

LIFE EXTENSION CENTER
425 Main Street
Ridgefield, Connecticut 06877
Phone (203) 431-6165
Fax (203) 431-6167

LIFE EXTENSION CENTER
2505 Boulevard of the Generals
Norristown, Pennsylvania 19403
Phone (203) 431-6165
Fax (203) 431-6167

Patient's Name _____ Sex _____ Age _____

Height _____ Weight _____ Date _____

Please bring this in with you on your first visit; or mail it.

We would appreciate a 48 hour cancellation notice.

Your appointment is: _____

Patient Selection

At the Life Extension Center, we understand that many of our patients...

- Are unresponsive or are poorly responsive to the conventional standard of care.
- Have acute or chronic conditions which have not been fully explored or diagnosed with conventional approaches.
- Have conditions which can be managed, in part, by conventional medicine, but with continued progression of the disease process and deterioration in quality of life.
- Have conditions for which no conventional standard of care is currently available.

The Life Extension Center has limitations, as do all providers of medical care. In order to provide more effective care for our patients, we strive to accept those individuals we believe can benefit the most through our integrative medicine approach. Therefore, patient selection is a critical aspect of our progress. As a result, all prospective new patients are interviewed by our staff and screened to determine if they are appropriate candidates for treatment at the Life Extension Center.

QUESTIONNAIRE

Please circle (NO) or (YES) if you have had any of the following life changes within the last two (2) years.

- | | | | | | |
|---|----|-----|--|----|-----|
| 1. Death of spouse | NO | YES | 22. Major revision of personal habit..... | NO | YES |
| 2. Divorce..... | NO | YES | 23. Changing to a new school..... | NO | YES |
| 3. Marital separation..... | NO | YES | 24. Change in residence..... | NO | YES |
| 4. Death of close family member..... | NO | YES | 25. Major change in recreation..... | NO | YES |
| 5. Marriage..... | NO | YES | 26. Major change in church activities..... | NO | YES |
| 6. Marital reconciliation..... | NO | YES | 27. Major change in social activities..... | NO | YES |
| 7. Major change in health of family..... | NO | YES | 28. Major change in sleeping habits..... | NO | YES |
| 8. Pregnancy..... | NO | YES | 29. Major change in eating habits..... | NO | YES |
| 9. Addition of new family member..... | NO | YES | 30. Vacation in the last 3 months..... | NO | YES |
| 10. Major change in arguments with wife/husband.. | NO | YES | 31. Christmas in the last 3 months..... | NO | YES |
| 11. Son or daughter leaving home..... | NO | YES | 32. Minor violations of the law..... | NO | YES |
| 12. In-law troubles..... | NO | YES | 33. Being fire from work..... | NO | YES |
| 13. Wife/husband starting or ending work..... | NO | YES | 34. Retirement from work..... | NO | YES |
| 14. Major change in family get-togethers..... | NO | YES | 35. Major business adjustment..... | NO | YES |
| 15. Detention in jail..... | NO | YES | 36. Changing to different line of work..... | NO | YES |
| 16. Major personal injury or illness..... | NO | YES | 37. Major change in work responsibility..... | NO | YES |
| 17. Sexual difficulties..... | NO | YES | 38. Trouble with boss..... | NO | YES |
| 18. Death of a close friend..... | NO | YES | 39. Major change in working conditions..... | NO | YES |
| 19. Outstanding personal achievement..... | NO | YES | 40. Major change in financial state..... | NO | YES |
| 20. Start or end of formal schooling..... | NO | YES | 41. Mortgage or loan over 50,000..... | NO | YES |
| 21. Major change of living conditions..... | NO | YES | 42. Mortgage foreclosure..... | NO | YES |
| | | | 43. Mortgage or loan less than 50,000..... | NO | YES |

Please circle appropriate answer.

1. If female, are you pregnant?..... NO YES
2. Have you any of the following diagnosed health history problems?
 - Heart disease..... NO YES
 - Cancer..... NO YES
 - Diabetes..... NO YES
 - High blood pressure..... NO YES
 - Kidney problems..... NO YES
 - Obesity..... NO YES
 - Stroke..... NO YES
 - Arthritis..... NO YES
 - Periodontal disease (oral, gum and bone problems)..... NO YES
3. Have you had a family history of any of the following conditions?
 - Heart disease..... NO YES
 - Cancer..... NO YES
 - Diabetes..... NO YES
 - High blood pressure..... NO YES
 - Kidney problems..... NO YES
 - Obesity..... NO YES
 - Stroke..... NO YES
4. Are you now taking any of the following medications?
 - Antihypertensive (blood pressure)..... NO YES
 - Antidiabetic..... NO YES
 - Antibiotic..... NO YES
 - Anticancer..... NO YES
 - Antidepressants..... NO YES
 - Drugs for ulcers or stomach upsets..... NO YES
 - Sleeping pills or muscle relaxants..... NO YES
 - Oral contraceptives..... NO YES
5. Do you exercise at least three times per week?..... NO YES
6. Do you use a seatbelt when in a car?..... NO YES
7. Do you have a history of high blood pressure?..... NO YES
8. Are you currently under greater than normal amounts of stress?..... NO YES
9. Do you brush your teeth after meals?..... NO YES
10. Do you floss your teeth each day?..... NO YES
11. What is your average daily alcoholic drink consumption? (1 drink = 1 ounce hard liquor, 1 beer or 1 glass of wine)
 1. none 2. 1-2 drinks 3. 3-4 drinks 4. 5 or more drinks
12. How much do you smoke daily?
 1. none 2. less than 1/2 pack 3. less than 1 1/2 packs 4. greater than 1 1/2 packs
13. Please give the daily overall hours for the following (should equal 24 hours):
Sleep: _____ Rest: _____
Physical Activity: Vigorous _____ Moderate _____ Light _____ Sedentary _____
14. What is your daily coffee, tea or cola consumption?
 1. one cup _____ 2. two to three cups _____ 3. more than three cups _____

- 25. Is your tongue cracked, bluish-red in color, or very smooth (no bumps)?
1. no 2. slight 3. moderate 4. significant.....
- 26. Are your teeth and gums infected, loose, or subject to periodontal disease?
1. no 2. slight 3. moderate 4. significant.....
- 27. Have you had major surgery including hysterectomy, coronary bypass, mastectomy, or other cancer surgery?
1. no 2. yes.....
- 28. Do you have difficulty urinating due to pain or poor flow?
1. no 2. slight 3. moderate 4. significant.....
- 29. Do you have muscle weakness?
1. no 2. slight 3. moderate 4. significant.....
- 30. Do you have bloodshot eyes or a feeling of sand in your eyes?
1. no 2. slight 3. moderate 4. significant.....
- 31. Do you have redness at the corners of your nose or mouth, cracked lips, or dermatitis?
1. no 2. slight 3. moderate 4. significant.....
- 32. Do you often feel drowsy after eating or feel shaky before meals?
1. no 2. slight 3. moderate 4. significant.....
- 33. Do your ankles swell in hot weather or do you have hay fever?
1. no 2. slight 3. moderate 4. significant.....
- 34. Is your skin rough or bumpy, particularly on the back of your arms?
1. no 2. slight 3. moderate 4. significant.....
- 35. To your knowledge, have you ever passed albumin (protein) in your urine?
1. no 2. slight 3. moderate 4. significant.....
- 36. Do you have night thirst or night sweats or are you constantly thirsty?
1. no 2. slight 3. moderate 4. significant.....
- 37. Do you have a history of boils, sores that do not heal, or acne?
1. no 2. slight 3. moderate 4. significant.....
- 38. Do you feel lightheaded when you stand up quickly?
1. no 2. slight 3. moderate 4. significant.....
- 39. Do you have recurring vaginal or urinary infections?
1. no 2. slight 3. moderate 4. significant.....
- 40. Do you have a history of kidney stones or blood in the urine?
1. no 2. slight 3. moderate 4. significant.....

41. Any further information important to your health:
