

Life Extension Center

425 Main Street
Ridgefield, Connecticut 06877

(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 in. 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 (2) two 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 fired 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 responsibilities | 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
 - Kidney problems NO YES
 - High blood pressure 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
 - Kidney problems NO YES
 - High blood pressure 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 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 _____

PERSONAL ASSESSMENT QUESTIONNAIRE

Please place the appropriate number of your answer in the box to the right.

- 1. If female, do you have irregular menstrual periods or menstrual pain?
1. no 2. slight 3. moderate 4. significant
- 2. If female, do you have excess hair on your face, arms, or legs?
1. no 2. slight 3. moderate 4. significant
- 3. If male, are you subject to impotence, premature ejaculation,
or difficulty in maintaining an erection?
1. no 2. slight 3. moderate 4. significant
- 4. Do you have a history of a weight problem?
1. no 2. slight 3. moderate 4. significant
- 5. Do you have white spots under your fingernails or ridges in your nails?
1. no 2. slight 3. moderate 4. significant
- 6. Do you feel consistently cold or have cold hands and/or feet?
1. no 2. slight 3. moderate 4. significant
- 7. Do you have allergies, asthma, or a chronic sniffle?
1. no 2. slight 3. moderate 4. significant
- 8. Is it difficult for you to get started in the morning? Do you feel tired?
1. no 2. slight 3. moderate 4. significant
- 9. Do you have dryness of the hair or skin or persistent dandruff?
1. no 2. slight 3. moderate 4. significant
- 10. Do you get frequent colds or infections?
1. no 2. slight 3. moderate 4. significant
- 11. Are you subject to constipation?
1. no 2. slight 3. moderate 4. significant
- 12. Do you often have bloating, gas, or abdominal pain; particularly after eating?
1. no 2. slight 3. moderate 4. significant
- 13. Do you suffer from aching and/or stiffness of the muscles and joints?
1. no 2. slight 3. moderate 4. significant
- 14. Do you get headaches?
1. no 2. slight 3. moderate 4. significant
- 15. After walking, do you have chest pain, a heaviness in your legs, or feel short of breath?
1. no 2. slight 3. moderate 4. significant
- 16. Do you have frequent bad breath or bad tastes in your mouth?
1. no 2. slight 3. moderate 4. significant
- 17. Does your stool appear yellow or clay-colored, foul-odored, or contain undigested foods?
1. no 2. slight 3. moderate 4. significant
- 18. Do you have a history of anemia?
1. no 2. slight 3. moderate 4. significant
- 19. Do you have symptoms aggravated by worry and/or tension?
1. no 2. slight 3. moderate 4. significant
- 20. Are your eyes sensitive to light or dark?
1. no 2. slight 3. moderate 4. significant
- 21. Does your heart pound and are you easily "shaken up" or startled by an unexpected noise?
1. no 2. slight 3. moderate 4. significant
- 22. How long can you hold your breath?
1. 60 seconds 2. 30-60 seconds 3. 10-30 seconds 4. less than 10 seconds
- 23. Does your heart seem to miss beats occasionally?
1. no 2. slight 3. moderate 4. significant
- 24. At rest, what is your heart beat per minute?
1. < 60-75 2. 76-90 3. 91-110 4. > 110
- 25. Is your tongue cracked, bluish-red in color, or very smooth (no bumps)?
1. no 2. slight 3. moderate 4. significant

