



**THE KLEIN  
CENTER FOR  
Holistic Medicine**

IN ASSOCIATION WITH  
FMS METABOLICS

PLEASE FAX ALL FORMS  
INCLUDING WAIVERS  
TO 719-457-0860  
OR EMAIL TO  
[jill@kleinholisticcenter.com](mailto:jill@kleinholisticcenter.com)

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Blood Type: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Sex: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_ Age: \_\_\_\_\_ Frame size: Sm \_\_\_\_\_ Med \_\_\_\_\_ Lg \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

**Please check the answer that applies to each question. Leave blank any questions you wish to discuss only with the doctor. Do you have a history of:**

	Does Not Apply	Myself	Siblings	Parents	Grand- Parents
1. Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Liver disease (hepatitis, cirrhosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Psychiatric illness (depression, panic attacks, Schizophrenia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Autoimmune disease (Lupus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Endocrine gland abnormalities (thyroid, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Neurological disease (stroke, seizures, Parkinson's disease, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Lung disease (asthma, emphysema, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Kidney disease (stones, infections, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Stomach disease (ulcers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Bowel disease (malabsorption, lactose intolerance, diverticulitis, Crohn's disease, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Alcoholism, prescription, or rec. drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Weight control problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Carpal tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Surgical procedures? Please list all procedures you've had, including plastic surgery:

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23. Please list all drug allergies:

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24. Please specify all medications that you are currently taking, including hormones:

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

Name: \_\_\_\_\_ Dose(mg): \_\_\_\_\_ Times/Day: \_\_\_\_\_

25. Are you currently receiving:  Radiation therapy  Chemotherapy

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**The following questions refer to your current status:**

26. Marital status:  Single  Married  Divorced  Widowed

27. Number of children: \_\_\_\_\_ Number living in household: \_\_\_\_\_

28. Occupation: \_\_\_\_\_

29. Alcohol consumption, drinks / week: \_\_\_\_\_

30. Smokers: Currently smoking: \_\_\_\_\_ at \_\_\_\_\_ per day.  
(what)

Previously smoked: \_\_\_\_\_ at \_\_\_\_\_ per day.  
(what)

31. Current recreational drug use: \_\_\_\_\_

32. Coffee: cups/ day: \_\_\_\_\_ 33. Water, 8 oz. cups/ day: \_\_\_\_\_

34. Diet soda or other drinks with aspartame/ day: \_\_\_\_\_

**Are you experiencing the following symptoms to a degree that you consider substantial or unusual?**

	YES	NO
35. Headaches	<input type="checkbox"/>	<input type="checkbox"/>
36. Visual problems	<input type="checkbox"/>	<input type="checkbox"/>
37. Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
38. Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
39. Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
40. Allergy symptoms (nasal congestion, watery eyes, post nasal drip, etc)	<input type="checkbox"/>	<input type="checkbox"/>
41. Loss of smell or taste	<input type="checkbox"/>	<input type="checkbox"/>
42. Lumps in neck, armpits, groin or breast	<input type="checkbox"/>	<input type="checkbox"/>
43. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
45. Shortness of breath with exertion	<input type="checkbox"/>	<input type="checkbox"/>
46. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
47. Abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>
48. Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
49. Constipation (hard or effortful bowel movements)	<input type="checkbox"/>	<input type="checkbox"/>
50. Blood in stool or black stool	<input type="checkbox"/>	<input type="checkbox"/>
51. Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
52. Leaking urine	<input type="checkbox"/>	<input type="checkbox"/>
53. Genital discharge or sores	<input type="checkbox"/>	<input type="checkbox"/>
54. Urinating at night specify time / night: _____	<input type="checkbox"/>	<input type="checkbox"/>
55. Muscle, bone or joint pain Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

**Males Only**

	YES	NO
56. Ejaculation causing pain	<input type="checkbox"/>	<input type="checkbox"/>
57. Difficulty maintaining / attaining erection	<input type="checkbox"/>	<input type="checkbox"/>
58. Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>
59. Infertile	<input type="checkbox"/>	<input type="checkbox"/>
60. Low sperm count	<input type="checkbox"/>	<input type="checkbox"/>
61. Date of last prostate exam: _____		
62. Sexual drive underactive	<input type="checkbox"/>	<input type="checkbox"/>
63. Sexual drive overactive	<input type="checkbox"/>	<input type="checkbox"/>

**Females Only**

	YES	NO
64. Sexual drive Underactive	<input type="checkbox"/>	<input type="checkbox"/>
65. Sexual drive overactive	<input type="checkbox"/>	<input type="checkbox"/>
66. Missed periods	<input type="checkbox"/>	<input type="checkbox"/>
67. Pelvic soreness	<input type="checkbox"/>	<input type="checkbox"/>
68. Menstrual pain	<input type="checkbox"/>	<input type="checkbox"/>

69. Heavy Menstrual bleeding
70. Hot flashes
71. Infertile
72. Form of birth control:  None  Pill  IUD  Sponge  Diaphragm  
 Foam  Condom  Other: \_\_\_\_\_
73. Date of last: Menstrual period: \_\_\_\_\_ Breast exam: \_\_\_\_\_  
Pap smear: \_\_\_\_\_ Mammogram: \_\_\_\_\_

**Males and Females**

74. Date of last: Colonoscopy (or sigmoidoscopy): \_\_\_\_\_ Rectal exam: \_\_\_\_\_  
Stress EKG (treadmill stress test): \_\_\_\_\_ Chest x-ray: \_\_\_\_\_

75. Were any of the above tests abnormal? Please describe:

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76. **YOUR GOALS:** What are your most important expectations as a patient?

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**Current Exercise Summary**

77. How often do you engage in aerobic exercise (walking, jogging, biking, swimming)? Times / week: \_\_\_\_\_

78. Please describe your routine:

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79. How often do you engage in flexibility and/or stretching exercises (yoga, tai chi, stretch & toning classes, brief stretching after aerobics or weights)? Times / week: \_\_\_\_\_

80. Please describe your routine:

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81. How often do you participate in resistance/ strength training exercises (free weights, weight machines, body pump classes, water aerobics)? Times/ week:\_\_\_\_\_

82. Please describe your routine:

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### Fitness Activity Assessment

	YES	NO
83. Are you currently involved in an exercise program?	<input type="checkbox"/>	<input type="checkbox"/>
84. Have you ever been a member of a health club?	<input type="checkbox"/>	<input type="checkbox"/>
85. For how long? _____		
86. Are you currently a member of a health club?	<input type="checkbox"/>	<input type="checkbox"/>
87. Have you ever worked with a personal trainer?	<input type="checkbox"/>	<input type="checkbox"/>
88. If YES for how long? _____		
89. Are you still with a personal trainer?	<input type="checkbox"/>	<input type="checkbox"/>
90. If YES to 88, did you enjoy working with a trainer?	<input type="checkbox"/>	<input type="checkbox"/>
91. Do you have any exercise equipment at home?	<input type="checkbox"/>	<input type="checkbox"/>
92. If YES, what type? _____ _____ _____		
93. Are you presently receiving physical therapy?	<input type="checkbox"/>	<input type="checkbox"/>
94. If YES, please describe: _____ _____ _____		
95. If exercise is not part of your weekly routine, please explain why:		
<input type="checkbox"/> Unsure of what to do	<input type="checkbox"/> Physical limitations	<input type="checkbox"/> No motivation
<input type="checkbox"/> Lack of time	<input type="checkbox"/> Don't enjoy it	<input type="checkbox"/> Other: _____

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### Supplementation

96. Are you taking vitamins, minerals or herbs on a regular basis?  YES  NO

97. If Yes, please list what you taking or copy labels and send in with questionnaire.

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## Symptoms

Please check the box that best describes the following symptoms you might have:

	Never	Mild / Rare	Moderate / Occasional	Sever / Often
98. Water retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99. Inflamed or bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100. Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
101. Indigestion after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
102. Flatulence (gas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
103. Allergy or food sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
104. Please List:				

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105. Lactose intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
106. Dependency on antacids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
107. Toe and fingernail fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
108. Boils or Stys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
109. Vaginal Yeast infections (women)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
110. Jock itch (men)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
111. Difficulty in gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
112. Bad breath (no relief by brushing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
113. Body odor (no relief by washing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
114. Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
115. Energy loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
116. Decreased self-image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
117. Back or spine problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
118. Please describe:				

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119. Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
120. Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
121. Rapid mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
122. Impatient, moody, nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
123. Lack of mental alertness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
124. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
125. Dry, flaky, brittle hair and/or skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
126. Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
127. Hair thinning or falling out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
128. Premenstrual tension (female only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
129. Any other health issues that are causing you problems:				

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## Lifestyle Changes

**Review the events below. For each one indicate the number of times each event has occurred in the past 12 months.**

- |            |                                      |            |                                     |
|------------|--------------------------------------|------------|-------------------------------------|
| 130. _____ | Death of a spouse                    | 151. _____ | Change in responsibilities at work  |
| 131. _____ | Divorce                              | 152. _____ | Son or daughter leaving home        |
| 132. _____ | Marital separation                   | 153. _____ | Trouble with in-laws                |
| 133. _____ | Jail terms                           | 154. _____ | Outstanding personal achievement    |
| 134. _____ | Death of close family member         | 155. _____ | Spouse begin or stop work           |
| 135. _____ | Personal injury or illness           | 156. _____ | Begin or end school                 |
| 136. _____ | Marriage                             | 157. _____ | Change in living conditions         |
| 137. _____ | Fired at work                        | 158. _____ | Revision of personal habits         |
| 138. _____ | Marital reconciliation               | 159. _____ | Trouble with boss:                  |
| 139. _____ | Retirement                           | 160. _____ | Change in work hours or conditions  |
| 140. _____ | Change in health of family member    | 161. _____ | Change in residence                 |
| 141. _____ | Pregnancy                            | 162. _____ | Change in schools                   |
| 142. _____ | Sexual difficulties                  | 163. _____ | Change in recreation                |
| 143. _____ | Gain of new family member            | 164. _____ | Change in religious activities      |
| 144. _____ | Business readjustment                | 165. _____ | Change in social activities         |
| 145. _____ | Change in financial state            | 166. _____ | Change in sleep habits              |
| 146. _____ | Death of a close friend              | 167. _____ | Change in # of family get-togethers |
| 147. _____ | Change to different line of work     | 168. _____ | Change in eating habits             |
| 148. _____ | Change in # of arguments with spouse | 169. _____ | Vacation                            |
| 149. _____ | Mortgage over \$100,000              | 170. _____ | Religious holidays                  |
| 150. _____ | Foreclosure of mortgage or loan      | 171. _____ | Minor violations of the law         |

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## Physician Information

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Fax: \_\_\_\_\_

Address:

Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# B-12 Lipotropic Injections

I, \_\_\_\_\_, hereby certify that i understand that unless specified, this product has Sulfa in the Ingredients.

I do not have an allergy to this product.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# LIABILITY WAIVER AND DISCLAIMER

Dear Patient,

Here is a summary of some very important points that we need to convey to you. The points are brief and specific. They recap information already indicated in the Disclaimer and FAQ's in your Enrollment materials. It is necessary to include this in all patient files.

Please initial that you understand each of the following items:

- \_\_\_\_\_ I understand that there are no refunds for services or products.
- \_\_\_\_\_ I understand that charges incurred by the pharmacy for all medications are separate from the charge for clinical services.
- \_\_\_\_\_ I understand that the pharmacy will contact me for credit card information in order to charge for medications.
- \_\_\_\_\_ I understand that I must adhere to the clinical programs as indicated by my treatment plan.
- \_\_\_\_\_ I understand that I must have the appropriate medical consultations each time I go through this program.
- \_\_\_\_\_ I understand that there is absolutely no guarantee that the science of weight reduction and hormone therapies will be totally effective.
- \_\_\_\_\_ I release Dr. Klein, The Klein Center for Holistic Medicine, and FMS Metabolics from any/all medical and legal liabilities during this treatment.
- \_\_\_\_\_ The Klein Center for Holistic Medicine and/or FMS Metabolics can withdraw services at any time for any reason.

Please sign and return prior to enrollment. Thank you for your cooperation

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_