Christian Medical Ministries, Inc.
Alan W. Gruning, D.O.

NEW PATIENT HISTORY

Name: _____ Age: ___ Date of Birth: _____

Social Security # last 4 digits: _____ Sex_____M _____F Dominant Hand _____R _____L

City/State of residence _____ Health insurance name _____

Why are you seeing us today? _____
_____

Are you involved in a lawsuit for your condition? _____yes _____no Attorney name _____

Have you had lab tests in the past 6 months? _____yes _____no We will need those results

Have you had COVID? _____yes _____no How many times? _____ When was the last episode? _____ Did you ever lose taste or smell? If so, for how long? _____
Have you ever recovered from COVID? _____yes _____no If no, since what date? _____

Have you had mRNA COVID shots? _____yes _____no How many? _____ Did you have any significant reaction to any of them? Please describe _____

What do you currently live in? _____own_____ rent _____
Did you have a mold/Biotoxin exposure that made you ill? _____yes _____no When was that and briefly describe _____
_____

Do you wear: _____Glasses _____Contacts _____Hearing Aids
Do you use a brace, orthotic, or assistive device? _____Yes _____No Type_____

Work Status: _____Employed Type of work: _____
_____Unemployed _____Retired _____At home caregiver

Do you follow a special diet? _____Yes _____ No Type _____
Do you eat wheat? _____ yes _____no How many ozs of water do you have/day? _____

Exercise: _____Yes _____No type of exercise: _____
How often? _____ Duration: _____

How many hours of sleep do you get most nights? _____ Is it restful? _____ disturbed? _____

List any supplements you take: _____

_____

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PAST MEDICAL HISTORY **Patient Name: _____**

(Check all that apply)

□ Brain Injury
□ Hearing loss; ear: R L
□ Dental Infections
□ Low thyroid
□ Diabetes, pills
□ Asthma
□ Rheumatic Fever
□ High cholesterol
□ Peptic ulcer disease
□ Reflux (heartburn)
□ Diverticulitis
□ Colon polyps
□ Kidney infection
□ TIA
□ Migraines
□ Chemotherapy
□ Sciatica
□ Depression
□ Chronic sleep disorder
□ Other Illness: _____

□ Visual Loss; Eye: R L
□ Sinusitis, chronic
□ Frequent throat infections
□ High Thyroid
□ Pneumonia
□ COPD/emphysema
□ Heart attack
□ Angina
□ Hiatal hernia
□ Gall bladder disease
□ Irritable Bowel
□ Hemorrhoids
□ Sexually transmitted disease
□ Seizures
□ Vertigo
□ Radiation
□ HIV
□ Anxiety disorder
□ Fibromyalgia

□ Cataracts; eye: R L
□ Allergies; nasal/sinus
□ Thyroid goiter
□ Diabetes, Insulin
□ Collapsed lung: R L
□ Tuberculosis
□ High Blood Pressure
□ Valve disease type: _____
□ Rhythm problems, type: _____
□ Pancreatitis
□ Hepatitis, type: _____
□ Kidney stones
□ Stroke
□ Paralysis, location: _____
□ Cancer, location: _____
□ Blood disorder, type: _____
□ Transfusion, year: _____
□ Other psych. Disorder: _____
□ Chronic pain, location: _____
□ Disk injury, location: _____

List all **MEDICATIONS** you are taking: _____

_____

_____

_____

_____

_____

_____

List all **ALLERGIES**: _____

_____

Obstetrical History: __# pregnancies __# Full Term

__# Premature __# Miscarriages __# Abortions

_____ First day last menstrual period

Past Surgical History – list all operations you have had: _____

_____

_____

_____

_____

Family History – List all illnesses of blood relatives in your family: _____

_____

Social History Single / Married / Divorced / Other

Does anyone ever slap you, hit you, hurt you or otherwise make you do anything that you don't want to do? _____
Are you being physically, emotionally, or sexually abused: Y / N

Florida Hotline 800-500-1119, A.C.T. 239-939-3112
C.A.R.E. 941-627-6000
Tobacco Use: Y / N # years: _____
□Smoke, packs per day ___ □Chew, amount ____

Alcohol Use: Y / N Rare / Weekly / Daily

Type: _____ Amount: _____

Drug Use: Y / N Type: _____ Amount: _____

Education (highest completed): High School College Vocational/Technical Graduate School Professional Degree

Spiritual: Do you attend religious services? Y / N

If yes, how often? _____

Where do you attend? _____

Do you pray? Y / N If yes, How frequently? _____

How important is religion to you? Not very / Somewhat / Very

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REVIEW OF SYMPTOMS:

(check all that apply)

Are you currently having any of the following symptoms?

□Fever
□Abnormal Sweats
□Changing Vision
□Difficulty speaking/swallowing
□Chest / Arm / Jaw Pain
□Short of Breath at night
□Calf pain while walking
□Sputum production
□Abdominal pain
□Loose Stools
□Constipation
□Burning w/urination
□Genital lesions
□Joint swelling
□Neck pain
□Masses under skin
□Breast problems
□Numbness/tingling in arms or legs
□Headache
□Anxiety
□Hallucinations
□Poor Appetite
□Intolerance to heat
□Bleeding easily
□Chills
□Generalized Weakness
□Loss of Consciousness
□Mouth Sores
□Palpitations
□Short of Breath w/activity
□Cough
□Bloody or rust-colored sputum
□Acid indigestion
□Black or tarry stools
□Yellow skin or eyes
□Retention/hesitancy of urine
□Incontinence of urine
□Warmth in joints
□Rash
□Infections in skin
□General or focal weakness
□Involuntary movements
□Tremors
□Depression
□Hearing voices that aren't there
□Severe Thirst
□Easy Bruising
□Weight Loss
□Visual Loss
□Hearing loss or changes
□Sinus / Nasal Congestion
□Short of breath when lying flat
□Swollen ankles
□Chest pain w/deep breath
□Wheezing
□Nausea / vomiting
□Vomiting blood
□Urinary frequency
□Vaginal / penile discharge
□Pain in joints
□Back pain
□Lesions of skin
□Itching
□Change in mentation (thinking)
□Ataxia or loss of balance
□Dizziness
□Suicidal thoughts
□Insomnia / sleep disorder
□Intolerance to cold
□Swollen Lymph Nodes

SPIRITUAL NEEDS

Do you have any spiritual needs that you would like addressed? Yes /No_____

_____

Do you have any prayer requests? Yes / No _____

_____

X_____ _____
Signature: Patient or Legal Guardian Date

Please Print Name: _____

Christian Medical Ministries, Inc.
Biotoxin Symptom Questionnaire

Name: _____ Please check **each** symptom you are experiencing:

_____Fatigue
_____Weakness
_____Decreased ability to retain new knowledge
_____Muscle aches
_____Headaches
_____Light sensitivity

_____Impaired memory
_____Decreased ability to find words
_____Difficulty concentrating

_____Joint pains
_____Morning stiffness
_____Muscle cramps

_____Unusual skin sensitivity
_____Tingling

_____Shortness of breath
_____Sinus congestion

_____Cough
_____Excessive thirst
_____Confusion

_____Appetite swings
_____Difficulty regulating body temperature
_____Increased urinary frequency

_____Red eyes
_____Blurry vision
_____Night sweats
_____Mood swings
_____Ice-pick pains

_____Static shocks
_____Vertigo (Dizziness)
_____Tearing of eyes
_____Disorientation
_____Metallic taste

_____Abdominal pain
_____Diarrhea
_____Numbness

_____

Signature _____ Date

Christian Medical Ministries, Inc.
Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and cirde a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question,

FSS Questionnaire

During the past week, I have found that:	**Disagree ■»- Agree**
1. My motivation is lower when I am fatigued.	1 2 3 4 5 6 7
2. Exercise brings on my fatigue.	1 2 3 4 5 6 7
3.1 am easily fatigued.	1 2 3 4 5 6 7
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me.	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 6 7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life.	1 2 3 4 5 6 7
Total Score:	

.

VISUAL ANALOGUE FATIGUE SCALE (VAFS)

Please mark an "X" on the number line which describes your global fatigue with 0 being worst and 10 being normal.

0	1	2	3	4	5	6	7	8	9	10

Patient Name – Printed _____ Date _____

Christian Medical Ministries, Inc.
(Epworth Sleepiness Scale ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze off or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:
0= would never dose
1=slight chance of dozing
2= moderate chance of dozing
3=high chance of dozing

It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of dozing (0-3)**
Sitting and reading	**0 1 2 3**
Watching television	**0 1 2 3**
Sitting inactive in a public place—for example, a theatre or meeting	**0 1 2 3**
As a passenger in a car for an hour without a break	**0 1 2 3**
Lying down to rest in the afternoon	**0 1 2 3**
Sitting and talking to someone	**0 1 2 3**
Sitting quietly after lunch (when you've had no alcohol)	**0 1 2 3**
In a car, while stopped in traffic	**0 1 2 3**
	Total Score:

Patient Name – Printed _____ Date _____

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

Consent for Alternative Treatment

I, _____, consent to have Alan W Gruning and all healthcare providers employed by or volunteering with Christian Medical Medical Ministries (CMM) treat me for my conditions. I have sought treatment at CMM because I have either failed standard medical treatments for my condition, and continue to be ill, or I desire a more holistic/functional medicine treatment approach for my conditions.

I give CMM permission to treat me with alternative therapies for my conditions, which include but are not limited to Fibromyalgia, Chronic Fatigue and Immune Dysfunction Syndrome, Autoimmune Disorders, Environmental Toxicity such as Biotoxin Illness (Chronic Inflammatory Response Syndrome), Thyroid and Adrenal Disorders, and Hormonal Imbalances. I will become knowledgeable about standard and alternative treatments for my conditions. I understand the treatments that CMM provides are not guaranteed to cure my condition and may not help me. I do not hold ICHW, Dr. Gruning, and the healthcare providers of CMM liable for any lack of progress, side effects of treatments, adverse outcomes, or unforeseen problems resulting from my treatment plan.

I consent to be a willing and compliant patient in the CMM medical practice. I will obtain all requested diagnostic tests in a timely manner. I will adhere to the prescribed treatment plan. I will comply with all required appointments, and I will schedule appointments as requested by CMM.

_____ _____

Patient Signature Date

Patient Partnership Agreement

CMM Staff & Volunteers love working with you on your path to healing. Because we are growing, we are formalizing our patient partnership with the goal of reaching and serving as many patients as possible. By signing this form, you agree to the following expectations in a mutual effort to provide healing to our community:

Eligibility Requirements

- All new patients must present a **valid Florida ID** or other **proof of Florida residency** to be eligible for care at our clinic.
- **The first appointment must be conducted in the state of Florida.**
- Once established, patients may only be seen **out of state a maximum of three (3) times**.

Appointment Guidelines

- Please arrive **30 minutes early** for your New Patient Appointment (for both in-person and telehealth appointments).
- Please arrive **15 minutes early** for each follow-up visit (for both in-person and telehealth appointments).
- **Late arrivals** may result in shortened or rescheduled appointments.
- If the patient is **under 18**, and a guardian is attending the appointment, the **child must also be present**.
- If the patient is **18 or older**, they are legally considered an adult and must attend their own visits, even if a parent or guardian is involved in their care. In these cases, a **signed HIPAA consent form** must be on file to allow our clinic to share medical information or involve others in the patient's treatment.
- All **DO/NP** visits must be conducted **in person or by video**. **Phone calls are not an acceptable substitute** unless approved due to technical issues like poor internet connection.

Counseling Evaluation

All patients are required to complete an **initial evaluation with our counselor**, with **ongoing counseling visits scheduled as needed** to support your healing process.

Follow-Up & Treatment Consistency

- Patients must be **consistent with follow-up visits** as outlined by their provider—typically **every 1 to 2 months**.
- **Delays or gaps in care** may result in paused treatment or dismissal from the clinic.

Cancellations & No-Shows

- **Please provide** at least 24 hours' notice **for cancellations or rescheduling.**
- Three (3) same-day cancellations or no-shows within a 6-month period **will result in** discharge from the clinic**.**
- **This policy protects access for patients waiting for care. Emergencies will be reviewed on a case-by-case basis.**

CIRS Coaching Requirement

- Patients being treated for Chronic Inflammatory Response Syndrome (CIRS) must schedule **coaching appointments with our CIRS Coach every other week** while becoming established.

- **Failure to follow this schedule will result in an inability to schedule further follow-up appointments with all providers** until coaching is resumed.

Environmental Testing Requirement

- We cannot help you get better if you remain in a toxic environment.
- **By your third visit, you are required to have completed an environmental test of your home**, as recommended by our providers.
- If this is not completed, we will **pause treatment** until testing is done

Communication & Staffing Limitations

- **Due to limited staffing**, we **do not handle insurance pre-authorizations** of any kind.
- Most of our communication is conducted via **text and email**. Please allow **up to 5 business days** for a response to your request.

Supplement Donations

- If financially possible, we appreciate a **$1 donation per supplement bottle** if provided at your in-person visit-based on availability.

Medical Records & Forms

- Health questions and medication needs will only be addressed **during appointment time and clinic hours**.
- Requests for medical records will be processed within **3 weeks**, depending on staff availability.
- Providers will only review patient records **during clinic hours**.
- We **do not complete disability determination forms** or participate in disability evaluations.
- If you are represented by an **attorney**, all requests for records, letters, or depositions must be made **in writing by your attorney**, and **pre-payment is required**.

Respectful Conduct & Discharge Policy

- Our clinic maintains a safe, respectful environment for staff, volunteers, and patients.
- **Disrespectful, abusive, or inappropriate behavior** toward staff will result in **immediate discharge** from care.
- Patients who are discharged will receive a certified letter and 30 days of emergency care only.
- Records are retained for **7 years**, and patients will be referred to the **local medical society** to find a new provider.

Patient Name	Signature	Date