Y N What for? _____

Have you had a Glucose Tolerance Test? Y N Do you have normal A1C but high Glucose? Y N

What labs have you received recently (less than 6months)? _____

Blood Sugar Readings (if applicable)

What was your lowest reading in the past 3 months? _____

What was your highest reading in the past 3 months? _____

What was your blood sugar level today? _____

What was your last Hemoglobin A1C level? _____ Date Checked: _____

Have you been tested for Insulin Resistance? Y N

Current Medications (prescribed and over the counter) If needed complete on separate sheet.

- 1. _____ 4. _____ 7. _____ 10. _____
- 2. _____ 5. _____ 8. _____ 11. _____
- 3. _____ 6. _____ 9. _____ 12. _____

Do you think medications are helping? Y N Explain: _____

Are you having any side effects? Y N Explain: _____

Current Supplements (Vitamins, Herbs, etc.) If needed complete on separate sheet.

- 1. _____ 4. _____ 7. _____ 10. _____
- 2. _____ 5. _____ 8. _____ 11. _____
- 3. _____ 6. _____ 9. _____ 12. _____

Do you have any body parts that are not your own? (implants, transplants)?_ Y N

Surgery



Type of Surgery	Date	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations

Date	Hospital	How long?	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History (If unknown, write “unknown”).

Family member	Living?	How old?	List Any health conditions: cancer, thyroid, stroke etc.
Mom	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Dad	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Mat. Grandmother	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Pat. Grandmother	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Mat. Grandfather	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Pat. Grandfather	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Sibling	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Sibling	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Sibling	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____

Kids

Name	Age	Health Status	Living with you?
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>

Vaccination: Enter last year (if known) of any vaccinations you have had.

Tetanus (Td) _____ W/ Pertussis (whooping cough) _____ Varicella (Chicken Pox) shot or illness _____ MMR _____
 Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ Meningitis _____
 HPV _____ Covid (shot(s)) _____ # _____ Complications since CV shot(s)? Y N Explain: _____
 How many x's have you been told you have CV? _____

Do you know the shots cause reoccurrences & long CV? Y N List any other vaccines not covered: _____

Have you had any reactions to any vaccines that you know of? Y N Explain: _____

If you reacted, would you like to learn about a less –invasive way to stay protected? Y N

Do you have any legitimate /legal exemptions? Y N Circle: Permanent Medical / Temp Medical / Religious or Philosophical. Who gave you this exemption? _____ When given? _____

Have you heard of Homeopropexis (homeopathic immunizations -1st created)? Y N Want to? Y N

Do you get the flu shot? Y N How many times? _____ Have you reacted or got the flu after? Y N

When was your last Tetanus shot? _____ Have you gotten overseas vaccines? Y N If so, which ones _____

Allergies

Are you allergic to any medications or drugs? Y N Allergic to vaccines? Y N

If yes, list names and type of reaction. (Example: penicillin – rash) _____



Have you ever been tested for food allergies? Y N Are you a real celiac? Y N

Do you have any food allergies (i.e., lactose, gluten, nuts)? Y N

If yes, what foods? _____

Do any foods bother you? Y N (Example: tomatoes – reflux). If yes, what foods? _____

Do you have any environmental allergies? (Example: Dust, ragweed, animals)? Y N

Do you have any seasonal allergies? Y N Please list all you can think of _____

General Constitution

On a scale of 1 – 10 (with 10 being the highest/best):

What is your present energy level (without pushing yourself)? 1 2 3 4 5 6 7 8 9 10 High

What was your energy level 1 year ago? Low 1 2 3 4 5 6 7 8 9 10 High

What time of day do you have the most energy? _____ am/pm to _____ am/pm

What time of day do you have the least energy? _____ am/pm to _____ am/pm

On a scale of 1 – 10 (with 10 being the best):

How would you rate your endurance? Poor 1 2 3 4 5 6 7 8 9 10 Best

Do you suffer from fevers? Y N Chills? Y N

Do you feel any generalized weakness? Y N

Do you have swollen or painful lymph nodes? Y N If Yes, where at: _____

Do you heal slowly? Y N Do you bruise easily? Y N Do bruises stay for a while? Y N

Do you have difficulty stopping bleeding? Y N Are you anemic? Y N

Do you have excessive hair growth? Y N Are you losing your hair? Y N

Can you stand cold? Y N Heat? Y N Do you have cold hands or feet? Y N

Do you have night sweats? Y N Excessive sweating? Y N

Do you have Increased thirst? Y N Increased hunger? Y N

Weight/Height

Current Height: _____ feet _____ inches

Current Weight _____ lbs. Weight 1 year ago _____ lbs. Weight 5 years ago _____ lbs.

Is your weight going up or down or is it stabilized? Up Down Stabilized

What is the most you ever weighed as an adult? _____ lbs. Was this during pregnancy? Y N

Can you explain your weight changes? _____

How much weight would you like to lose in 6 months? Be realistic. _____

Unexplained weight loss/gain? Y N

Eyes/Vision

Do you ever get blurred vision? Y N When (Ex: computer, high blood sugars, etc.)? _____

Do you wear glasses? Y N Contacts? Y N Reading glasses? Y N

Do you ever get double vision? Y N When? _____ Last eye exam? _____

How is your night vision? Great Average Poor

Do you have an eye disease (i.e., glaucoma, cataracts, retinopathy)? Y N

What type? _____

Have you had any eye injuries? Y N Type and date: _____

Eye Infections? Y N Eye discharge? Y N Pain or irritation? Y N

Ears/Nose/Mouth/Throat

Did you or do you suffer from chronic sinus problems Y N

Do you have swollen glands in the neck? Y N Was any testing performed? Y N

Do you have any difficult swallowing? Y N Does food get stuck in your throat? Y N



Do you grind your teeth? Y N C-Pap? Y N Snore? Y N TMJ problems? Y N
Do you have mouth sores? Y N How many teeth are pulled? _____ Root Canals? _____
Do you have bleeding gums? Y N Do you have bad breath? Y N Bad taste? Y N
Does your voice change? Y N Do you get frequent hoarseness? Y N Either yes then how often? _____

Do you have amalgam or any metal fillings? Y N How Many? _____
Do you have speech difficulties? Y N Tourette's? Y N Stutter? Y N
Do you get sore throats? Y N How often? _____
Do you have any hearing loss? Y N Hearing aids? Y N
Did you or do you suffer from tinnitus? Y N What do you do? _____
Do you get earaches, infections, or drainage? Y N How often? _____
Do you get a stuffy or runny nose? Y N Dry nose? Y N Nose Bleeds? Y N

Hematologic/Lymphatic/Other

Have you ever been told you were anemic? Y N If so, which type? _____
Do you bleed easily? Y N
Have you ever had any blood clots? Y N Where? _____
Have you ever been told you have phlebitis? Y N
Have you ever had a blood transfusion? Y N Date(s) _____
Have you ever been diagnosed with a bleeding disorder? Y N

Cardiovascular System

Do you have high blood pressure? Y N Low blood pressure? Y N Get dizzy? Y N
Do you have a heart murmur? Y N Pounding or racing? Y N Difficulty breathing? Y N
Have you ever been diagnosed with heart disease? Y N What? _____
Have you ever had chest pains? Y N Date(s) _____ EKG performed? Y N
Do you ever get heart palpitations? Y N Irregular beat? Y N Butterflies? Y N
Have you ever had a stroke? Y N TIA? Y N Are you on medications for this: Y N
Have you ever been told you have mitral valve prolapse (MVP)? Y N Damage to heart valves? Y N
Do you have swelling in lower limbs? Y N Do you have leg pain? Y N Purple/discolored? Y N
Do you get shortness of breath? Y N When? (i.e., exertion, stairs) _____
Have you been diagnosed with: Myocarditis? Y N Pericarditis? Y N Angina? Y N
Pleurisy or Pleuritic Pain? Y N Inflammation of muscle, tissues, and/or membrane? Y N
Have you been diagnosed with Deep Vein Thrombosis (DVT)? Y N Does it hurt? Y N
Do you have varicose veins? Y N Do you have spider veins? Y N Do they hurt? Y N
Have you ever been diagnosed with an aortic aneurysm? Y N Heart Failure? Y N
Do you have plaque build-up in your carotid arteries? Y N Poor circulation? Y N
Any issues with: CNS: Y N PNS: Y N SNS: Y N ANS : Y N POTS: Y N
Have you ever spit up blood? Y N When? _____ How often? _____ Recently? Y N
Does your heart rate get really high? Y N Does your heart rate get really low? Y N
Do you have a pacemaker? Y N Heart Transplant? Y N Stents? Y N
Had atrial fibrillation (AFib)? Y N Diagnosed with heart or blood vessel disorders? Y N
Elevated levels of: Plasma (hyperproteinemia)? Y N C-Reactive Protein (CRP), Y N
Homocysteine (HCY)? Y N Myeloperoxidase (MPO) Y N Creatinine? Y N
HBS (Hyperglycemia) or LBS (Hypoglycemia) Y N BNP or NT-proBNP Y N
Cholesterol Levels: High Y N Normal Y N Low Y N Triglycerides: High Y N Normal Y N
Low Y N What other tests have you had done? _____

Sleep Patterns

If you work, what shift do you work? Day Afternoon Nights Start time: _____ End Time: _____
How many hours of sleep do you get? _____ How many do you think you need? _____
Describe how you fall asleep: Watch TV Read a book Go to Bed On cellphone Other _____
Do you have trouble falling asleep? Y N Trouble staying asleep? Y N



If yes, how long does it take you to fall asleep (give me a range: i.e., 15 -30 min.)? _____

If you awaken at night, do you have trouble falling back asleep? Y N How often? _____

If yes, how long until you to fall back to sleep (give me a range: i.e., 15 -30 min.)? _____

If you dream how often? _____ Do you remember your dreams? Y N

What time do you go to bed? _____ What time do you get up? _____

Are your sleep habits routine? Y N If not, why? _____

Do you have trouble waking up in the morning? Y N Sometimes

Do you feel well rested upon awakening? Y N Sometimes

When are you most awake and alert? From _____ am/pm to _____ am/pm

Do you get tired during the day? Y N Sometimes What times? _____

Do you get a second wind late at night when you want to stay up later? Y N Sometimes

If so, how many days per week? _____

Rate your sleep on a scale of 1-10 (with 10 being the best) 1 2 3 4 5 6 7 8 9 10 Best

Do you sleep with your phone in your room or next to your bed: Y N

Is your room darkened? Y N If so, can you see lights in your room? Y N

Do you watch TV up until you go to bed? Y N

Do you do anything relaxing before you go to bed? Y N

To you take any medication to help you fall asleep? Y N Does it work? Y N

Do you take any supplements, CBD or Hemp to sleep? Y N Does is help? Y N

How many hours are your sleep a night? _____ It is a daily routine? Y N

Do you know how to "reset" your circadian rhythm? Y N

Brain

Do you get Anxiety attacks? Y N Panic attacks? Y N How often? _____

Do you feel depressed? Y N Sometimes Do you have seasonal affective disorder? Y N

Have you ever been diagnosed with clinical depression? Y N When? _____

Do you have a hard time turning your mind off? Y N Are you an overthinker? Y N

Do you have nervousness? Y N Shakey? Y N Dizzy? Y N Feel Anxious? Y N

Do you have a high level of stressors daily? Y N Work _____ Home _____ Both _____

Have you ever been bulimic or anorexic? Y N Treatment: _____

Have you ever been diagnosed a schizophrenic or Bipolar? Y N Treatment: _____

Have you ever been diagnosed with ADHD OR ADD? Y N Treatment: _____

Have you ever been diagnosed with OCD? Y N Treatment: _____

Have you ever been diagnosed with PTSD: Y N Treatment: _____

Have you ever been diagnosed with Alzheimer's or Dementia? Y N Treatment: _____

Have you ever been diagnosed with any cognitive issues? Y N Treatment: _____

Have you ever had Traumatic Brain Injury? Y N When? _____ How old _____

Have you ever had a seizure? Y N How often? _____

Do you have bran fog? Y N Did is start or worsen after Covid and/or shot(s)? Y N

How is your short-term memory? Poor 1 2 3 4 5 6 7 8 9 10 Best

Are you forgetful? Y N How big of a problem is it? Mild Moderate Severe

How do you sleep? Poor 1 2 3 4 5 6 7 8 9 10 Best

Do you have trouble concentrating? Y N Do you forget easily? Y N

Do you get mentally exhausted throughout the day? Y N

Do you feel like you cannot get things done or tasks completed? Y N

Is you mind overly active in thoughts? Y N What do you do to help this? _____

Have you ever been diagnosed with any cancer or abnormality of the brain? Y N

If so, please explain: _____

Have you tried Transcranial Photobiomodulation Therapy? Y N Would you? Y N



Genitourinary

Any increase of urinary urgency? Y N If yes, for how long? _____
How many times do you urinate during the night? 1 2 3 4 5 6 Hourly
Do you have burning or painful urination? Y N Do you have blood in your urine? Y N
Do you have any urinary incontinence? Y N (i.e., get urinary leakage when you cough, laugh, etc.) If yes, how long? _____ Do you wear bladder leakage pads? Y N
Do you strain to empty your bladder? Y N Is there dribbling at the end of urination? Y N
How many UTI's, Cystitis (bladder infections) etc. have you had? _____
What color is your urine? _____ Does it smell bad? _____ Is it strong smelling? _____
Is your urine stream weaker than it used to be? Y N Do you leak urine at time? Y N
Have you ever had kidney stones? Y N # of times: _____ Infections? Y N
Have you ever been diagnosed with kidney disease? Y N What stage? _____
Kidney/Renal cancer? Y N What stage? _____ Did you undergo treatments? Y N
Bladder cancer? Y N What stage? _____ Did you undergo treatments? Y N
Adrenal cancer? Y N What stage? _____ Did you undergo treatments? Y N
If you've had cancer of the above, when was your last treatment(s)? Chemo _____ Radiation _____
Have you ever had hemorrhoids? Y N Did they bleed? Y N
Have you ever used Renelix? Y N Would you like to know more about it? Y N

Males Only

Do you have a decrease in morning erections? Y N
Difficulty achieving erections and/or maintaining an erection? Y N Recent? ___ Ongoing? ___
Have you ever been diagnosed with erectile dysfunction (ED)? Y N
Are you on medications for ED? Y N Type: _____ Dosage: _____
Is it helping? Y N Would you like a natural alternative? Y N
Do you avoid sexual activity because of physical problems? Y N Which? _____
Do you still enjoy sexual activity? Y N If not, why? _____
Do you have prostate trouble? Y N Enlarged? Y N BPH (benign prostatic hyperplasia)? Y N
Have you had your PSA checked? Y N If yes, date: ___/___/___ Results: _____
Have you had a prostate digital exam? Y N Date: ___/___/___ Results: Normal Enlarged
Have you ever had a sexually transmitted disease? Y N If yes, explain: _____
Do you have AIDS or HIV? Y N
What is the frequency of your present sexual activity? _____
Does your partner use hormone replacement therapy? Y N What type? _____
Ever had blood in your stool? Y N Change in bowels? Y N Abdominal pain/cramping? Y N
Have you ever been diagnosed with: Penile cancer? Y N Prostate cancer? Y N
Testicular cancer? Y N Rectal cancer? Y N (also known as colorectal cancer)

Both Male & Female: Have you ever had a sexually transmitted disease? Y N
Chlamydia Y N Gonorrhea Y N Herpes Y N Syphilis Y N Trichomoniasis Y N
Pelvic Inflammatory Disease (PID) Y N Mycoplasma genitalium (Mgen) Y N AIDS / HIV Y N
Bacterial Vaginosis (BV) Y N Scabies Y N Lymphogranuloma Venereum (LGV) Y N
Pubic Lice (crabs) Y N Chancroid Y N Human Papillomavirus (HPV) Y N Other _____

Females Only (Please fill out completely)

Age and year periods began (Onset of menarche) _____
Date of LMP (Last Menstrual Period) _____
Are you perimenopausal? Y N When did it start? _____ Age: _____
Do you have: Night sweats Y N Profuse sweating? Y N Mood Swings? Y N
How many days from start of one period to start of the next?
Early years _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
How many days does(did) your period last? _____ Is/has this been the norm? Y N



Is (was) your cycle regular? Y N Not Always
 Do (did) you pass any clots? Y N If yes, was it? mild moderate or severe
 Is (was) the flow: Heavy Medium Light
 How many pads _____ tampons _____ cup _____ are/were used on heavy days? _____
 Do you have cramps BEFORE your period? Y N If yes, how many days? _____
 Do you have cramps DURING period? Y N If yes, how many days? _____
 Do you have spotting (bleeding between periods)? Y N
 Have you ever had (circle all that apply)

Fibrocystic breasts Uterine Fibroids Endometriosis Genital Warts HPV
 Pelvic Inflammatory Disease Herpes Venereal disease Any Cancers

Do you do breast self-exams? Y N How often? _____
 Approximate age and year of menopause (if applicable) _____
 Do you have hot flashes? Y N #times during day _____ Mild Moderate Severe
 Do you have night sweats? Y N # during night _____ Mild Moderate Severe
 # per week: Hot flashes _____ Night sweats _____

Have you ever taken estrogen, progesterone, or hormone replacement therapy (HRT)? Y N
 Have you ever try or still using Bio-Identical Hormone replacement? Y N

Name of hormone	Dosage	Pill or Cream
_____	_____	_____
_____	_____	_____
_____	_____	_____

Approximate age and year of estrogen/HRT _____ For how many years? _____
 Are you still on HRT? Y N Does your partner use HRT? Y N
 Date of last mammogram and findings: Negative Positive For what? _____
 How many mammograms have you had in your life? _____ Last one done: _____
 Date of last pap test and result: Negative Positive For what? _____
 Do you get yeast infections? Y N If yes, how often? _____ Date of last one: _____
 Do you have pain/discomfort with sexual intercourse? Y N If yes, explain: _____
 Have you used an IUD? Y N If yes, what type? _____

Describe any problems with IUD: _____
 Have you used any form of Birth Control Pill, Patch or Shot? Please indicate which type & how long:
 Pill How long? _____ Shot How long? _____ Patch How long?: _____
 How old were you when you started birth control? _____ How many total years on birth control? _____
 Describe any problems while on Birth Control (i.e., weight gain)? _____

Do you find your present birth control method satisfactory for your health? Y N
 Have you ever been pregnant? Y N Are you pregnant now? Y N
 Number of Pregnancies: 1 2 3 4 5 6 7+
 How old were you during pregnancies? _____
 Describe any complications with pregnancies/deliveries? _____
 Did you breastfeed? Y N Bottle Feed? Y N How long? _____
 What is the frequency of your present sexual activity? _____

Gastrointestinal

Do you get bellyaches or stomach pain? Y N Abdominal pains? Y N IBS? Y N
 If yes, how many times? per week: _____ per month: _____ Mild Moderate Severe
 Do you get bloated after you eat? Y N Do you feel hungry all of the time? Y N
 If yes, when do you notice? 15 min. after meal 1 hour after meal 2+ hours after meal
 How long does it take to go away? _____
 When did this start? _____
 Do you pass gas? Y N Foul smelling? Y N Burping/belching? Y N
 Do you get heartburn/gastric reflux? Y N Hiatal hernia? Y N



Have you ever had ulcers? Y N What do you take? _____

Do you get nausea? Y N If so, when? _____

Do you have any vomiting? Y N If so, is there ever any blood in your vomit? Y N

Do you have liver problem? Y N Fatty Liver? Y N NAFLD Y N Cirrhosis Y N

Autoimmune hepatitis? Y N Hemochromatosis Y N Primary Biliary Cholangitis Y N

Have you ever had Jaundice? Y N When? _____ Age: _____ What was done: _____

Have you ever had hepatitis? Y N If yes, type: Hep. A Hep. B Hep. C

Have you ever had gallbladder problems? Y N Gallstones Y N Cancer Y N

Have you ever had your gallbladder removed? Y N Date(year): _____

Have you ever had any colon problems (i.e., Crohn's, colitis, diverticulitis, cancer, etc.)? Y N

Have you ever had appendicitis? Y N Did you have it removed? Y N

Have you ever had pancreatitis? Y N Pancreatic cancer? Y N

Have you ever had parasites? Y N What test did you do? _____

Have you ever noticed a loss in your appetite? Y N When? _____

Have you ever noticed an increase in your appetite? Y N When? _____

Have you ever been diagnosed with intestinal cancer(s)? Y N What were you diagnosed with: _____

How many rounds of: Chemo _____ Radiation _____

Did you have surgery? Y N What was done? _____

Bowel Movements

How many bowel movements do you have per day? _____ If not daily, how many per week? _____

Have you ever had blood in your stool? Y N If yes, how long? _____

If yes, what was the color of the blood? Bright red Darker color Pale stools

Are bowel movements painful? Y N How often? _____ per week _____ per month

Do you have hemorrhoids? Y N Are they painful? Y N Do you hurt right now? Y N

Are you more: Constipated Y N Have diarrhea? Y N Hard dry stools? Y N

Respiratory

Do you have a chronic cough? Y N Do you have coughing spells? Y N

Did you have coughing before or after COVID-19? _____ If you had CV is it worse? Y N

Do you spit up blood? Y N Mucus? Y N Color? _____

Have you had pneumonia? Y N # of times: _____ Last episode: _____

Do you have wheezing attacks? Y N

Have you had pleurisy (inflammation of the lung lining)? Y N When? _____

Do you have difficulty breathing? Y N

Diagnosed with asthma? Y N What medications are you taking? _____

Have you ever been diagnosed with emphysema or COPD? Y N

Do you get infections/illnesses easily? Y N

Have you had any cancers? Y N If so, what were you diagnosed with? _____

Do you have anaphylaxis? Y N How severe? _____

Do you take any over the counter medication for respiratory issues? Y N

Endocrine

Do you get sick or illnesses often? Y N

Do you have excessive thirst? Y N

Do you have depression and/or irritability? Y N

Does cold and/or cold weather bother you or are you sensitive to heat? Y N

Do your hands and feet get cold? Y N

Do you startle easily or do loud noises make you jump? Y N

Do you have dry skin, acne, or other skin conditions? Y N Mild Moderate Severe

Do you have any swollen glands? Y N Where? _____

Do you feel fatigued, tired, and/or exhausted? Y N



- Do you have weight problems? Y N
- Do you have vision problems or blurred vision? Y N
- Do you have adrenal fatigue or issues? Y N
- Do you have liver/gallbladder problems? Y N
- Do you have high blood sugar or high blood pressure? Y N
- Do you have Hypothalamus, pituitary or pineal gland problems? Y N
- Do you have hormone problems or imbalances? Y N
- Do you have anxiety or stress (moderate or high) in your life? Y N
- Do you have trouble sleeping, wake up in the night, or hard to fall asleep? Y N
- Do you exercise daily _____ once a week _____ twice a week _____ 3 or more x's _____?
- Do you live by field(s) with which they spray their crops? Y N
- Have you ever heard of HPA Axis? Y N
- Have you been diagnosed with any cancers of the endocrine system? Y N
- Have you had your cortisol levels checked? Y N If so, what was the level? _____
- Have you ever been diagnosed with chronic fatigue syndrome? Y N
- Have you ever been diagnosed with diabetes? Y N
- Have you ever been diagnosed with any inflammatory diseases? Y N
- Have you ever been diagnosed with any auto-immune diseases? Y N
- Have you ever had any thyroid and/or parathyroid gland problems? Y N
- Have you ever been told you have a goiter or nodule on your thyroid? Y N When? _____
- Have you ever been diagnosed with Hashimoto's Thyroiditis? Y N
- Have you ever been diagnosed with Hyperthyroidism or Hypothyroidism? Y N

Musculoskeletal

- Do you have a spinal curvature or scoliosis? Y N
- Do you have arthritis? Y N If yes, where? _____ What type? _____
- What is your pain level? Best 1 2 3 4 5 6 7 8 9 10 Worst
- Do you have joint pain? Y N What joints? _____
- What is your pain level? Best 1 2 3 4 5 6 7 8 9 10 Worst
- Does your joint pain move around (i.e., from knees to shoulder)? Y N
- Do you have muscle pain or cramps? Y N Where? _____
- Do you cramp when active? Y N What activity? _____
- Do you cramp when resting (i.e., in bed)? Y N
- Do you have any muscle/joint weakness? Y N
- Do you have difficulty walking? Y N If yes, why? _____

Neurologic

- Do you get or have headaches frequently? Y N When: Morning Y N Afternoon Y N All day Y N and/or Migraines? Y N How many per week? _____ Per month? _____
- Have you ever had a seizure? Y N When did they start? _____ Meds taking: _____
- Do you feel you have lost coordination? Y N Lost of balance? Y N
- Do you experience numbness or tingling? Y N If so, where? _____
- Do you feel you have tremors? Y N When did it start? _____ What are you doing for it? _____
- Have you ever had a head injury? Y N Concussion? Y N How many? _____ TBI? Y N
- Have you ever had: A stroke or TIA? Y N MS Y N Cerebral or Bell's palsy Y N Ataxia Y N
- Vascular diseases Y N Neurodegenerative diseases Y N Brain Tumor Y N Guillain-Barre Y N
- Restless leg syndrome Y N Muscular dystrophy Y N Spinal cord injury Y N Parkinsons Y N
- Cerebrospinal Fluid leakage Y N Chiari malformation Y N Hydrocephalus Y N Dementia Y N
- Alzheimer's Disease? Y N Amyotrophic lateral sclerosis Y N Lou Gehrig's disease (ALS) Y N
- Do you get dizzy? Y N Do you have spinning? Y N Blurred vision? Y N
- Do you get lightheaded? Y N Does it happen if you stand up too quickly? Y N



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Do you have fainting spells? Y N Difficulty speaking or swallowing? Y N

Are you slow to heal after cuts? Y N

Have you ever had cancer? Y N Type(s): _____

Have you ever had infectious MONO? Y N Meningitis? Y N

Integumentary (Skin/Breast)

Do you have any rashes? Y N Where? _____

Do you have an itching or crawling sensation? Y N Where? _____

Do you have any of the following on your body? (Circle all that apply)

Hives Eczema Psoriasis Open Wounds Lesions Ulcers

Do you have any bumps, warts, skin tags, or other skin growths? Y N

Do you have loss of skin pigment? Y N

Does your skin peel easily when sunburnt and/or peel without having a sunburn? Y N

Do you have pain, bleeding, swelling, redness or blistering anywhere on your body? Y N

Do you have any changes in skin color? Y N

Is your hair thinning? Y N If so, how severe is the problem? Mild Moderate Severe

Do you have fungus on your toenails? Y N Finger nails? Y N

Do you have brittle nails (nails that break easy)? Y N

Do you have any damage on your body from intense heat, radiation, chemicals etc.? Y N

Have you been diagnosed with dehydration or electrolyte imbalance? Y N

Have you been diagnosed with kidney/renal or circulatory issues or failures? Y N

LIFESTYLE HISTORY

On a scale of 1 to 10 with 10 being the most willing to do what you need to in order to achieve optimal health. Mark the number that best describes your motivation to:

Significantly modify your diet? Least 1 2 3 4 5 6 7 8 9 10 Most

Take nutritional supplements or patches daily? Least 1 2 3 4 5 6 7 8 9 10 Most

Keep a record of everything that you eat? Least 1 2 3 4 5 6 7 8 9 10 Most

Modify your lifestyle (diet, sleep, habits)? Least 1 2 3 4 5 6 7 8 9 10 Most

Practice relaxation techniques? Least 1 2 3 4 5 6 7 8 9 10 Most

Engage in regular exercise? Least 1 2 3 4 5 6 7 8 9 10 Most

Have periodic lab tests to assess progress? Least 1 2 3 4 5 6 7 8 9 10 Most

At the present time, how supportive do you think people in your household will be to your implementing the above changes? Least 1 2 3 4 5 6 7 8 9 10 Most

Where do you think you will be health-wise in 1 year if you DO NOT get help now? _____

Where do you think you will be health-wise in 5 years if you DO NOT get help now? _____

How motivated are you doing what it takes to move forward? Somewhat or Completely

Is health your top priority? Y N If no, why? _____

How serious are you about doing what it takes to get better? (circle below)



Tobacco

Do you currently use tobacco? Y N If yes, complete the below

cigars # per day _____ How many years? _____

cigarettes # packs per day _____ # per week _____ How many years? _____

chewing tobacco how many times in a day? _____ How many years? _____

vaping # per day _____ How many years? _____

pipe tobacco # per day _____ How many years? _____

hookah (waterpipes) # per day _____ How many years? _____

nicotine pouches # per day _____ How many years? _____

E-cigarettes (different from vaping) # per day _____ How many years? _____

Have you ever tried to quit the use of tobacco? Y N How many times? _____ Stopped? _____

Did you ever use tobacco? Y N When? _____ How long? _____ How much? _____

Were you (or are you) exposed to second-hand smoke (home, work etc.)? Y N

Do you use recreational drugs (i.e., marijuana, cocaine, etc.)? Y N

Beverages – Liquids:

Water: How many ounces of water (by itself) do you drink per day? _____

What type of water? Filtered City / Well Spring Distilled Reverse Osmosis

Milk: Do you drink milk? Y N Type: Skim 1% 2% Whole Soy Almond Other

How many glasses per day? _____ Per week? _____

Decaffeinated Beverages: Do you drink any caffeine-free beverages? Y N

Type: Decaf Coffee Y N How many cups? _____ Day _____ Week _____

Decaf – Herbal Tea Y N How many cups? _____ Day _____ Week _____

No-Caffeine Sodas Y N How many cups? _____ Day _____ Week _____

Caffeinated Beverages: Do you drink any caffeinated beverages? Y N Organic? Y N

Type: Coffee: How many cups? _____ Day _____ Week & What type? _____

Tea: How many cups? _____ Day _____ Week & What type? _____

Energy Drinks: How Many _____ Day _____ Week & What type? _____

Soda/Diet Soda: How many cups? _____ Day _____ Week _____

Name(s) of soda: _____

Alcohol: Do you consume any alcoholic beverages? Y N

Type	# per Day	# Per Week	# Per Month	# Per Year
Beer <input type="checkbox"/>	_____	_____	_____	_____
Wine <input type="checkbox"/>	_____	_____	_____	_____
Mixed Drinks <input type="checkbox"/>	_____	_____	_____	_____
Whisky, Rum etc. <input type="checkbox"/>	_____	_____	_____	_____

Exercise Habits

Are you doing any type of exercise? Y N Consistently? Y N

What type (ex. swimming, walking, aerobic, weights)? _____

Type	# times per week	Length of time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dietary Patterns:

Were you as an Infant: Breast Fed? Y N or Bottle Fed (infant formula)? Y N

Delivery: Vaginal? Y N C-Section? Y N



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Childhood Diet: Standard? Y N Vegetarian? Y N Other? explain) _____

Teenager Diet: Standard? Y N Vegetarian Y N Other? (explain) _____

Present Diet: Standard? Y N Vegetarian Y N Other? (explain) _____

What diet to you follow? Paleo ___ Keto ___ Weight Watchers ___ Mediterranean ___

DASH ___ Cancer ___ Diabetic ___ Intermittent Fasting ___ Plant-based ___

Atkins ___ Zone ___ Blood Type ___ South Beach ___ Gluten-free ___

HCG ___ Raw Food ___ Low Carb ___ High Protein ___ Other _____

How many meals do you eat per day? _____

What % of your meals are eaten at home? _____% Do you steam your veggies? Y N

What % of the food you eat is cooked? _____% What % is raw? _____%

Do you eat/consume any: Soy/tofu products? Y N If yes, how often? _____

Do you eat fast food? _____% Do you eat at restraints? _____% Gas stations? _____%

Do you eat fish? Y N How often? _____ Cooked ___ Fried ___ Baked _____

Do you use protein powders? Y N What do you use? _____

How many meals are replaced with protein powder or bars? _____

Do you eat snacks? Y N How often? _____ What time of day/night? _____

What types of snacks do you eat: _____

Do eat desserts? Y N How often? _____ Type: _____

Do you crave sweet things? Y N Do you crave salty things? Y N Sour taste? Y N

Do you have diagnosed food allergies, sensitivities or intolerances? Y N

What are the diagnosed: _____

What foods or mixtures do you avoid and why do you avoid them? _____

Do you have food cravings? Y N . If so, which foods or type of foods do you usually crave?

Do you eat processed and/or ultra processed foods? Y N How often? _____

How much veggie to you eat daily? _____ Fruits ___ Simple Carbs ___ Complexed ___

Whole Grains ___ Dairy ___ Fats ___ Healthy Fats ___ Animal Meat ___

Lean Meats ___ Saturated Oils ___ Healthy Oils ___ Fiber ___ Sugars ___

Artificial Sugars/sweeteners ___ Nuts ___ Nut milks ___ Tofu ___ Soy products ___

What type of sugar are you using? _____ How often? _____ Do you know sugar affect your body

in several ways and refined, artificial sugars etc. feed cancer cells & tumors? Y N

Do you use any nutritional supplements or patches? Y N What are you taking? _____

Additional Information: Is there anything you would like to add that I did not ask you?

Emotional:

Are you generally in a good mood? Y N Do you get upset easily? Y N

Have you noticed any changed in your mood? Y N Recently? Y N

Has anything happened recently that's been affecting your emotions? Y N



If yes, please explain: _____

Do you feel overwhelmed? Y N Please explain: _____

Are you stressed? Y N Please explain: _____

What helps you feel better when you're feeling down? _____

Do you feel happy, sad, anxious, or angry? (circle) Why? _____

Is there something specific bothering you in your life? _____

Do you feel like speaking about anything to me today? Y N Maybe another time: _____

What do you do to manage your stress? _____

Who do you normally speak to when you have these feelings? _____

Do you get offended easily? Y N

Are you around critical and negative people or positive, uplifting, and encouraging people? (circle)

What is a "safe place" for you? _____

Have you had thoughts of suicide? Y N Do you today? Y N

Are you seeing a counselor? Y N Are they helping you? Y N

Mindfulness:

Do you have a way to relax at home? Y N

How do you relax? _____

Do you know that lights stimulate you? Y N

Do you know that blue light is not good for you? Y N

Do you know amber lights help your body relax at night time and help you sleep better? Y N

Do you know EMF is toxic and can make you sick? Y N

Do you know you should go to bed at a certain time? Y N

Do you know you should wake up at a certain time? Y N

Do you know you should go outside daily? Y N

Do you like to take walks? Y N What's best: nature _____ woods _____ park _____ other _____

Do you know that your water could be toxic for you? Y N

Have you ever gone to www.EMG.org to check your water in your location? Y N

Do you know there are 5 domain nutrients? Y N

Do you know how many hours you should sleep soundly daily? Y N

Do you know it's not good or ideal to exercise after 6pm? Y N

Do you know there are things you can do to quiet your mind before bed? Y N

Would you like to learn about any of the above? Y N

Questions:

Why did you come today? _____



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What are you expecting me to do for you? _____

Health Goals:

What are your health goals? Be specific and realistic!

Examples: more energy, better sleep, reduced medications, weight loss, improved digestion etc.

1. _____
2. _____
3. _____
4. _____
5. _____

Thank you for taking time to fill this out. I look forward to getting to know you better and helping you heal from the inside out!

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