Castle Rock Natural Health
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Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (Fax) _____ (Email) _____

Date of Birth _____ Sex: M F Marital Status: S M D W # Children _____

Blood Type _____ Nationality/Heritage _____

Occupation _____ Referred by: _____

Current Symptoms:

1) _____

2) _____

3) _____

Health History (childhood health, family patterns, surgeries - including tonsillectomy, etc. Use backside if needed)

_____

_____

_____

Have you ever had a head injury and/or concussion? _____YES _____NO If yes, please explain:

_____

Do you have or have you ever had mercury fillings? ____YES ____NO

_____

Desired Outcome/Goals:

1) _____

2) _____

3) _____

I, _____, understand that nutritional results may vary and information and statements made are for educational purposes and not intended to replace the advice of your Physician. Castle Rock Natural Health does not dispense medical advice, prescribe or diagnose illness. The views and nutrition advice expressed by Dr. Mulkin and Castle Rock Natural Health are not intended to be a substitute for conventional medical service. If you have a severe medical condition or health concern, please contact your physician.
All tests at this office are released ONLY after your follow up consultation with Dr. Mulkin and must be paid in full before copies are released.
I will give a 24-hour notice of my need to cancel or will be charged according to the appointment time I make.

Patient's Signature _____ Date _____

SUBSTANCE SURVEY FORM

Circle any of the medications you are taking:

- Antacids	- Aspirin/Tylenol	- Heart Medications	- Laxatives	- Thyroid
- Antibiotic/Fungal	- Chemotherapy	- Blood Pressure	- Oral Contraceptives	- Ulcer Med
- Antidepressants	- Cortisone/Anti-inflammatory	- Hormones	- Relaxants/ Sleeping Pills	- Other _____

Elaborate below, listing any additional prescription medications you are currently taking or have taken in the last year:

Medications & how long taken	Diagnosis

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product	Symptom	Quantity & Frequency

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year. (Use other side if needed) If currently taking, please bring them in with you as well.

Product	Amount Taken Daily	How Long Taken

Check the following items which apply to you and indicate the amount used:

☐ Coffee	_____	☐ Antacids	_____	☐ Alcohol	_____
☐ Tea	_____	☐ Laxatives	_____	☐ Cigarettes	_____
☐ Soft Drinks	_____	☐ Candy	_____	☐ Other Tobacco Products	_____
☐ Artificial Sweetener	_____	☐ Ice Cream	_____		

How many desserts do you have in an average week? _____

Daily Patterns:

What are the typical daily choices as to what you eat and drink? Please be specific. The more information that I have, the better I can help you. For example: list the timing of your meals, how often you might skip them, what kinds of proteins, breads, vegetables, fruits, drinks, salad dressings & sweeteners that you use, etc.

I get up at: _____ a.m.

Breakfast: _____ a.m.

Eat: _____ Drink: _____

Mid-morning snack: _____ a.m.

Eat: _____ Drink: _____

Lunch: _____ a.m./p.m.

Eat: _____ Drink: _____

Mid-afternoon snack: _____ p.m.

Eat: _____ Drink: _____

Dinner: _____ p.m.

Eat: _____ Drink: _____

Evening Snack: _____ p.m.

Eat: _____ Drink: _____

Do you use salt? ___ yes ___ no Brand of salt: _____

Any patterns or challenges with foods? Do certain foods upset you? Why?

_____

_____

_____

I go to bed at: _____ p.m./a.m.

Do you sleep well? _____ Are you waking up during the night, if so, when? _____

_____

Energy patterns throughout the day (highs & lows):

_____

Bowel movement patterns:

How often: _____

Color & Consistency (i.e., firm, loose, diarrhea)? _____

Do they sink or do they float? _____

Urinary Patterns:

Does it feel appropriate to the amount that you drink? _____

Any incontinence or dribbling? _____

Are you up at night to go to the bathroom? _____

Exercise: Type	Length of time performing exercise	# Times/Week

Women:

Height_____ **Weight** _____If weight loss is desired, what is your goal weight? _____
Menstrual periods: cycle every _____ days, period lasts _____ days.
Do you have PMS or menstrual discomfort? ____irritability ____ fatigue ____ bloating ____ cramps
Any other ? _____
Do you use birth control pills? If so, what brand and for how long? _____
Do you use or have you had an IUD _____ If so, is/was it copper? _____
Cysts, fibroids, endometriosis or abnormal paps? _____
Menopause - _____ years. Any hormonal discomfort? _____
Hysterectomy _____ How long ago? _____ Total or partial? _____
Reason for hysterectomy? _____

Men:
Height_____ **Weight**_____
Prostate concerns/issues: _____

Work Habits (i.e.: hours you work, does it involve traveling, etc.):

SYSTEMS SURVEY FORM

Client _____ Clinician _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male .. Female ..

Pulse: Recumbent _____ Standing _____ Vegetarian .. Gluten-free ..

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ..

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurs rarely).
○ ● ○ MODERATE symptoms (occurs several times a month).
○ ○ ● SEVERE symptoms (occurs almost constantly)
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Gag occasionally
8	○	○	○	Unable to relax; startles easily
9	○	○	○	Extremities cold, clammy
10	○	○	○	Strong light irritates
11	○	○	○	Occasionally weak urine flow
12	○	○	○	Heart pounds after retiring
13	○	○	○	"Nervous" stomach
14	○	○	○	Appetite reduced occasionally
15	○	○	○	Cold sweats often
16	○	○	○	Get heated easily
17	○	○	○	Nerve discomfort
18	○	○	○	Staring, blinks little
19	○	○	○	Sour stomach frequent
				GROUP 2
20	○	○	○	Joint stiffness on arising
21	○	○	○	Muscle-leg-toe cramps at night
22	○	○	○	"Butterfly" stomach, cramps
23	○	○	○	Eyes or nose watery
24	○	○	○	Eyes blink often
25	○	○	○	Eyelids swollen, puffy
26	○	○	○	Indigestion soon after meals
27	○	○	○	Always seems hungry; feels "lightheaded" often
28	○	○	○	Digestion rapid
29	○	○	○	Vomiting occasionally
30	○	○	○	Hoarseness frequent
31	○	○	○	Uneven breathing
32	○	○	○	Pulse slow
33	○	○	○	Gagging reflex slow
34	○	○	○	Difficulty swallowing
35	○	○	○	Temporary constipation or diarrhea
36	○	○	○	"Slow starter"
37	○	○	○	Get "chilled"
38	○	○	○	Perspire easily
39	○	○	○	Sensitive to cold
40	○	○	○	Upper respiratory challenges
				GROUP 3
41	○	○	○	Eat when nervous
42	○	○	○	Excessive appetite
43	○	○	○	Hungry between meals
44	○	○	○	Irritable before meals
45	○	○	○	Get "shaky" if hungry
46	○	○	○	Fatigue, eating relieves
47	○	○	○	"Lightheaded" if meals delayed
48	○	○	○	Heart palpitates if meals missed or delayed
49	○	○	○	Fatigue in afternoons
50	○	○	○	Overeating sweets upsets
	1	2	3	
51	○	○	○	Awaken after few hours sleep - hard to get back to sleep
52	○	○	○	Crave candy or coffee in afternoons
53	○	○	○	Moods of “blues” or melancholy
54	○	○	○	Craving for sweets or snacks
				GROUP 4
55	○	○	○	Hands and feet go to sleep easily, numbness
56	○	○	○	Sigh frequently, "air hunger"
57	○	○	○	Aware of "breathing heavily"
58	○	○	○	High altitude discomfort
59	○	○	○	Opens windows in closed rooms
60	○	○	○	Immune system challenges
61	○	○	○	Afternoon "yawner"
62	○	○	○	Get "drowsy" often
63	○	○	○	Swollen ankles, worse at night
64	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
65	○	○	○	Difficulty catching breath, especially during exercise
66	○	○	○	Tightness or pressure in chest, worse on exertion
67	○	○	○	Skin discolors easily after impact
68	○	○	○	Tendency to anemia
69	○	○	○	Noises in head, or "ringing in ears"
70	○	○	○	Fatigue upon exertion
				GROUP 5
71	○	○	○	Dizziness
72	○	○	○	Dry skin
73	○	○	○	Burning feet
74	○	○	○	Blurred vision
75	○	○	○	Itching skin and feet
76	○	○	○	Hair loss
77	○	○	○	Occasional skin rashes
78	○	○	○	Bitter, metallic taste in mouth in mornings
79	○	○	○	Occasional constipation
80	○	○	○	Worrier, feels insecure
81	○	○	○	Nausea occasionally after eating
82	○	○	○	Greasy foods upset
83	○	○	○	Stools light colored
84	○	○	○	Skin peels on foot soles
85	○	○	○	Discomfort between shoulder blades
86	○	○	○	Occasional laxative use
87	○	○	○	Stools alternate from soft to watery
88	○	○	○	Sneezing attacks
89	○	○	○	Dreaming, nightmare type bad dreams
90	○	○	○	Bad breath (halitosis)
91	○	○	○	Milk products cause upset
92	○	○	○	Sensitive to hot weather
93	○	○	○	Burning or itching anus
94	○	○	○	Crave sweets
				GROUP 6
95	○	○	○	Loss of taste for meat
96	○	○	○	Lower bowel gas several hours after eating
97	○	○	○	Burning stomach sensations, eating relieves
98	○	○	○	Coated tongue
99	○	○	○	Pass large amounts of foul-smelling gas
100	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
101	○	○	○	Watery or loose stool
102	○	○	○	Gas shortly after eating
103	○	○	○	Stomach "bloating"

	1	2	3	GROUP 7A
104	O	O	O	Difficulty sleeping
105	O	O	O	On edge
106	O	O	O	Can't gain weight
107	O	O	O	Intolerance to heat
108	O	O	O	Highly emotional
109	O	O	O	Flush easily
110	O	O	O	Night sweats
111	O	O	O	Thin, moist skin
112	O	O	O	Inward trembling
113	O	O	O	Heart races
114	O	O	O	Increased appetite without weight gain
115	O	O	O	Pulse fast at rest
116	O	O	O	Eyelids and face twitch
117	O	O	O	Irritable and restless
118	O	O	O	Can't work under pressure
				GROUP 7B
119	O	O	O	Increase in weight
120	O	O	O	Decrease in appetite
121	O	O	O	Fatigue easily
122	O	O	O	Ringing in ears
123	O	O	O	Sleepy during day
124	O	O	O	Sensitive to cold
125	O	O	O	Dry or scaly skin
126	O	O	O	Temporary constipation
127	O	O	O	Mental sluggishness
128	O	O	O	Hair coarse, falls out
129	O	O	O	Tension in head upon arising wears off during day
130	O	O	O	Slow pulse, below 65
131	O	O	O	Changing urinary function
132	O	O	O	Sounds appear diminished
133	O	O	O	Reduced initiative
				GROUP 7C
134	O	O	O	Failing memory with age
135	O	O	O	Increased sex drive
136	O	O	O	Episodes of tension in head
137	O	O	O	Decreased sugar tolerance
				GROUP 7D
138	O	O	O	Abnormal thirst
139	O	O	O	Bloating of abdomen
140	O	O	O	Weight gain around hips or waist
141	O	O	O	Sex drive reduced or lacking
142	O	O	O	Tendency for stomach issues
143	O	O	O	Increased sugar tolerance
144	O	O	O	Menstrual disorders
				GROUP 7E
145	O	O	O	Dizziness
146	O	O	O	Headaches
147	O	O	O	Hot flashes
148	O	O	O	Hair growth on face or body (female)
149	O	O	O	Sugar in urine (not diabetes)
150	O	O	O	Masculine tendencies (female)
				GROUP 7F
151	O	O	O	Weakness, dizziness
152	O	O	O	Tired throughout day
153	O	O	O	Nails weak, ridged
154	O	O	O	Sensitive skin
155	O	O	O	Stiff joints
156	O	O	O	Perspiration increase
157	O	O	O	Bowel discomfort
158	O	O	O	Poor circulation
159	O	O	O	Swollen ankles
160	O	O	O	Crave salt
161	O	O	O	Areas of skin darkening
162	O	O	O	Upper respiratory sensitivity
163	O	O	O	Tiredness
164	O	O	O	Breathing challenges

	1	2	3	GROUP 8
165	O	O	O	Muscle weakness
166	O	O	O	Lack of Stamina
167	O	O	O	Drowsiness after eating
168	O	O	O	Muscular soreness
169	O	O	O	Heart races
170	O	O	O	Hyper-irritable
171	O	O	O	Feeling of a band around your head
172	O	O	O	Melancholia (feeling of sadness)
173	O	O	O	Swelling of ankles
174	O	O	O	Change in urinary function
175	O	O	O	Tendency to consume sweets or carbohydrates
176	O	O	O	Muscle spasms
177	O	O	O	Blurred vision
178	O	O	O	Involuntary muscle action
179	O	O	O	Numbness
180	O	O	O	Night sweats
181	O	O	O	Rapid digestion
182	O	O	O	Sensitivity to noise
183	O	O	O	Redness of palms of hands and bottom of feet
184	O	O	O	Visible veins on chest and abdomen
185	O	O	O	Hemorrhoids
186	O	O	O	Apprehension (feeling that something bad will happen)
187	O	O	O	Nervousness causing loss of appetite
188	O	O	O	Nervousness with indigestion
189	O	O	O	Gastritis
190	O	O	O	Forgetfulness
191	O	O	O	Thinning hair
				FEMALE ONLY
192	O	O	O	Very easily fatigued
193	O	O	O	Premenstrual tension
194	O	O	O	Menses more painful than usual
195	O	O	O	Depressed feelings before menstruation
196	O	O	O	Painful breasts during menses
197	O	O	O	Menstruate too frequently
198			O	Hysterectomy / ovaries removed
199	O	O	O	Menopausal hot flashes
200	O	O	O	Menses scanty or missed
201	O	O	O	Acne, worse at menses
				MALE ONLY
202	O	O	O	Less involved in exercise/social activities
203	O	O	O	Difficult to postpone urination
204	O	O	O	Weak urinary stream
205	O	O	O	Feeling of “blues” or melancholy
206	O	O	O	Feeling of incomplete bowel evacuation
207	O	O	O	Lack of energy
208	O	O	O	Muscles in arms and legs seem softer/smaller
209	O	O	O	Tire too easily
210	O	O	O	Avoids activity
211	O	O	O	Leg nervousness at night
212	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

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

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TOXICITY QUESTIONNAIRE

The Toxicity Questionnaire is designed to aid in assessing a potential need for a Clinical Purification ™ program

Name:_____ Date:_____

SECTION I: SYMPTOMS

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number:	
0	Rarely or never experience the symptom
1	Occasionally experience the symptom, effect is not severe
2	Occasionally experience the symptom, effect is severe
3	Frequently experience the symptom, effect is not severe
4	Frequently experience the symptom, effect is severe

1. Digestive

a. Nausea and/or vomiting	**0**	**1**	**2**	**3**	**4**
b. Diarrhea	**0**	**1**	**2**	**3**	**4**
c. Constipation	**0**	**1**	**2**	**3**	**4**
d. Bloated feeling	**0**	**1**	**2**	**3**	**4**
e. Belching and/or passing gas	**0**	**1**	**2**	**3**	**4**
f. Heartburn	**0**	**1**	**2**	**3**	**4**
Total					

2. Ears

a. Itchy ears	**0**	**1**	**2**	**3**	**4**
b. Earaches, ear infections	**0**	**1**	**2**	**3**	**4**
c. Drainage from ear	**0**	**1**	**2**	**3**	**4**
d. Ringing in ears, hearing loss	**0**	**1**	**2**	**3**	**4**
Total					

3. Emotions

a. Mood swings	**0**	**1**	**2**	**3**	**4**
b. Anxiety, fear, nervousness	**0**	**1**	**2**	**3**	**4**
c. Anger, irritability	**0**	**1**	**2**	**3**	**4**
d. Depression	**0**	**1**	**2**	**3**	**4**
e. Sense of despair	**0**	**1**	**2**	**3**	**4**
f. Apathy/lethargy	**0**	**1**	**2**	**3**	**4**
Total					

4. Energy/Activity

a. Fatigue/sluggishness	**0**	**1**	**2**	**3**	**4**
b. Hyperactivity	**0**	**1**	**2**	**3**	**4**
c. Restlessness	**0**	**1**	**2**	**3**	**4**
d. Insomnia	**0**	**1**	**2**	**3**	**4**
e. Startled awake at night	**0**	**1**	**2**	**3**	**4**
Total					

5. Eyes

a. Watery, itchy eyes	**0**	**1**	**2**	**3**	**4**
b. Swollen, reddened or sticky eyelids	**0**	**1**	**2**	**3**	**4**
c. Dark circles under eyes	**0**	**1**	**2**	**3**	**4**
d. Blurred/ tunnel vision	**0**	**1**	**2**	**3**	**4**

6. Head

a. Headaches	**0**	**1**	**2**	**3**	**4**
b. Faintness	**0**	**1**	**2**	**3**	**4**
c. Dizziness	**0**	**1**	**2**	**3**	**4**
d. Pressure	**0**	**1**	**2**	**3**	**4**
Total					

7. Lungs

a. Chest congestion	**0**	**1**	**2**	**3**	**4**
b. Asthma, Bronchitis	**0**	**1**	**2**	**3**	**4**
c. Shortness of breath	**0**	**1**	**2**	**3**	**4**
d. Difficulty breathing	**0**	**1**	**2**	**3**	**4**
Total					

8. Mind

a. Poor memory	**0**	**1**	**2**	**3**	**4**
b. Confusion	**0**	**1**	**2**	**3**	**4**
c. Poor concentration	**0**	**1**	**2**	**3**	**4**
d. Poor coordination	**0**	**1**	**2**	**3**	**4**
e. Difficulty making decisions	**0**	**1**	**2**	**3**	**4**
f. Stuttering, stammering	**0**	**1**	**2**	**3**	**4**
g. Slurred speech	**0**	**1**	**2**	**3**	**4**
h. Learning disabilities	**0**	**1**	**2**	**3**	**4**
Total					

9. Mouth/Throat

a. Chronic coughing	**0**	**1**	**2**	**3**	**4**
b. Gagging, frequent need to clear throat	**0**	**1**	**2**	**3**	**4**
c. Swollen or discolored Tongue, gums, lips	**0**	**1**	**2**	**3**	**4**
d. Canker sores	**0**	**1**	**2**	**3**	**4**
Total					

10. Nose

a. Stuffy nose	**0**	**1**	**2**	**3**	**4**
b. Sinus problems	**0**	**1**	**2**	**3**	**4**
c. Hay fever	**0**	**1**	**2**	**3**	**4**
d. Sneezing attacks	**0**	**1**	**2**	**3**	**4**

11. Skin

a. Acne	**0**	**1**	**2**	**3**	**4**
b. Hives, rashes, dry skin	**0**	**1**	**2**	**3**	**4**
c. Hair loss	**0**	**1**	**2**	**3**	**4**
d. Flushing	**0**	**1**	**2**	**3**	**4**
e. Excessive sweating	**0**	**1**	**2**	**3**	**4**
Total					

12. Heart

a. Skipped heartbeats	**0**	**1**	**2**	**3**	**4**
b. Rapid heartbeats	**0**	**1**	**2**	**3**	**4**
c. Chest pain	**0**	**1**	**2**	**3**	**4**
Total					

13. Joint/Muscles

a. Pain or aches in joints	**0**	**1**	**2**	**3**	**4**
b. Rheumatoid arthritis	**0**	**1**	**2**	**3**	**4**
c. Osteoarthritis	**0**	**1**	**2**	**3**	**4**
d. Stiffness, limited movement	**0**	**1**	**2**	**3**	**4**
e. Pain, aches in muscles	**0**	**1**	**2**	**3**	**4**
f. Recurrent back aches	**0**	**1**	**2**	**3**	**4**
g. Feeling of weakness or tiredness	**0**	**1**	**2**	**3**	**4**
Total					

14. Weight

a. Binge eating/drinking	**0**	**1**	**2**	**3**	**4**
b. Craving certain food	**0**	**1**	**2**	**3**	**4**
c. Excessive weight	**0**	**1**	**2**	**3**	**4**
d. Compulsive eating	**0**	**1**	**2**	**3**	**4**
e. Water retention	**0**	**1**	**2**	**3**	**4**
f. Underweight	**0**	**1**	**2**	**3**	**4**
Total					

15. Other

a. Frequent illness	**0**	**1**	**2**	**3**	**4**
b. Frequent or urgent urination	**0**	**1**	**2**	**3**	**4**
c. Leaky bladder	**0**	**1**	**2**	**3**	**4**
d. Genital itch, discharge	**0**	**1**	**2**	**3**	**4**
Total					

Total	Total

SECTION I TOTAL

SECTION II: Risk of Exposure

Rate each of the following based upon your environmental profile for the past 120 days.

16. circle the corresponding number for questions 16a through 16f below:					
0 Never	1 Rarely	2 Monthly	3 Weekly	4 Daily	
a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	**0**	**1**	**2**	**3**	**4**
b. How often are pesticides used in your home?	**0**	**1**	**2**	**3**	**4**
c. How often do you have your home treated for insects?	**0**	**1**	**2**	**3**	**4**
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense or varnish in your home or office?	**0**	**1**	**2**	**3**	**4**
e. How often are you exposed to nail polish, perfume, hair spray and other cosmetics?	**0**	**1**	**2**	**3**	**4**
f. How often are you exposed to diesel fumes, exhaust fumes or gasoline fumes?	**0**	**1**	**2**	**3**	**4**
				Total	_____

17. circle the corresponding number for questions 17a through 17b below:					
0 No	1 Mild Change	2 Moderate Change	3 Drastic Change		
a. Have you noticed any negative change in your health since you moved into your home or apartment?	**0**	**1**	**2**	**3**	**4**
b. Have you noticed any negative change in your health since you started your new job?	**0**	**1**	**2**	**3**	**4**
				Total	_____

18. Answer "yes" or "no" and circle the corresponding number for questions 18a through 18 d below:	**No**	**Yes**
a. Do you have a water purification system in your home?	**2**	**0**
b. Do you have any indoor pets?	**0**	**2**
c. Do you have an air purification system in your home?	**2**	**0**
d. Are you a dentist, painter, farm worker, or construction worker?	**0**	**2**
Total		_____

SECTION II TOTAL _____

Add up the numbers to arrive at a total for each section, then add the totals for each section to arrive at the grand total:

GRAND TOTAL (Section I + Section II) **TOTAL** _____

If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a Clinical Purification ™ program.