

Name: _____ Date: _____

GI Disorder - Part 1a

Primary Complaint: Abdominal Pain-Acid Reflux/GERD-Constipation-Crohn's-Celiac- Diarrhea-IBS-IBD-Ulcers-Vomiting-Other

Instructions: There are seven (7) pages of 'Fill-In' pdf forms. Please provide as much information as possible - this is your opportunity to tell me what has been occurring in the past, your current condition as well as concerns you have for your future should this condition continue.

Name most significant issue: _____

If previously diagnosed condition please name or mark from below your Primary Complaint.

Mark with "X" all abnormalities that occur simultaneously with your Primary Complaint:

- | | | | | | |
|-------------------------------------|-------------------------------------|--|--------------------------------------|--|--|
| <input type="checkbox"/> Balance | <input type="checkbox"/> Appetite | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Energy | <input type="checkbox"/> Addiction | <input type="checkbox"/> Injury (Past) |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Defecation | <input type="checkbox"/> Cardio | <input type="checkbox"/> Libido | <input type="checkbox"/> Attitude change | <input type="checkbox"/> Injury (Recent) |
| <input type="checkbox"/> Smell | <input type="checkbox"/> Digestion | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Menses | <input type="checkbox"/> Behavior change | <input type="checkbox"/> Fertility |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Thirst | <input type="checkbox"/> Skin | <input type="checkbox"/> Semen flow | <input type="checkbox"/> Cravings | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Swallowing | <input type="checkbox"/> Urination | <input type="checkbox"/> Sleep | <input type="checkbox"/> Excess naps | <input type="checkbox"/> Emotions | <input type="checkbox"/> Pain (physical) |
| <input type="checkbox"/> Taste | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Mental function | <input type="checkbox"/> Memory | <input type="checkbox"/> Twitching-Ticks | |
| <input type="checkbox"/> Touch | <input type="checkbox"/> Mucus flow | <input type="checkbox"/> Pain & Emotions | | | |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Swelling | | | | |

Is the current episode the first time this primary complaint has occurred? ☐ Yes ☐ No, it has occurred _____

When did the primary complaint become disruptive to your Activities of Daily Living or caused significant impairment?

How many days, weeks, months or years ago or the date.

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?

Indicate the number of days, weeks, months or years or the date.

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?

Indicate number of minutes, hours in a day or number of days/weeks

What do you think is the origin or cause of the primary complaint? _____

What provides relief to the primary complaint? _____

Mark with "X" all that apply:

Type of Pain or Sensation: Quality of Primary Complaint:

- | | | |
|------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Cramping | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Tightening | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stiffness | Trigger or Aggravates PC: |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Swelling | |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Heat | <input type="checkbox"/> Food <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Cold | <input type="checkbox"/> Physical activity |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Crawling | <input type="checkbox"/> Emotional upset |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Itching | <input type="checkbox"/> Stress <input type="checkbox"/> Beverage |

What provides relief of Pain or sensation? _____

Rate any related pain at it's most and least painfulness:

- ☐ 0 None
- ☐ 1 Mild - nagging, annoying, interferes little with ADLs
- ☐ 2 Mild - nagging, annoying, interferes little with ADLs
- ☐ 3 Mild - nagging, annoying, interferes little with ADLs
- ☐ 4 Moderate - Interfere's significantly with ADLs
- ☐ 5 Moderate - Interfere's significantly with ADLs
- ☐ 6 Moderate - Interfere's significantly with ADLs
- ☐ 7 Severe - Disabling, unable to perform ADLs (need med's)
- ☐ 8 Severe - Disabling, unable to perform ADLs (need med's)
- ☐ 9 Severe - Disabling, unable to perform ADLs (need meds)
- ☐ 10 Severe - Disabling, unable to perform ADLs (need hospital)

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.

Example: John_Doe_GI Disorders Part 1a

Date_____

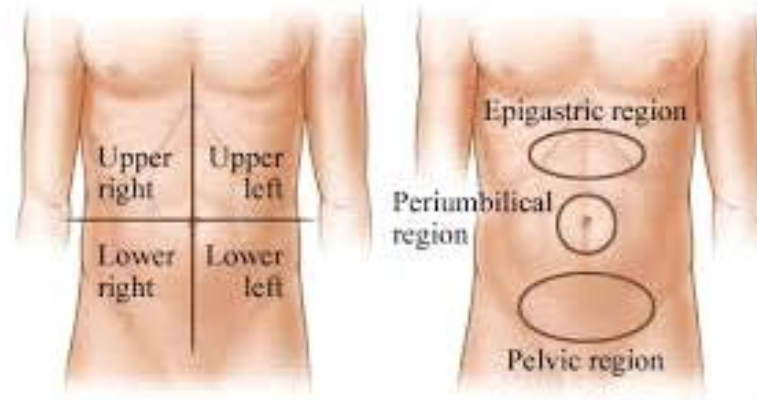
GI Disorders - Part 1b

Primary Complaint: Abdominal Pain-Acid Reflux/GERD-Constipation-Crohn's-Celiac- Diarrhea-IBS-IBD-Ulcers-Vomiting-Other

Instructions: Please write the symptom(s) “number” on the drawings at location of most frequent occurrence.

Symptoms

- 1 Cold
- 2 Heat or Hot
- 3 Pain
- 4 Excess abdominal noises
- 5 Swelling
- 6 Hard masses
- 7 Discomfort relieved w/pressure
- 8 Discomfort increased w/pressure



- ☐ Belching
 - ☐ Acid reflux
 - ☐ Hiccups
 - ☐ Cramp or rectal spasm when defecating
 - ☐ Sweat, Chills or Feverish before defecating
 - ☐ Nausea relieved by defecating
 - ☐ Require more than 5 minutes to defecate
- If so, how many minutes? _____
- ☐ Must use finger to expel feces
 - ☐ Anal tears after defecating
 - ☐ Anal burning sensation

Bristol Stool Scale 1-7: _____

Stool color Scale 1- 6: _____

Do your stools contain:

Blood ☐ No ☐ Yes

Black grit ☐ No ☐ Yes

Green water ☐ No ☐ Yes

Undigested food ☐ No ☐ Yes

Worms ☐ No ☐ Yes

- ☐ Excessive foul odor
- ☐ Float in or atop toilet water
- ☐ Sink to bottom of toilet

Urine Color Scale 1-8: _____

Urinate more than 5 time daily? ☐ No ☐ Yes

Urine Characteristics:

Bloody ☐ No ☐ Yes

Clear ☐ No ☐ Yes

Cloudy ☐ No ☐ Yes

Sandy-gritty ☐ No ☐ Yes

Pungent ☐ No ☐ Yes

Anmonia-like ☐ No ☐ Yes

Sweet-fruity ☐ No ☐ Yes

Egg-sulfur-like ☐ No ☐ Yes

Did you have any contact or handle:

- ☐ Dogs, cats, hamster, gerbils, guinea pigs, etc?
- ☐ Reptiles: snake, iguana, lizards, turtles, etc?
- ☐ Avian: birds, ducks, geese
- ☐ Equine: horse, pony, donkey, mule?
- ☐ Food animal: pig, cattle, sheep, goat, chicken?
- ☐ Pet food, pet treats, rawhide chews?
- ☐ Water: pond, lake, river, streams, cisterns, livestock water troughs or containers, farm irrigation, well water, municipal water?

Is someone else in your home sick and is vomiting or diarrhea? ☐ Yes ☐ No

Did you stay in another's home, hotel, motel,
camping overnight? ☐ Yes ☐ No

Describe the your bowel habits and the symptoms marked above:

[illegible]

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.

Example: John Doe GI Disorder Part 1b

Name: _____ Date _____

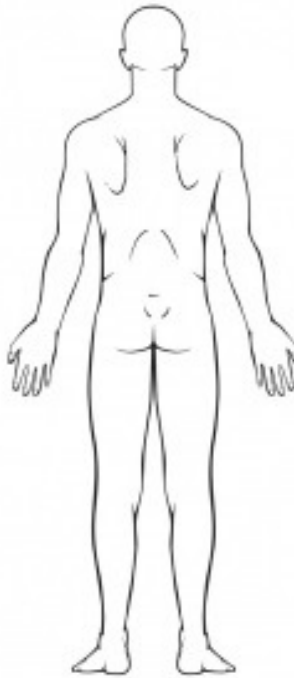
GI Disorders- Part 1c

Primary Complaint: Abdominal Pain-Acid Reflux/GERD-Constipation-Crohn's-Celiac- Diarrhea-IBS-IBD-Ulcers-Vomiting-Other

Instructions: Please place a "Number" on the area of the Primary Complaint and/or the associated symptoms.



Front



Rear



Right



Left

Describe the Pain or Sensation you experience at the locations marked above. List them by their "Number".

[illegible]

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.

Example: John_Doe_GI Disorders Part 1c

Name: _____ Date _____

Use the next four (4) pages to embellish upon the details of your Primary Complaint and Life Experiences.

GI Disorders - Part 2

Primary Complaint: Abdominal Pain-Acid Reflux/GERD-Constipation-Crohn's-Celiac- Diarrhea-IBS-IBD-Ulcers-Vomiting-Other

Instructions: The Day Your GI Disorder became disruptive to your ADL or caused significant impairment

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order starting with the morning of and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

Please identify the date. This does not have to be an exact calendar date – it can be ‘mid-November 2011’, or sometime in the summer of 2009, or it might be as specific as the morning of New Year’s Day 2012. Then describe the following:

- where you were located when you noticed the problem (or a medical diagnosis that was given),
- how you felt and any pain and/or emotional responses
- what ADL you could not do or what bodily functions were significantly impaired
- the duration of the symptom(s) and characteristics (qualities)
- anything that seemed to make it worsen or improve it
- any observations by other people of your behavior, emotions or physical condition

Date your GI Disorder or associated symptoms became disruptive to your ADL or caused significant impairment:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.

Example: John Doe GI Disorders Part 2

Name: _____ Date _____

GI Disorders - Part 3

Primary Complaint: Abdominal Pain-Acid Reflux/GERD-Constipation-Crohn's-Celiac- Diarrhea-IBS-IBD-Ulcers-Vomiting-Other

Instructions: Your Life Prior to the Day the GI Disorder became disruptive to your ADL or caused signif-icant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back to the earliest date when you noticed the GI Disorder and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be ‘mid-November 2011’, or sometime in the summer of 2009, or it might be as specific as the morning of New Year’s Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your GI Disorder became disruptive to your ADL or caused significant impairment. These events include:
travel in or outside the USA or Canada moving your home changing jobs marriage divorce separation
pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters
child rearing problems children leaving home for college child custody illness accidents incarceration
institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date of earliest recall of GI Disorder or associated symptoms:

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If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.

Example: John Doe GI Disorders Part 3

Name: _____ Date _____

GI Disorders - Part 4

Primary Complaint: Abdominal Pain-Acid Reflux/GERD-Constipation-Crohn's-Celiac- Diarrhea-IBS-IBD-Ulcers-Vomiting-Other

Instructions: Your Life 1 year Prior to the Earliest Date you noticed the GI Disorder or associated symptoms cited in Part 3.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back 1 year prior to the earliest date when you noticed the GI Disorder and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be ‘mid-November 2011’, or sometime in the summer of 2009, or it might be as specific as the morning of New Year’s Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your GI Disorder became disruptive to your ADL or caused significant impairment. These events include:
travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation
pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters
child rearing problems children leaving home for college child custody illness accidents incarcerated
institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date 1 year prior to the earliest recall of the GI Disorder or associated symptoms:

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If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.

Example: John Doe GI Disorders Part 4

Name: _____ Date _____

GI Disorders - Part 5

Primary Complaint: Abdominal Pain-Acid Reflux/GERD-Constipation-Crohn's-Celiac- Diarrhea-IBS-IBD-Ulcers-Vomiting-Other

Instructions: Your Symptoms and Actions since the day your GI Disorder or associated symptoms became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Describe to best of you abilities the chronological sequences of the following starting from the Day the GI Disorder or associated symptoms became disruptive to your ADL or caused significant impairment through to today. Include the following:
 - changes of the symptoms over time (duration, intensity, improvements, worsening, etc)
 - the actions you have employed to treat the problem via MD, ND, DO, DC, LAc, PT and other therapists as well as home remedies. Include the diagnosis, therapies, medications and natural remedies (herbs, homeopathy, nutritional) that have been used. Include any and all improvements or worsening of the problem/condition due to any of the actions you employed.
- Include the events of your life that occurred during this time period. These events include:
 travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation
 pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters
 child rearing problems children leaving home for college child custody illness accidents incarcerated
 institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Symptoms and Actions since the GI Disorder or associated symptoms became disruptive to ADL or causative to significant impairment:

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.

Example: John Doe GI Disorders Part 5