

PATIENT INFORMATION

LEGAL NAME: LAST _____ FIRST/MIDDLE INITIAL _____

NAME YOU WISH TO BE CALLED _____ REFERRED BY: _____

If you're satisfied with your experience at the end of treatment are you okay with me asking you for a referral? ___YES___NO

DATE OF BIRTH _____ MALE ___ FEMALE ___ MARITAL STATUS _____

PHYSICAL ADDRESS _____ CITY, STATE, ZIP _____

MAILING ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ E-MAIL _____

WORK PHONE _____ EMPLOYER _____

SOCIAL SECURITY # _____ OCCUPATION _____

PATIENT'S PRIMARY CARE PHYSICIAN _____

RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN/LEGAL REPRESENTATIVE)

LAST NAME _____ FIRST NAME _____

MAILING ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ WORK PHONE _____

RELATIONSHIP TO PATIENT _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

LAST NAME _____ FIRST NAME _____

MAILING ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ WORK PHONE _____

RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION / PERSON RESPONSIBLE FOR BILL (PROVIDE A CURRENT INSURANCE CARD AT TIME OF SERVICE)

INSURANCE COMPANY _____ NO INSURANCE

INSURANCE ID# _____ COPAY\$ _____ DEDUCTIBLE\$ _____

POLICY HOLDER: LAST NAME _____ FIRST NAME _____

MAILING ADDRESS _____ CITY, STATE, ZIP _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYEER _____ WORK PHONE _____

By signing this form, I verify that the information listed above is accurate and current to the best of my ability:

Signed by Patient / Legal Guardian / Legal Representative

Date

I authorize payment of medical benefits to undersigned Physician or supplier for these services and all future claims:

Signed by Patient / Legal Guardian / Legal Representative

Date

Acupuncture Disclosure Form

The practice of Acupuncture is regulated by the Colorado Department of Regulatory Agencies (DORA); Concerns are directed to Director of Division of Registrations, Acupuncture Registration, 1560 Broadway, Suite 1545; Denver, CO 80202; 303-894-2464.

This Acupuncture Clinic complies with rules and regulations promulgated by the department of health and environment including the use of sterilized acupuncture needles, the use of disposal able needles and the sanitation of this acupuncture office.

Caleb F. Gates III, L.Ac. Diplomat of Acupuncture NCCAOM, LLC
1199 Main Ave., Ste. 220; Durango, CO 81301; 970-259-9488

Treatment Fees:

Acupuncture Initial Treatment \$100, Acupuncture follow up \$95

Herbal Consultation \$65 and Herbal Products \$15- \$80 each

Advanced Allergy Therapeutics: Initial Treatment \$150, Follow up \$100

Field Control Therapy Initial \$265, FCT Follow up \$195, FCT Herbal Assessment \$165

Payment is due at time of services and is the responsibility of the patient if insurance does not cover treatments.

Discounts may be applied at time of payment. There is a 24-hour cancellation policy. Missed Appointments will be charged full price.

State of Colorado Acupuncture Registration #967, City of Durango Massage License #210080

Every patient is entitled to receive information about the duration and type of therapy available which includes Acupuncture, Chinese Herbal and Nutritional Therapy, Therapeutic Massage, Chinese Medical Massage, Moxibustion and Cupping. Patients may seek a second opinion from another health care professional or may terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the division at DORA.

Caleb Gates is a Licensed Acupuncturist, Certified by the National Commission for the Certification of Acupuncture and Oriental Medicine. Registered Acupuncturists are certified in clean needle technique by the Council of Colleges of Acupuncture and Oriental Medicine. He is a graduate of Colorado School of Traditional Chinese Medicine, a 3.5-year program in Acupuncture and Chinese Herbal Medicine. Member: Acupuncture Association of Colorado.

Caleb Gates is trained and clinically experienced to perform acupuncture, the insertion of sterile needles into the body and the use of Chinese Herbal Remedies and nutritional therapy in the form of plant, powder or pills as defined by Traditional Oriental Medical principals of diagnosis and treatment.

Treatment is quite safe and can improve and heal existing conditions as well temporarily aggravate existing symptoms. Patients might experience temporary disorientation, dizziness, nausea, digestive disturbance, slight bruising, Moxibustion burns and other discomforts.

I fully understand that there is no implied or stated guarantee of the success or effectiveness of a specific treatment or series of treatments. I am hereby advised to consult with my primary care medical physician on medical issues and that Acupuncture, Oriental Medicine or alternative care is not substitution for appropriate medical advise and care from a medical doctor.

Patients Signature _____ Date _____

Caleb Gates L.Ac. CMT LLC
1199 Main Ave. Ste. 220, Durango, CO 81301; 970-259-9488

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Caleb Gates LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Caleb Gates LLC, Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Caleb Gates LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a request to Caleb Gates LLC Privacy Officer at (1199 Main Ave., Suite 230, Durango, Co 81301).

With my consent, Caleb Gates LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. I have the right to have restrictions to any of the above information, which I am required to do in writing on the appropriate office forms.

With my consent, Caleb Gates LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Caleb Gates LLC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Caleb Gates LLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print name of Patient or Legal Guardian

DURANGO ACUPUNCTURE AND ALLERGY RELIEF

CALEB GATES, L.Ac

PATIENT INTAKE FORM

Date: _____

PATIENT INFORMATION			
Last Name:	First:	Middle:	Date of Birth:

Chief Complaint Currently: _____

Additional Health Priorities:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

SYMPTOMS

Symptom & Description (worst first)	Known triggers Worse (<) or better (>) for...	When Started	Rating: 1 → 10: 1 = hardly there 10 = extremely bad

Amount/Level Of	Very Low	Low	Medium	High	Excessive	Erratic
General Energy						
Sleep						
General Appetite						
General Thirst						
Circulation/warmth/heat						
Daily Exercise						

Exercise Routine: _____

- Energy is best: a.m. p.m. Night Between meals Just after meals When moving Or still
- Energy is worst: a.m. p.m. Night Between meals Just after meals When moving Or still

MIND & EMOTIONS: Tick if Current: Mood Swings Anger/Frustration Grief/Sadness Racing Mind
Worry Fear Brain Fog Poor Memory Poor Concentration Difficulty Communicating

STRESS: Current stress level between 1 and 10 _____ (1 = very relaxed 10 = very stressed)

Factors most contributing to your stress: Health _____ Work _____ Money _____ Family _____ Other _____

What best helps you deal with stress? _____

SYSTEMS CHECK: Check any current problems.

General Symptoms

- | | | |
|---|--|---|
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Feel Warm Mostly |
| <input type="checkbox"/> Cold Limbs | <input type="checkbox"/> Cold Body | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Overweight | <input type="checkbox"/> Feel Thirsty Often |
| <input type="checkbox"/> Poor Sleeper | <input type="checkbox"/> Normal Energy Level | <input type="checkbox"/> Strong Immunities |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Prefer Warm Drinks | <input type="checkbox"/> Low Metabolism |
| <input type="checkbox"/> Prefer Cold Drinks | <input type="checkbox"/> High Metabolism | <input type="checkbox"/> Lack of Thirst |
| <input type="checkbox"/> Weak Immunities | <input type="checkbox"/> Night Sweat | |

When I am active I sweat: a lot little almost never

I usually sweat on

- | | | |
|----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> my head | <input type="checkbox"/> back | <input type="checkbox"/> lower body |
| <input type="checkbox"/> face | <input type="checkbox"/> upper body | <input type="checkbox"/> whole body |
| <input type="checkbox"/> neck | <input type="checkbox"/> arm pit | <input type="checkbox"/> palm and sole |

Sleep

- | | | |
|---|---|-----------------------------|
| <input type="checkbox"/> Problem getting to Sleep | <input type="checkbox"/> Dreams | _____ Hours slept per night |
| <input type="checkbox"/> Frequent Waking | <input type="checkbox"/> Nightmares | _____ Typical Bedtime |
| <input type="checkbox"/> Early Waking | <input type="checkbox"/> Snoring | _____ Typical Wake time |
| <input type="checkbox"/> Wake Unrefreshed | <input type="checkbox"/> Early Waking | |
| <input type="checkbox"/> Sleepiness | <input type="checkbox"/> Fall Asleep without Meds or
Supplements | |
| <input type="checkbox"/> Night Sweats | | |
| <input type="checkbox"/> Grinding Teeth | | |

Infections

- | | | | |
|--|-----------------------------------|---|---|
| <input type="checkbox"/> Recurring Frequent
Colds | <input type="checkbox"/> Ear | <input type="checkbox"/> Food Poisoning | <input type="checkbox"/> Swollen Lymph
Nodes |
| <input type="checkbox"/> Flu | <input type="checkbox"/> Bladder | <input type="checkbox"/> Poor Immunity | <input type="checkbox"/> Phlegm |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Cystitis | <input type="checkbox"/> General 'run down' | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Kidney | <input type="checkbox"/> Intestinal | |
| | <input type="checkbox"/> Stomach | | |

Head

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Blurred Vision- Near | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Visual Spots | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Confusion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Presently in Counseling |
| <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Considered/Attempted
Suicide |
| <input type="checkbox"/> Ringing | <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Blurred Vision- Distance | <input type="checkbox"/> Mental Disorders | |

Cardiovascular

- High Blood Pressure
- High Cholesterol
- Palpitations
- Varicose Veins
- Low Blood Pressure
- Low Cholesterol
- Irregular Heart Beat
- Bruise Easily
- Chest Pain/ Pressure
- Heart Attack
- Cardiovascular Disease
- Stroke
- Anemia
- Edema - (Legs/Hands/Eyes)

Respiratory

- Coughing
- History Sinus Infections
- Phlegm
- Difficulty Breathing
- Asthma
- Tight Chest
- Allergies
- History Pneumonia
- Post Nasal Drip
- Bronchitis/Emphysema
- Sinus Congestion
- Nose Bleeds

Urination

- Frequent Urination
- Bladder/Kidney Stones
- Urgency to Urinate
- Urinary Incontinence
- Blood in Urine
- Difficult Urination
- Painful Urination
- Recurrent Urinary Infections
- Kidney Disease
- Cloudy/Bubbly Urine

_____ # of glasses a water a day Is your urine clear? (If no, please describe) _____
 _____ # of times night urination Do you have any urinary diseases diagnosed by an MD? _____

Gastrointestinal

- Bowel Habits Changed
- Bloating
- History of Candida
- Laxative Use
- Gallbladder Troubles
- Nausea
- Heartburn
- Gas
- Constipation
- Ulcers
- Blood in Stool
- History of Parasites
- Mouth Tastes Bitter/Sour
- Vomiting
- Acid Reflux
- History of Polyps
- Diarrhea
- Abdominal Pain
- Hemorrhoids
- Diabetes
- Bad Breath
- Stomachaches
- Belching
- Rectal Itching
- Chronic Loose Stools
- Dry Hard Stools

Do you have any digestive diseases diagnosed by an MD? _____

Bowel Movements every _____ days(s) # per day _____

When passing the bowel does it most of the time feel complete or incomplete?

When passing the bowel do you sit for a prolonged period need to push or is it excreted in a few seconds? *Stools Tend to be:* Well Formed Loose (L) Constipated (C) Alternating (L & C)

Skin & Hair

- Eczema
- Psoriasis
- Rash
- Itchiness
- Dryness
- Spots
- Athlete's Foot
- Jock Itch
- Hair Loss
- Dermatitis/Warts
- Brittle Hair
- Skin Rashes
- Early Gray
- Dry Scalp
- Facial Hair
- Acne
- Hives
- Fungal Infections
- Had Shingles

Do you have any skin diseases diagnosed by an MD? _____

Musculoskeletal

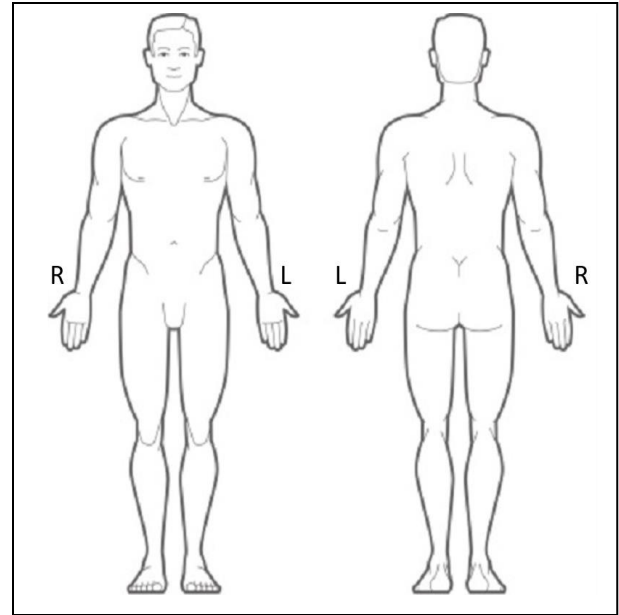
- Burning
- Numbness
- Tingling
- Sensitivity
- Poor Mobility
- Poor Coordination
- Muscle Weakness
- Pain Back
- Pain Neck
- Pain Shoulder
- Swollen Joints
- Tendonitis
- Bone Pain
- TMJ
- Muscle Pain
- Repetitive Strain Injury
- Arthritis
- Joint Pain
- Muscle Spasms/Cramps
- Recurring Pain _____

Mark any muscular soreness and/or pain on the picture model using the following symbols:

- +++ = Sharp Stabbing**
- ooo = Pins & Needles/Tingling**
- vvv = Dull or Aching**
- lll – Numbness**
- = Trembling or Twitching**

Severity of pain on a scale of 1 to 10 (1 is low) _____

Is the pain fixed or does it move? _____



Sensory

- | | | |
|--|---|---|
| <input type="checkbox"/> Eye Irritation | <input type="checkbox"/> Spots in Vision | <input type="checkbox"/> Nasal Discharge |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Dry Mouth & Throat |
| <input type="checkbox"/> Ear Congestions | <input type="checkbox"/> Gum/Teeth Problems | <input type="checkbox"/> Lumps in Throat |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Tearing Eyes |
| <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Ear Ringing | |

Do you have any sensory diseases diagnosed by an MD? _____

Note: If you feel ready to be open in this area, the purpose of the following is to enable us to better assist your health.

Men Only:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sexual Impotence | <input type="checkbox"/> Infertility | <input type="checkbox"/> Increased Sex Drive |
| <input type="checkbox"/> Low Libido | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Genital Discharge | <input type="checkbox"/> Hepatitis (A, B, or C) | <input type="checkbox"/> Decreased Sex Drive |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Hernias | |
| <input type="checkbox"/> Testicular Pain | <input type="checkbox"/> Herpes | |

Women Only: # of Children _____ # of Miscarriages _____ # of Abortions _____

Menses: Late Early Regular Irregular Absent Days of Period _____ Time Between Periods _____

The flow has been: Heavy Light Regular Dark Menses PMS Clotty menses Cramps

Birth Control Type: _____ Dates on Birth Control Pill _____

List any symptoms which are worse Before During menses: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Infertility/Fertility Issues | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Breast Tenderness |
| <input type="checkbox"/> Pregnant now | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> History of Fibroids/Cysts |
| <input type="checkbox"/> Planning pregnancy | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Hepatitis (A, B, or C) | <input type="checkbox"/> Difficult birth(s) Details: _____ |
| <input type="checkbox"/> Increased Sex Drive | <input type="checkbox"/> Hot Flashes/Night Sweats | |
| <input type="checkbox"/> Yeast Infection | <input type="checkbox"/> Mood Swings | |

DIET

How much do you eat/drink of the following:	None	Very Little	Moderate	Very Much
Vegetables	_____	_____	_____	_____
Beans/legumes, nuts, seeds	_____	_____	_____	_____
Meat, fish (Which? _____)	_____	_____	_____	_____
Chicken, turkey, or eggs (<u>not organic</u> , even if free range)	_____	_____	_____	_____
Chicken, turkey, or eggs (organic)	_____	_____	_____	_____
Dairy Foods: milk, cheese, yogurt, etc.	_____	_____	_____	_____
White flour/starches: bread, pasta, potatoes, rice	_____	_____	_____	_____
Whole grains: whole wheat, oats, spelt, barley, rye	_____	_____	_____	_____
Sweets: cakes, biscuits, puddings, chocolate, soft drinks...	_____	_____	_____	_____
Fruit and/or Fruit Juice	_____	_____	_____	_____

Amount of water consumed daily (on its own): _____ Mark the type(s) of water you drink:

Tap Filtered Tap Reverse Osmosis Distilled Bottled What Brand? _____

Your known Allergies/ Sensitivities Many Few Don't Know _____

MEDICAL HISTORY / PAST TREATMENTS

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Mental Illness/Depression | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Auto-Immune | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Venereal Disease | | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid |
| | | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Diabetes |

Have you ever had a negative reaction to any medications? Yes No

If so, which medication and what was the reaction? _____

Approximate number of course of **Antibiotics** received in your life: 0-10 11-20 21+

For what? _____ When was last one received? _____

Approx. number of **X-rays** received in your life: 0-10 11-20 21+ When was last one received? _____

For what? (mammograms, injuries, dental, chest, etc) _____

Vaccination

Approximate number of **Vaccinations** received in your life: 0-10 11-20 21+

Which ones? _____ When was last one received? _____

Have you received any Flu Vaccinations any time in your life? Yes No When? _____

Have you ever had negative reactions to any vaccinations? Yes No Explain: _____

DENTAL HISTORY

Current number of dental amalgam fillings (these are silver or black colored): _____ Tooth Pain _____

How long since the first one was placed? _____ Total number that have been removed: _____

When removed? _____ Removed by Regular dentist or Holistic mercury-free dentist

Did your mother have amalgam fillings before your birth? Yes No Probably No idea

Did your father and/or grandparents have amalgam fillings? Yes No Probably No idea

Number of gold caps, root canals or other dental restorations (please indicate): _____

Medications

Briefly list your previous treatment / detoxification history (including conventional or alternative medicine):

WHEN BEGUN	WHEN ENDED	TREATMENT	WHEN BEGUN	WHEN ENDED	TREATMENT

ACCIDENTS / HOSPITALIZATIONS / SURGERIES

Have you ever been knocked unconscious? _____ Any blows to the head spine other injuries?

Details: _____

INCIDENT	DATE	INCIDENT	DATE

CURRENT TREATMENTS

List medications you currently use (prescribed or over-the-counter): **BRING A SAMPLE OF EACH TO YOUR APPT.**

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

Long Term Medications(s) Past Present Details: _____

Any negative reactions to medication? _____

Have you had Bloodwork / X-rays / CT Scans or any other studies pertaining to your current condition(s) **done within the past year?** Yes No Results: _____

List supplements / homeopathies / herbs you currently taking: **BRING SAMPLES OF THESE TOO!**

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

Is any other practitioner providing treatments/therapies for you at the present time? Yes No

Details: _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings
HEART DISEASE					
HIGH BLOOD PRESSURE					
STROKE					
TUBERCULOSIS					
CANCER					
GLAUCOMA					
DIABETES					
EPILEPSY					
BLEEDING DISORDER					
KIDNEY DISEASE					
THYROID DISEASE					
MENTAL ILLNESS					

TOXICITY

Do you smoke? Yes No Have you ever smoked Yes No Smokeless Tobacco Yes No
 Packs/Cans daily _____ How long? _____ When stopped? _____

Have you used recreational drugs? Yes No

Please note any that apply to you now or in the past, and indicated your usage per day or week.

	Per Day/Week	Age Started	Age Quit	History of Addiction	Family History of Addiction
Tobacco					
Alcohol					
Coffee					
Marijuana					
Cocaine					
Heroin					
Other					

Cups (8oz) of caffeinated beverages a day: _____

Average alcohol consumption per week: _____

History of alcohol addiction

Have you ever been exposed to industrial/chemical toxins at work or home? (e.g. factory, farming...) Yes No

What chemicals/what industry/how long? _____ When stopped? _____

Have you ever used weed killer or other agricultural chemicals? Yes No

Do your neighbors? Yes No No Idea

Do you use a coal stove/fire (either regular or 'smokeless' coal)? Yes No

Do your neighbors? Yes No No Idea

Do you live near any of the following (i.e. within 1 – 2 miles, OR further if downwind)

- Nuclear Plant Crematorium Industrial Zone Polluting Factory Golf Course
 Agricultural Area

Have you ever been exposed to any other known major environmental toxins? Yes No No Idea

Please explain: _____

EMFS

Your home is a House Apartment Which apartment floor? _____ How many stories? _____

How far is the nearest: Mobile phone mast _____ Electricity pylon _____ High power generator _____

Describe the view from your bedroom window: _____

Do you use: Cordless phone Wifi Electric: blanket, shaver, toothbrush Protective devices Magnets

Number of _____ Fluorescent lights _____ Striplights _____ Long life (mercury) lightbulbs
in your Home Office

Do any direct neighbors have a cordless phone? Yes No No idea

Number in your home: TVs _____ Computers/Laptops _____

Check specifications of each: How many are "LCD"? _____ vs. "LCD/LED"? _____

If unsure, write here all TV and Computer brand names: _____

Do you use a laptop **without** an external keyboard and mouse? Yes No

Do you use any phones: Held to ear Speakerphone function

Type of heating used in home: _____ Which room do power lines enter? _____

Devices in your bedroom: TV Computer Clock radio Lamp Mobile phone Other appliances

	Average Hours of Use per Day
TV	
Computer or Tablet	
Mobile phone	
Landline phone	
In a motor vehicle	

TRAVEL

Have you ever travelled to remote regions (e.g. Asia, Africa, South America) Yes No

Date	Destination	Health Incidents There or After?	Date	Destination	Health Incidents There or After?