James Valcarcel, DC
136 N Orchard St #3,
Ormond Beach, FL 32174
p. 386.310.8096

Comprehensive Health History

Date: ___/___/____

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, provide effective use of your scheduled time and ultimately lead to enhanced clinical success.

We know this is a lengthy document but takes most people only **20-30 minutes** to complete. Rest assured that we will spend considerable time reviewing and analyzing it. We will be going through this document, whatever lab/diagnostic tests you provide for us, as well as ALL applicable medical records in preparation for your consultation- Sometimes this takes as long as 2-3 hours, cumulatively. All of this is at no extra cost to you and enables us to ensure that we are as thorough as possible. Your health and well-being obviously matter to you, and are our number one priority, as well.

If you need more room please write on the back of any page.

First Name: _________________________ Middle: _____________________ Last: ___________________________________

Address: _______________________________Apt: _____ City: ______________________State____ Zip Code: _____________

Home Phone: (______)_______-_________ Work: (______)______-__________ Cell: (______)______-_________

E-mail: _______________________________ Age: ______ Date of birth: ___/___/____ Gender: F___M___

Place of birth: ____ (town & country)

Referred by: ____

Name, address, phone # of primary care physician: ____

____

Marital Status: Single___ Married___ Divorced ___ Widowed ___ Long Term Partnership ___

Emergency Contact: ____
Relationship Name Phone

____
Address

Occupation: _______________________________ Hours per week: ______ Retired: ______

Nature of business: ____

Current Health Status/Concerns

Please provide us with current and ongoing problems

0-no pain 10-worst possible pain

Problem	Date of Onset	Frequency	Severity 0-10
Example: Headaches	May 2006	2x/week	7
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

What diagnosis, or explanation(s), if any, have been given to you for these concerns? ____________________

____

____

What treatments have been used and how would you rate their success? (0= no success, 10=complete resolution of problem) ____

____

____

When was the last time you felt well? ____

What seems to trigger your symptoms? ____

What seems to worsen your symptoms? ____

What seems to make you feel better? ____

If you have experienced REOCCURENCE of an illness, please circle it:

Anemia
Arthritis
Asthma
Bronchitis
Cancer
Chicken pox
Chronic fatigue syndrome
Crohn's Disease
Ulcerative Colitis
Diabetes(I / II)
Stroke

Emphysema
Epilepsy, convulsions, or seizure
Gallstones
German Measles (Rubella)
Gout
Heart Attack, Angina
Heart Failure
Hepatitis
Herpes lesions/Shingles
High cholesterol / triglycerides
Thyroid Disease

High blood pressure (hypertension)
Irritable Bowel Syndrome
Kidney Stones
Measles
Mononucleosis
Mumps
Pneumonia
Rheumatic Fever
Sinusitis
Sleep Apnea
Whooping Cough

Other: ____

Other: ____

Injuries	When
Back injury	
Broken Bones	
Head injury	
Neck injury	
Other:	

Diagnostic Studies	When
Blood Test	
Bone Density	
Bone Scan	
Carotid Artery Ultrasound	
CAT/CT Scan	
Colonoscopy	
EKG	
Liver Scan	
Mammogram	
Neck X-ray	
MRI	
X-ray (body part imaged)	
Other:	
Other:	

Surgeries	When
Appendectomy	
Dental	
Gall Bladder	
Hernia	
Hysterectomy	
Tonsillectomy	
Tubes in Ears	
Other:	
Other:	

Hospitalizations

Where	When

List all Medications, including over the counter non prescription drugs.

Medication Name	Date Started	Date Stopped	Dosage

List all vitamins, minerals, herbs, and nutritional supplements you are currently taking.

Name	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:____

Childhood History

	Yes	No	Don't know
Were you a full term baby?			
Premature? How much?			
Breast fed?			
Bottle fed?			
While pregnant, did your mother:			
Smoke tobacco?			
Use recreational drugs?			
Drink alcohol?			
Use estrogen?			
Other non/prescription drugs?			

Immunization History

	Yes	No	Don't know
Smallpox			
Tetanus			
Diphtheria			

Pertussis			
Polio (oral)			
Polio (injection)			
Mumps			
Mumps			
Measles			
Rubella (German Measles)			
Typhoid			
Cholera			

Childhood Illnesses

Indicate which of the following you experienced as a child (birth to 12 years) and approximate age of onset.

	Yes	Age		Yes	Age
ADD (Attention Deficit Disorder)			Jaundice		
Asthma			Mumps		
Bronchitis			Seasonal Allergies		
Chicken Pox			Skin disorders (e.g. dermatitis)		
Colic			Strep infections		
Congenital Problems			Tonsillitis		
Ear Infections			Upset stomach/digestive problems		
Fever Blisters			Whooping Cough		
Frequent Colds or Flu			Measles		
Frequent Headaches			Other:		
Hyperactivity			Other:		

As a child did you: Have a high absence from school? Yes___ No ___

If yes, why?: ____

Experience chronic exposure to second hand smoke? Yes___ No ___

Experience abuse? Yes___ No ___

Have alcoholic parents? Yes___ No ___

Female Medical History

Obstetetrics History

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

☐ Pregnancies _____ ☐ Abortion _____ ☐ Post Partum Depression _____

☐ Miscarriage _____ ☐ Toxemia ______ ☐ Living Children _____

☐ Caesarean _____ ☐ Vaginal Deliviries _____ ☐ Gestational Diabetes _____

Gynecological History

Age at first menses? _____ Frequency: ________________ Length: ______________

Painful: Yes ____ No ____ Clotting: Yes ____ No _____

Date of last menstrual period: ___/___/____

Do you currently use contraception? Yes ____ No ____

If yes, what form?: ☐Condom ☐Diaphragm ☐IUD ☐Partner Vasectomy ☐Other: ________________________________

Hormonal: ☐Birth control pills ☐Patch ☐Nuva Ring ☐Other: ____

Even if you are not currently using contraception, but have used hormonal birth control in the past, please indicate which type and for how long: ____

Please advise of any other symptoms that you feel are significant: ____

____

____

Are you menopausal? Yes ____ No ____ If yes, age of menopause: _____

Do you currently take hormone replacement? Yes ____ No ____

If yes, what type and for how long? ________ ☐Estrogen ☐Ogen ☐Estrace ☐Premarin ☐Progesterone ☐Provera

Other: _________________________________

Diagnostic Testing

Last PAP test: ___/___/____ Normal: _____ Abnormal: _____

Last Mammogram: ___/___/____ Breast biopsy? Date: ___/___/____

Date of last bone density: ___/___/____ Results: High ____ Low ____ Within Normal Range ____

Family Health History

Check Family Members that apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if living)									
Age at death									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ALS or other Motor Neuron Disease									
Alzheimer’s									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Disease (IE Lupus)									
Bipolar									
Bladder Disease									
Blood Clotting problems									
Celiac Disease									
Dementia									
Depression									
Diabetes (I / II)									
Eczema									
Emphysema									
Epilepsy									
Genetic Disorders									

Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, psoriatic, Ankylosing Spondylitis, etc)									
Inflammatory Bowel Disease									
Kidney Disease									
Multiple Sclerosis (MS)									
Obesity									
Osteoporosis									
Parkinson's									
Psoriasis									
Sleep Apnea									
Check Family Members that apply									
Stroke									
Substance abuse (ie alcoholism)									

Review of Symptoms

Check those that applied to you in the past. Circle those that presently apply.

General

☐ Fever	☐ Difficulty sweating	☐ Nightmares	☐ No dream recall
☐ Chills/colds all over	☐ Excessive sweating	☐ Sleepwalker	☐ Early waking
☐ Aches/pains	☐ Swollen glands	☐ Difficulty falling asleep	☐ Daytime Sleepiness
☐ General weakness	☐ Cold hands & feet	☐ Fatigue	☐ Distorted Vision

Skin

☐ Cuts heal slowly	☐ Psoriasis	☐ Fungus on nails	☐ Athletes foot
☐ Bruise easily	☐ Dryness/cracking	☐ Peeling skin	☐ Cellulite
☐ Rashes	☐ Oiliness	☐ Shingles	☐ Bugs love to bite you
☐ Pigmentation	☐ Itching	☐ Nails split	☐ Bumps on back of arms & front of thighs
☐ Changing moles	☐ Acne	☐ White spots/lines on nails	☐ Skin cancer
☐ Calluses	☐ Boils	☐ Crawling sensation	☐ Strong body odor
☐ Eczema	☐ Hives	☐ Burning on bottom of feet	

Is your skin sensitive to: ☐ Sun ☐ Fabrics ☐ Detergents ☐ Lotions/creams

Head

☐ Poor concentration	☐ Concussion/whiplash	☐ Mental sluggishness	☐ Face twitch
☐ Confusion	☐ Poor memory	☐ Forgetfulness	☐ Indecisiveness
☐ Hair loss			

Headaches: ☐ After meals ☐ Severe ☐ Migraine ☐ Frontal ☐ Afternoon ☐ Occipital ☐ Daytime

☐ Relieved by eating sweets

Ears

☐ Aches	☐ Hearing aid	☐ Frequent infections	☐Ringing
☐ Discharge/conjunctivitis	☐ Pressure	☐Tubes in ears	☐ Deafness/hearing loss
☐ Pains	☐ Itching	☐Sensitive to loud noises	☐ Hearing hallucinations

Eyes

☐ Feeling of sand in eyes	☐ See bright flashes	☐ Cataracts	☐ See bright flashes
☐ Double vision	☐ Halo around lights	☐ Floaters in eyes	☐ Dark circles under eyes
☐ Blurred vision	☐Eye pains	☐ Visual hallucinations	☐ Poor night vision

Nose / Sinuses

☐ Stuffy	☐ Watery nose	☐ Polyps	☐ Sneezing spells
☐ Bleeding	☐ Congested	☐ Acute smell	☐ Post nasal drip
☐ Running/discharge	☐ Infection	☐ Drainage	☐ No sense of smell

Does the change of seasons tend to make your symptoms worse? Yes ___ No ___

If yes, is it worse in the: ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Mouth

☐ Coated tongue	☐ Canker sores	☐ Chapped lips	☐ Grind teeth when sleeping
☐ Sore tongue	☐ TMJ	☐ Fever blisters	☐ Bad breath
☐ Teeth problems	☐ Cracked lips/corner	☐ Wear dentures	☐ Dry mouth
☐ Bleeding gums			

Throat

☐ Mucus	☐ Frequent Hoarseness	☐ Enlarged glands	☐ Throat closes up
☐ Difficulty swallowing	☐ Tonsillitis	☐ Constant clearing	

Neck

☐ Stiffness	☐ Swelling	☐ Lumps	☐ Neck glands swell

Circulation/Respiration

☐ Swollen ankles	☐ Sensitive to hot	☐ Sensitive to cold	☐ Extremities cold/clammy
☐ High blood pressure	☐ Chest pain	☐ Pain between shoulders	☐ Dizziness upon standing
☐ Fainting spells	☐ High cholesterol	☐ High triglycerides	☐ Wheezing
☐ Low exercise tolerance	☐ Frequent coughs	☐ Palpitations	☐ Irregular heartbeat
☐ Breathing heavily	☐ Frequently sighing	☐ Shortness of breath	☐ Night sweats
☐ Varicose/spider veins	☐ Mitral valve prolapse	☐ Murmurs	☐ Skipped heartbeat
☐ Heart enlargement	☐ Angina pain	☐ Bronchitis/Pneumonia	☐ Emphysema
☐Croup	☐Frequent colds	☐ Heavy/tight chest	☐ Phlebitis

Do your hands/feet go to sleep or feel numb/tingly? Yes ___ No ___

Prior heart attack? Yes ___ No ___ If yes, when? Date: ___/___/____

Gastrointestinal

☐ Peptic/duodenal ulcer	☐ Gall bladder pain	☐ Nervous stomach	☐ Full feeling after small meal

☐ Poor appetite	☐ Indigestion	☐ Heartburn	☐ Acid reflux
☐ Excessive appetite	☐ Nausea	☐ Vomiting	☐ Hiatal Hernia
☐ Gallstones	☐ Vomiting blood	☐ Abdominal pain/cramps	☐ Gas
☐ Gas	☐ Diarrhea	☐ Constipation	☐ Changes in bowels
☐ Rectal bleeding	☐ Tarry stools	☐ Rectal itching	☐ Use laxatives
☐ Bloating	☐ Belch frequently	☐ Anal itching	☐ Anal fissures
☐ Bloody stools	☐ Undigested food in stool		

Kidney/Urinary Tract

☐ Burning	☐ Problem passing urine	☐ Bladder infections	☐ Bedwetting
☐ Frequent urination	☐ Kidney pain	☐ Kidney infections	☐ Have trichomonas
☐ Blood in urine	☐ Kidney stones	☐ Syphilis	☐ Painful urination
☐ Night time urination			

Women's History

Cross out if N/A

☐ Fibrocystic breast(s)	☐ Lumps in breast(s)	☐ Fibroid tumors/breast	☐ Spotting
☐ Heavy periods	☐ Fibroid tumors/uterus	☐ Painful periods	☐ Change in period
☐ Breast soreness prior to period	☐ Endometriosis	☐ Non-period bleeding	☐ Breast soreness during period
☐ Vaginal dryness	☐ Vaginal discharge	☐ Partial/total hysterectomy	☐ Hot flashes
☐ Mood swings	☐ Poor concentration/memory	☐ Breast cancer	☐ Ovarian cysts
☐ Pregnant	☐ Infertility	☐ Decreased libido	☐ Heavy bleeding
☐ Joint pains	☐ Headaches	☐ Weight gain	☐ Loss of bladder control
☐ Palpitations			

Men's History

Cross out if N/A

Have you had a PSA test done? When? ___/___/____ Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ 10+

☐ Prostate enlargement	☐ Prostate infection	☐ Change in libido	☐ Impotence
☐ Decreased/poor libido	☐ Infertility	☐ Lumps in testicles	☐ Sore on penis
☐ Genital pain	☐ Hernia	☐ Prostate cancer	☐ Low sperm count
☐ Difficulty obtaining erection	☐ Difficulty maintaining erection	☐ Nocturia (urination at night) How often? _____	☐ Urgency/hesitancy or change in urinary stream
☐ Loss of bladder control			

Joint/Muscles/Tendons

☐ Pain wakes you	☐ Weakness in legs & arms	☐ Balance problems	☐ Muscle cramping
☐ Head injury	☐ Muscle stiffness in morning	☐ Damp weather bothers you	

Emotional

☐ Convulsions	☐ Dizziness	☐ Fainting spells	☐ Blackouts/amnesia

☐ Had prior shock therapy	☐ Frequently jittery	☐ Startled by sudden noises	☐ Anxiety/feeling of panic
☐ Go to pieces easily	☐ Forgetful	☐ Listless/groggy	☐ Withdrawn/lost feeling
☐ Had nervous breakdown	☐ Poor concentration	☐ Poor attention	☐ Vision changes
☐ Unable to reason	☐ Others consider you nervous	☐ Worry needlessly	☐ Unusual tension
☐ Frustration	☐ Emotional numbness	☐ Break out in cold sweats	☐ Profuse sweating
☐ Depressed	☐ Previously admitted for psychiatric care	☐ Often awakened by frightening dreams	☐ Family member had a nervous breakdown
☐ Use tranquilizers	☐ Misunderstood by others	☐ Irritable	☐ Feeling of hostility or aggression
☐ Fatigue	☐ Hyperactive	☐ Restless leg syndrome	☐ Considered clumsy
☐ Unable to coordinate muscles	☐ Have difficulty falling asleep	☐ Have difficulty staying asleep	☐ Daytime sleepiness
☐ Am a workaholic	☐ Have had hallucinations	☐ Have considered suicide	☐ Have overused alcohol
☐ Family history of alcohol abuse	☐ Cry often	☐ Feel insecure	☐ Have overused drugs
☐ Been addicted to drugs	☐ Extremely shy		

PAIN ASSESSMENT

Are you currently in pain? Yes___ No ___

If you answered NO you may skip this section

If yes, is the source of your pain due to an injury? Yes___ No___

If yes, please describe your injury and the date when it occurred: ____

____

____

If no, please describe how long you have experienced this pain and what you believe it is attributed to: ___________

____

____

Please use the area(s) and illustration below to describe the severity of your pain. (0=no pain, 10= most severe pain)

Example: _____Neck________________

1 2 3 4 5 (6) 7 8 9 10

Area 1: _________________________

1 2 3 4 5 6 7 8 9 10

Area 2: _________________________

1 2 3 4 5 6 7 8 9 10

Area 3: _________________________

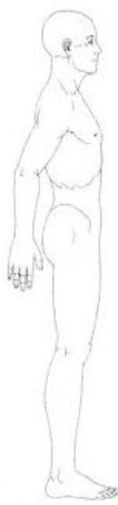
1 2 3 4 5 6 7 8 9 10

Area 4: _________________________

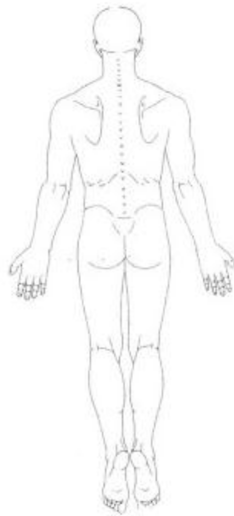
1 2 3 4 5 6 7 8 9 10

Use the letters provided to mark your area(s) of pain on the illustration

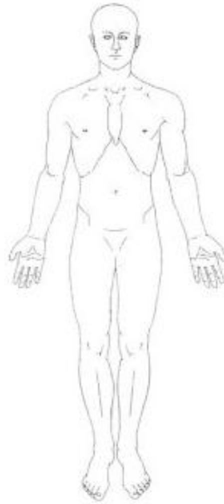
A = Ache B = Burning N = Numbness S = Stiffness T= Tingling Z = Sharp/Shooting



Right side



Back



Front

Left Side

Nutritional History

Have you made any changes in your eating habits because of your health? Yes ___ No ___

If you answered YES, please explain those changes: ____

____

Do you currently follow a special diet or nutritional program? Yes ___ No ___

☐ Ovo-lacto ☐ Diabetic ☐ Dairy restricted ☐ Vegetarian ☐ Vegan ☐ Blood type

☐ Other: ____

Please tell us if there is anything special about your diet that we should know: ______________________________

____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc? Yes ___ No ___

If yes, are these symptoms associated with any particular food or supplement? Yes ___ No ___

If yes, please name the food or supplement and symptoms: ____

____

Do you feel that you have delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more): Yes ___ No ___

Do you feel worse when you eat a lot of: ☐ High fat foods ☐ High protein foods ☐ High carbohydrate foods (breads, pastas, cereals) ☐ Refined sugars (candy, junk) ☐ Fried foods ☐ 1 or 2 alcoholic drinks ☐ Other: _______________

Do you feel better when you eat a lot of: ☐ High fat foods ☐ High protein foods ☐ High carbohydrate foods ☐ Refined sugars (candy, junk) ☐ Fried foods ☐ 1 or 2 alcoholic drinks ☐ Other: _______________

Does skipping meals greatly affect your symptoms? Yes ___ No ___

Has there ever been a food that you have craved or binged on over a period of time? Yes ___ No ___

If yes, what food(s)? ____

____

Do you have an aversion to certain foods? Yes ___ No ___

If yes, what food(s)? ____

____

Please complete the following chart as it relates to your bowel movements:

Frequency		**Consistency**		**Color**	
More than 3x/day		Soft and well formed		Medium brown consistently	
1-3x/day		Often floats		Very dark or black	
4-6x/week		Difficult to pass		Greenish color	
2-3x/week		Diarrhea		Blood is visible	
1 or fewer x/week		Thin, long or narrow		Varies a lot	
		Small and hard		Dark brown consistently	
		Loose but not watery		Yellow, light brown	
		Alternating between hard and loose/watery		Greasy, shiny appearance	

Intestinal gas: ☐ Daily ☐ Occasionally ☐ Excessive ☐ Present with pain ☐ Foul smelling ☐ Little odor

Lifestyle History

Tobacco History

Have you ever used tobacco? Yes ___ No ___

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/gum

How much? ____

Number of years? ___________________________ If not a current user, year quit? __________________

Attempts to quit: ________________

Are you exposed to 2nd hand smoke regularly? Yes ___ No ___ If yes please explain: ___________________________

____

Caffeine History

Do you drink coffee? Yes ___ No ___

If yes, how many cups per day? ____________ cups/day

How long have you been drinking coffee for? ______________________________________

Soft Drink History

Do you drink soda/pop or other sugar sweetened beverages (sweet tea, etc)? Yes ___ No ___

If yes, how much per day? _____________________________________

Do you drink artificially sweetened beverages? (diet sodas/pops, etc) Yes ___ No ___

If yes, how much per day? _____________________________________

Alcohol History

Have you ever used alcohol? Yes ___ No ___

If yes, how often do you now drink alcohol?

- ☐ No longer drink alcohol
- ☐ Average 1-3 drinks per week
- ☐ Average 4-6 drinks per week
- ☐ Average 7-10 drinks per week
- ☐ Average > 10 drinks per week

Do you notice a tolerance to alcohol? (can you hold more than others) Yes ___ No ___

Have you ever had a problem with alcohol? Yes ___ No ___

If yes, indicate time period (month/year) From ___________ to __________

Other Substances

Do you currently or have you previously used recreational drugs? Yes ___ No ___

If yes, what type(s) and method(s)? (IV, smoked, inhaled, etc) ____

____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes ___ No ___

If yes, indicate which: ☐ Lead ☐ Arsenic ☐ Aluminum ☐ Cadmium ☐ Mercury ☐ Other: ____________________

Sleep & Rest History

Average number of hours you sleep at night? ☐ Less than 6 ☐ 6-8 ☐ 8-10 ☐ More than 10

Do you: ☐ Have trouble falling asleep ☐ Have trouble staying asleep ☐ Feel rested upon waking ☐ Use sleeping aids ☐ Snore ☐ Have problems with insomnia

Exercise History

Do you exercise regularly? Yes ___ No ___

If yes please indicate:

Type of exercise	Times per week				Length of session			
	1	2	3	4+	15	16-30	31-45	45+
Jogging/walking								
Aerobics								
Strength training								
Sports (tennis, golf, basketball, etc)								
Pilates/Yoga/Tai Chi								
Other:____								

If no, please indicate what problems limit your activity (lack of motivation, fatigue after exercising, etc.):

____

____

____

Social History

Stress/Psychosocial History

Are you overall happy? Yes ___ No ___

Do you feel you can easily handle the stress in your life? Yes ___ No ___

If no, do you believe that stress is presently reducing the quality of your life? Yes ___ No ___

If yes, do you believe that you know the source of your stress? Yes ___ No ___

If yes, what do you believe it to be? ____

Have you ever contemplated suicide? Yes ___ No ___

If yes, how often? ___________________ When was the last time? ___________________________________

Have you ever sought help through counseling? Yes ___ No ___

If yes, what type? (e.g. pastor, psychologist, etc) ____

Did it help? Yes ___ No ___

Which of the following provide you emotional support? ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets

☐ Other:

Have you ever been involved in an abusive relationship in your life? Yes ___ No ___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No ___

Did you feel safe growing up? Yes ___ No ___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No ___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No ___

How important is religion (or spirituality) for you and your family's life?

☐ Not at all important ☐ Somewhat important ☐ Extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? ____

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: _______________

Hobbies and leisure activities: ____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here?

Yes ___ No ___

If you feel there is anything else you need to add that may be beneficial for me to know please add below:

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

I look forward to helping you achieve lifelong health and well-being.

Sincerely,

Dr. James Valcarcel