



LOTUS HOLISTIC MEDICINE

Dr Sandeep Gupta MBBS FACNEM at Medicine on Second
50 Second Ave, Maroochydore, QLD 4558 Ph: 07 5443 9455

Dear client,

Congratulations on making an important step towards long-term vibrant health. As you probably know, the emphasis in my practice is **on seeking the underlying causes of disease rather than focusing on symptom relief.**

This means going deeply into your diet, lifestyle and daily routine and assisting you to find the individualised health regime which will help to “switch off” the program which is driving many of your current health challenges.

This approach means that you will be able to take your health into your own hands, and learn how to stay well, track your progress and learn better to work in with your individual make-up.

In order to achieve the best possible outcome, we ask that you please have the following information available prior to the first appointment:

- Completed Charts and Checklists**
- Completed Health History Questionnaire**
- Completed Medical Consent Form**
- Completed Readiness Assessment**
- Copies of any pathology results you may have had over the last 2-3 years.**
This may mean calling some of the laboratories to request copies. You can try
 - i. Queensland Medical Laboratories (QML) on (07) 3121 4444
 - ii. Sullivan & Nicolaides (S&N) on (07) 3377 8756
 - iii. Healthscope (previously Gribbles) on 1300 453 688
- Copies of recent medical records from your main treating practitioner, if at all possible**

These forms can be brought to your initial consultation or sent to us in advance for our review.

I look forward to being of service.

In good health,

Dr Sandeep Gupta

Consent Form

Medical Consent Form

I, _____
(client's name)

of _____
(client's address)

understand that:

- I am seeking to consult Dr Sandeep Gupta in his capacity as a medical practitioner with a special interest in nutritional and environmental medicine.
- This means that he offers a longer consultation time, a more holistic approach to patient diagnosis and care – an approach primarily involving diet, supplementation, exercise, lifestyle and stress management.
- Only Dr Sandeep Gupta and Dr Peter Hodgkinson act in this capacity at Medicine on Second, and therefore all questions regarding treatment of this nature should be addressed to them.
- Dr Gupta charges a private fee for his consultations, which, in the majority of cases attract a Medicare rebate. In most cases he does not bulk bill. General fees are:
 - \$250 for a one-hour consultation
 - \$120 for a half-hour consultation
 - \$95 for a twenty minute consultation
 - \$70 for a ten minute consultation
- The majority of diagnostic tests ordered by Dr Gupta do attract a Medicare rebate, however specific functional pathology tests may not attract a rebate.
- The costs of these tests will be discussed with me by Dr Gupta at the time of ordering.
- Dr Gupta may offer some of the recommended products for purchase from him directly. This may include a small profit margin. There is no obligation to purchase the products via this avenue, and they may be purchased from any local retailer.
- Some of the treatment suggestions (eg nutritional or digestive supplements) offered by Dr Gupta are considered to be outside the parameters of conventional medicine in Australia.
- These treatments fall under the category of complementary or alternative medicine.
- These interventions are in the majority of cases supported by research evidence, and are only prescribed with utmost care.

I am attending Dr Gupta's clinic of my own free will and consent and exercise my right to discuss and choose any useful and suitable treatment(s) made available to me.

Signed: _____

Date: / / 2010

Charts and Checklists

Basal Body Temperature Chart

There is considerable evidence that the current tests for the diagnosis of hypothyroidism (low thyroid function) are insensitive and somewhat lacking in accuracy.

Broda Barnes, M.D., endocrinologist and thyroid specialist, in his book, "Hypothyroidism and Unexpected Illness", explains his feelings and theories about this matter. He proposes that the most sensitive and accurate test for picking up people with low thyroid function is simply to check the basic function of the thyroid which is its ability to regulate the metabolic furnace of the body, i.e. create heat or control temperature. Dr Barnes feels that recording basal body temperature daily for ten days is the most simple and best means of doing this. For accuracy, he insists that the patient be totally relaxed and not get out of bed before completing the test.

This temperature recording data will be correlated with your thyroid hormone level (when indicated). We are attempting to search out and find all the undiscovered hypothyroidism that our patients have, since this is such a common and usually easily treatable condition. Barnes estimates that approximately 40% of the adult population has this problem and it can be associated with hypoglycaemia, allergies, psoriasis, acne, undiagnosed skin problems, hypertension, obesity, depression, and many other conditions.

Taking your basal body temperature:

Your body temperature reflects your metabolic rate, which is largely determined by hormones secreted by the thyroid gland. All that's needed is a thermometer.

If using a non digital thermometer, shake the thermometer to below 35 degrees Celsius and place it by your bedside before going to sleep at night.

2. On waking: DO NOT GET OUT OF BED. Place the thermometer in your armpit for a full 10 minutes. Try not to move – lie resting with your eyes closed. Do not get up until the 10 minutes is complete. (If using a digital thermometer await the beep to show that temperature recording is complete).
3. After 10 minutes, read and record the temperature and the date.
4. Check your temperature for at least 10 mornings in a row (preferably at the same time of day). Women who menstruate must perform the test from the second, third or fourth day of menstruation onwards, men and post menopausal women can commence the test on any day.

Day	1	2	3	4	5	6	7	8	9	10
Date										
Temp.										

36.5 C or below is considered abnormal. If the majority of the data is low, it probably suggests low thyroid function

One Week Dietary History

Please complete a record of your meals for one week prior to your appointment with Dr Gupta

	Breakfast Time: _____	Lunch Time: _____	Dinner Time _____	Other Snacks Note Time
Sun				
Mon				
Tue				
Wed				
Thur				
Fri				
Sat				

Hypoglycaemia Checklist

Please rate the occurrences of the below symptoms on a scale of 0 (never) – 4 (every day).

	Upon Awakening	Before Lunch	Late Afternoon	All the Time	Under Stress
Unexplained mood changes					
Unexplained anxiety					
Unexplained depression					
General low energy					
Cravings for sweets					
Constant hungry feelings					
Tired feelings					
Physical weakness					
Drowsiness					
Constant worrying					
Concentration fade-out					
Periods of confusion					
Disoriented feeling					
In-coordination					
Trouble pronouncing words					
Decreased memory					
Sweats, shakiness, trembling					
Heart Palpitations					
Headaches					
Blurred vision					
Sunlight hurts eyes					
Impotence or lack of sex drive					
Phobias, fears					
Menstrual problems					
Digestive disturbances					
Insomnia					
Nightmares					
Allergy or sensitivities					
Hay Fever					
Asthma					
Muscle pains					
Areas of body numbness					

Metal Toxicity Checklist

1) Have you had sore gums (gingivitis) often over the years?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
2) Have you had mental symptoms such as confusion or forgetfulness?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
3) Has severe depression been a problem?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
4) Has ringing in the ears (tinnitus) been present?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
5) Have TMJ (temporal mandibular joint) problems been a concern of yours?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
6) Have you had unusual shakiness (tremors) of your hands or arms or twitching of other muscles?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
7) Do you have "brown spots" or "age spots" under your eyes or elsewhere in the skin of your body?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
8) Have you tended to have more colds, flu, and other examples of infectious diseases than normal?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
9) Have you had food allergies or intolerances?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
10) Have you been to many doctors for your health problems and they have usually said, "There is nothing wrong"?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
11) Do you have numbness or burning sensations in your mouth or gums?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
12) Do you have numbness or unexplained tingling in your arms or legs?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
13) Have you developed difficulty in walking (ataxia) over the years?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
14) Do you have 10 or more "silver" fillings?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
15) Do you often have a "metallic" taste in your mouth?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
16) Have you ever worked as a painter or in manufacturing/chemical or pesticide/fungicide factories (fungicides with methyl mercury ingredients) or in pulp/paper mills that used mercury?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
17) Have you worked as a dentist, hygienist, or dental assistant?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
18) Have you ever had Candida-Related-Complex (CRC) or yeast infections (vagina, mouth or GI tract)?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
19) Do you have a lot of bad breath (halitosis) or white tongue (thrush)?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
20) Have you frequently had low basal body axillary temperature (below 97.4 degrees F.) over the years?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
21) Do you have problems with constipation?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
22) Do you have heart irregularities or rapid pulse (tachycardia)?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
23) Do you have unexplained arthritis in various joints?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
24) Is it common for you to have a lot of mucus in your stools?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
25) Do you have unidentified chest pains even after EKGs, X-ray, and heart studies are normal?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
26) Is your sleep poor or do you have frequent insomnia?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
27) Have you had frequent kidney infections or do you have significant kidney problems?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
28) Are you extremely fatigued much of the time and never seem to have enough energy?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
29) Do you have irritability or dramatic changes in behavior?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
30) Are you on antidepressants now or have you been in the past?	<input type="checkbox"/> Y <input type="checkbox"/> O <input type="checkbox"/> N	
TOTAL:	Y	N
	<input type="checkbox"/>	<input type="checkbox"/>

Health History Questionnaire

Health History Questionnaire

The information on this form is to help Dr Gupta to assess and treat your condition effectively. It is important that you take the time to fill this out completely to ensure the best outcome can be achieved. If you are unsure about any information you will be able to discuss it with your practitioner.

Date _____ Name _____

Address _____

Ph (H) _____ Ph (W) _____ DOB _____

Ph (M) _____ Email _____

Preferred method of contact _____

MAIN CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

What diagnoses or explanations have been given to you? _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel **worse**? _____

What makes you feel **better**? _____

Please list other practitioners you have seen for the above health conditions:

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |
-

Please check all the Complementary Medicine Treatments you have tried for your condition(s)

- | | | | |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Massage | <input type="checkbox"/> Yoga | <input type="checkbox"/> Environmental medicine |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Rolfing | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Nutritional Therapy |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Reiki | <input type="checkbox"/> Ayurveda | <input type="checkbox"/> Biological Dentistry |
| <input type="checkbox"/> Iridology | <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Light therapy | <input type="checkbox"/> IV (chelation) therapy |
| <input type="checkbox"/> Colonics | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Meditation | <input type="checkbox"/> Naturopathic medicine |
-

PAST ILLNESSES AND TESTS

Please place the date corresponding to when you started to suffer from any of the following conditions in the past.

ILLNESSES	Date	Date	Date	Comments
Chicken Pox		X	X	
German Measles		X	X	
Measles		X	X	
Mononucleosis		X	X	
Mumps		X	X	
Whooping cough		X	X	
Anaemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue Syndrome				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				

High blood pressure				
Irritable bowel				
Kidney stones				
Glandular fever				
Pneumonia				
Rheumatic fever				
Sinusitis				
ILLNESSES	Date	Date	Date	Comments
Sleep apnoea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	Date	Date	Date	Comments
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES	Date	Date	Date	Comments
Chest X-ray				
Mammogram				
ECG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CT scan of Abdomen				
CT scan of brain				
CT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone Density Test				
Carotid Artery Ultrasound				
Blood Tests				
Other (describe)				
OPERATIONS	Date	Date	Date	Comments
Tonsillectomy		X	X	
Tubes in Ears				
Appendectomy		X	X	
Gall Bladder		X	X	
Hernia				
Hysterectomy		X	X	
Dental Surgery				
Other (describe)				

FAMILY HISTORY

Does anyone in your family or a near relative have any of the following? Indicate whether maternal or paternal side of the family and which relative, i.e. paternal, grandfather. Relationship (M=maternal P=paternal)									
	Yes	No	M	P		Yes	No	M	P
• allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• kidney difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• anemia or any blood diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• hereditary or congenital defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• colitis, ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• recurrent depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• abnormal fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• uncontrollable temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• diabetes/hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• thyroid deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• menstrual irregularities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REST AND RELAXATION

Do you take time to relax each day? □Y□N	
What is your present rest and relaxation pattern?	
Is it enough for you? □Y□N	
Is your life one of excess □ or moderation□? Please explain:	
Do you modulate your time and energy so that you often find yourself: (check those that apply):	
Relaxed and refreshed □Y□N	Hurried □Y□N
Exhausted □Y□N	Irritable □Y□N
Centered □Y□N	Un-centered and scattered □Y□N
Bored □Y□N	Desperate □Y□N

NUTRITION & LIFESTYLE HISTORY

NUTRITION

Have you made any changes in your eating habits because of your health? Yes____ No____

Do you currently follow a special diet or nutritional program? Yes____ No____

Check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Mixed food diet (animal and vegetable sources) | <input type="checkbox"/> Fat restriction | <input type="checkbox"/> Specific Program for Weight Loss/Maintenance Type:_____ |
| <input type="checkbox"/> High protein | <input type="checkbox"/> Low starch/carbohydrate | _____ |
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> The Blood type Diet | _____ |
| <input type="checkbox"/> Vegan / raw food vegan | <input type="checkbox"/> Metabolic Typing Diet | _____ |
| <input type="checkbox"/> Gluten restricted | <input type="checkbox"/> The Zone Diet | _____ |
| <input type="checkbox"/> Low sodium | <input type="checkbox"/> Total calorie restriction | _____ |
| | <input type="checkbox"/> Diabetic | _____ |

Please check any specific food restrictions you have:

- | | |
|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Corn |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Wheat | <input type="checkbox"/> All gluten |

Anything else special about your diet?

LIFESTYLE

Have you ever smoked? If so, for how long? _____

In an average week, please detail how much and what type of the following you partake in:

Alcohol _____

Recreational drugs: _____

Exercise: _____

Relaxation or stress management? _____

Do you have any regular spiritual or religious practice? _____

If it feels appropriate for you, please tell us more about your practice: _____

How often often do you:

Walk barefoot on the earth: _____

Get away from the city and into nature: _____

Get direct sunlight for 30min/day: _____

Chew your food until it is like a liquid in your mouth: _____

Express gratitude for all you have: _____

Forgive significant people in your life: _____

Take time out to relax and turn the stress system off: _____

Go deeply into the silence within your own self: _____

WORK/HOME ENVIRONMENT

Is your home environment emotionally and spiritually uplifting ? _____

Is your work environment emotionally and spiritually uplifting ? _____

Are you regularly exposed to noise pollution, chemicals, polluted air or visual pollution?

MARKETING / FEEDBACK

How did you find out about Dr Gupta's practice?

Referral from other practitioner _____ (who?)

Website _____ (which one)

Friend/family _____

Magazine/newspaper _____ (which one)

Do you wish to receive a periodic email newsletter with recent information from the world of holistic health and clinic news (usually sent every 3-6 months).

Yes

No

The information on this form is true and filled out in sincerity.

Signed _____ Date _____