Health Questionnaires

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HEALTH QUESTIONNAIRES

GENERAL INFORMATION

Name	First: _____ MI: ____ Last:_____
Preferred Name	_____
Date of Birth	_____
Age	_____
Gender	☐ Female ☐ Male
Genetic Background	☐ African ☐ European ☐ Native American ☐ Asian ☐ Ashkenazi ☐ Mid. Eastern ☐ Mediterranean ☐
Highest Education Level	☐ No High Sch. ☐ High School ☐ Under-Grad ☐ Post-Grad
Job Title	_____
Nature of Business	_____
	_____
Primary Address	Street: _____ Apt. No. _____ City: _____ St.: _____ Zip: _____
Alternate Address	Street: _____ Apt. No. _____ City: _____ St.: _____ Zip: _____
Home Phone 1	_____
Home Phone 2	_____
Work Phone	_____
Cell Phone	_____
Fax	_____
Email	_____
Emergency Contact	Name: Phone: Address: Apt. No. City: State: Zip:
Physician	Name: Phone: Fax:
Referred by	☐ Book ☐ Website ☐ She Mag ☐ Newspaper/TV ☐ Friend/Family ☐ Dr._____ ☐ Social media ☐ Event/Seminar_____

INSURANCE INFORMATION

Primary Insurance Name			
Address			
City/State/Zip			
Phone	( ) -		
Fax	( ) -		
Member ID		Unique Health ID	
Policy Name		Policy Number	
Group Name		Group Number	
Effective Date		Expires	
Co-Pay		Co-insurance	

Secondary Insurance			
Address			
City/State/Zip			
Phone	( ) -		
Fax	( ) -		
Member ID		Unique Health ID	
Policy Name		Policy Number	
Group Name		Group Number	
Effective Date		Expires	
Co-Pay		Co-insurance	

PHARMACY INFORMATION

Preferred Pharmacy	
Address	
City/State/Zip	
Phone	( ) -
Fax	( ) -
Email	

Compounding/Supplement Pharmacy	
Address	
City/State/Zip	
Phone	( ) -
Fax	( ) -
E-mail	

*It is extremely important that you list the pharmacy's fax number.

CREDIT CARD INFORMATION

Preferred method of Payment (please circle one): Cash/Check/Credit Card (Amex, Discover, MasterCard, Visa)

Primary Card	*Secondary Card*
Cardholder name	*Cardholder Name*
Billing Address	*Billing Address*
City/State/Zip	*City/State/Zip*
Card Number	*Card Number*
Expiration Date (MM/YY) /	*Expiration Date (MM/YY)* /
CVV#	*CVV#*

MEDICAL QUESTIONNAIRE	
Complaints and Concerns	
What is the reason for your visit (Chief Complaint)	
Other complaints (1)	
(2)	
(3)	
(4)	
(5)	

If you had a magic wand, and could erase three problems, what would they be?
(1)
(2)
(3)

When was the last time you felt well?
Did something happen to trigger your change in health?
What makes you feel better?
What makes you feel worse?

Please list all current and ongoing problems in order of priority							
Describe Problem	Mild	Moderate	Severe	Treatment Used	Good	Fair	Poor
Example: Migraine		X		Elimination Diet	X		

ALLERGIES

Drug Name	Reaction(s)

MEDICATIONS

What medications are you taking now? Include non-prescription drugs.

Medication Name	Dosage	Frequency	Date Started	Reason

Vitamins and Supplements

List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Dosage	Frequency	Date started	Reason

Medication Side Effects

Yes	No	Check Yes or No and explain if yes	Explain
		Have your medications or supplements ever caused you unusual side effects or problems?	
		Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, etc.)	
		Have you had prolonged or regular use of Tylenol?	
		Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec or omeprazole, Nexium etc.)	
		Have you had frequent antibiotics (more than three times a year)?	
		Have you used steroids (Prednisone, nasal allergy sprays, or steroid inhalers)?	
		Do you, or have you used oral contraceptives in the past?	

PATIENT'S BIRTH AND CHILDHOOD HISTORY

Yes	No	Don't know	Question	Comment
			Were you a	
			Full term?	
			Premie?	
			Breast fed?	
			Bottle fed?	
			Did you have developmental problems?	
			Did you have ear infections as a child?	
			Did you have a lot of antibiotics as a child?	
			As a child, did you eat a lot of sugar and/or candy?	
			As a child, were there any foods that you had to avoid because they gave you symptoms? If yes, please name the food and the symptoms you had.	

MEDICAL HISTORY

DISEASES/DIAGNOSES/CONDITIONS *(Check appropriate box and write date of onset)*
C=Current or ongoing problem. P=Past problem, resolved.

C	P		C	P	
		Gastrointestinal			**Genital and Urinary**
		Irritable Bowel Syndrome			Kidney Stones
		Inflammatory Bowel Disease			Gout
		Crohn's Disease			Interstitial Cystitis
		Ulcerative Colitis			Frequent Urinary Tract Infections
		Gastritis or Peptic Ulcer Disease			Frequent Yeast Infections
		GERD			Erectile Dysfunction
		Celiac Disease			Sexual Dysfunction
		Other			Other
		Cardiovascular			**Inflammatory and Autoimmune**
		Heart Attack			Chronic Fatigue Syndrome
		Stroke			Autoimmune Disease
		Elevated Cholesterol			Rheumatoid Arthritis

		Irregular Heart Beat (Arrhythmia)			Lupus
		Hypertension			Immune Deficiency Syndrome
		Rheumatic Fever			Genital Herpes
		Mitral Valve Disease			Severe Infectious Disease
		Other Valve Disease			Frequent Infections
		Other Heart Disease			Food Allergies
					Environmental Allergies
		Metabolic or Endocrine Disease			Multiple Chemical Sensitivities
		Diabetes			Latex Allergy
		Low Blood Sugar			Other Immune Illness
		Metabolic Syndrome X			
		Pre-diabetes or Insulin Resistance			**Respiratory Disease**
		Low Thyroid (Hypothyroid)			Asthma
		Overactive Thyroid (Hyperthyroid)			Chronic Sinusitis
		Polycystic Ovary Syndrome			Bronchitis
		Infertility			Emphysema
		Weight Gain			Pneumonia
		Weight Loss			Tuberculosis
		Frequent Weight Fluctuations			Sleep Apnea
		Bulimia			Sarcoidosis
		Anorexia			Pulmonary Fibrosis
		Binge Eating Disorder			Respiratory Failure
		Night Eating Syndrome			Using Oxygen at home
		Eating Disorder (Non-specific)			Lung Transplant
					Other Lung or Respiratory Illness
		Cancer			
		Lung Cancer			**Neurologic/Mood**
		Breast Cancer			Anxiety
		Colon Cancer			Depression
		Ovarian Cancer			Bipolar Disorder
		Prostate Cancer			Schizophrenia
		Testicular Cancer			Headaches
		Skin Cancer			Migraines
		Liver cancer			ADD/ADHD
		Leukemia			Autism
		Lymphoma			Mild Cognitive Impairment
		Melanoma			Memory Problems
		Other			Parkinson's Disease
					Multiple Sclerosis
					ALS (Lou Gehrig's Disease)
					Seizures
		Skin Diseases			Neuropathy
		Eczema			
		Psoriasis			
		Acne			**Musculoskeletal**
		Skin Cancer			Osteoarthritis
		Decubitus Ulcers			Osteoporosis
		Fungal Toenails			Fibromyalgia
		Nail Disease			Chronic Pain
		Other Disease			Other Musculoskeletal Disease

TESTS AND PROCEDURES

Check "Yes" for any tests or procedures you have had, write date or test or procedure

Yes	Test or procedure	Date	Reason
	Full Physical Exam		
	Appendectomy		
	Bone Density		
	Hysterectomy Total Partial		
	Colonoscopy		
	Gall Bladder		
	Cardiac Stress Test		
	Hernia		
	EBT Heart Scan		
	Tonsillectomy		
	EKG		
	Dental Surgery		
	Stool Occult Blood Test		
	Joint Replacement Hip Knee		
	MRI		
	Heart Surgery Bypass Valve		
	Upper Endoscopy		
	Angioplasty or Stent		
	Upper GI Series		
	Pacemaker or Defibrillator		
	Ultrasound		
	Other		

HOSPITALIZATIONS		
Where Hospitalized?	When?	For What Reason?

What is your blood type? □ A □ B □ AB □ O
□ Rh+ □ Rh-

Any injuries? (Check all that apply and explain).

□ Back injury_____

□ Head injury_____

□ Neck injury_____

□ Broken bones_____

□ Other Injury (Describe) _____

Gynecologic and Obstetric History

Menarche	Age at first period: _____ years old
Menstruation	Regular menstruations: _____ Yes, _____ No Days of flow _____ 1-3, _____ 4-6, _____ >6 days Heavy Clots: _____ Yes, _____ No In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No____ Not applicable
Contraception	Birth Control Pills? _____ Current use, _____ Previous use, _____ Never used Any complications from use of contraception? _____ Yes, _____ No Explain complication(s) _____
Pregnancy	Have you ever been pregnant? _____ Number of miscarriages _____ Number of abortions _____ Number of preemies _____ Number of term births _____ Weight of largest baby _____ Weight of smallest baby _____ Did you have Toxemia or pre-eclampsia? _____ Did you have diabetes (or gestational diabetes?) _____ Did you have postpartum depression? _____
Menopause	Are you in menopause? _____ Yes, _____ No (If no, go to Prevention). Age at last period _____ years old. Do you take hormone replacement therapy (HRT)? _____ Yes, _____ No What do you take? _____ Do you have menopausal symptoms? _____ Yes, _____ No Explain _____ How long have you been on HRT? _____ years
Prevention	Do you do monthly breast self-exams? _____ Yes, _____ No When was your last mammogram? _____ When was your last pap smear? _____ Have you had the HPV vaccine? _____

Dental History

Men's History

Please circle the appropriate response and explain where necessary

Yes No Do you have prostate enlargement? _____

Yes No Do you have prostate infection(s)? _____

Yes No Any change in sexual desire? _____

Yes No Any issues with Impotence? _____

Yes No Any difficulty obtaining or maintaining an erection? _____

Yes No Urinating at night? If yes, how many times at night? _____

Yes No Any difficulty starting urine flow? _____

Yes No Any change in the stream? _____

Yes No Any loss of control of your urine? _____

GI Travel History

1. Have you lived or traveled outside of the United States? Yes____ No____
   If so, when and where? _____

   _____
2. Destination(s): _____
3. Departure date: _____ Return date: _____
4. Terrain visited: ( ) Rural ( ) Urban ( ) Forest ( ) Mountain
5. Duration of travel: _____
6. Purpose of travel: ( ) Relief or missionary work ( ) Vacation ( ) Business ( ) Employment
7. Degree of contact with locals ( ) Extensive ( ) Moderate ( ) Sparing
8. Disease contacts? ( ) Yes ( ) No
9. Insect or animal bites? ( ) Yes ( ) No
10. Scratches or licks? ( ) Yes ( ) No
11. Unprotected sex? ( ) Yes ( ) No
12. Diet while traveling: _____
13. Did you get vaccinated for travel? ( ) Yes ( ) No
14. Did you take malaria prophylaxis? ( ) Yes ( ) No
15. Did you sustain injury or illness during travel? ( ) Yes ( ) No

Family History

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other	
Age (if still alive)													
Age at death (if deceased)													
Cancer													
Colon cancer													
Breast or ovarian cancer													
Heart disease													
Hypertension													
Obesity													
Diabetes													
Stroke													
Inflammatory arthritis (rheumatoid ankylosing, psoriatic)													
Inflammatory Bowel Disease													
Multiple Sclerosis													
Autoimmune disease (Lupus, Sjogren's, scleroderma etc.)													
Irritable Bowel Syndrome													
Celiac disease													
Asthma													
Eczema													
Psoriasis													
Food allergies													
Environmental sensitivities													
Dementia													
Parkinson's													
ALS or other muscle disease													
Genetic disorders													
Substance abuse													
Psychiatric disease													
Depression													
Schizophrenia													

Social History

Yes	No	Check the appropriate response.	Explain: If yes, how successful was the diet?
		Are you on a special diet?	
		Atkins Diet	
		Beverly Hills Diet	
		DASH Diet	
		Diabetic Diet	
		Grapefruit Diet	
		Weight Watchers	
		Ketogenic Diet	
		Gluten free Diet	
		Dairy free Diet	
		Vegan Diet	
		Vegetarian Diet	
		Ovo-Lacto	
		Blood Type Diet	
		Other _____	

How much of the following do you consume each week?			
Candy (pieces)		Diet sodas	
Cheese (Slices)		Ice cream (cups)	
Chocolate (pieces)		Salty foods (servings)	
Cups of coffee containing caffeine		Slices of white bread (rolls/bagels)	
Cups of decaffeinated coffee or tea		Sodas with caffeine	
Cups of hot chocolate		Sodas without caffeine	
Cups of tea containing caffeine			

Place a check mark next to the food/drink that applies to your current diet.								
	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

Eating Habits					
Check all the factors that apply to your current eating habits					
	Fast eater		Healthy foods not available		Negative relationship to food
	Erratic eating pattern		Do not plan meals or menus		Struggle with eating issues
	Eat too much		Reliance on convenience foods		Emotional eater
	Late night eating		Poor snack choices		Eat too much under stress
	Dislike healthy food		Spouse or family don't like healthy foods		Eat too little under stress
	Time constraints		Spouse or family have special dietary needs		Don't care to cook
	Eat more than half of meals away from home		Love to eat		Late supper (after 7 pm)
	Travel frequently		Eat because I have to		Confused about nutrition advise

The most important thing I should change about my diet to improve my health is: _____

Diet and Weight Loss		
Yes	No	
		Have you ever had a nutrition consultation?
		Have you made any changes in your eating habits because of your health?
		How often do you weigh yourself?
		Have you ever had your metabolism (resting metabolic rate) checked?
		Do you avoid any particular foods?
		If you could only eat a few foods a week, what would they be?
		Do you grocery shop? If no, who does the shopping?
		Do you read food labels?
		Do you cook? If no, who does the cooking

Please fill in the chart below with information about your bowel movements:					
Frequency		**Consistency**		**Color**	
	More than 3x/day		Soft and well formed		Medium brown consistently
	1-3x/day		Often float		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		Greasy, shiny appearance

EXERCISE

Current Exercise Program: *(List type of activity, number of sessions/week, and duration)*

Activity	Type	Frequency Per Week	**Duration in Minutes**
Stretching			
Cardia/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: _____

Do you usually sweat when exercising? ☐ Yes ☐ No If yes, how long? _____ Minutes.

Food Allergies, Sensitivities and Intolerances

Do you have known adverse food reactions or sensitivities? □ Yes □ No If yes, describe symptoms: _____
Do you have any food allergies or sensitivities? □ Yes List all: _____
Do you have an adverse reaction to caffeine? □ Yes □ No Describe: _____
When you drink caffeine do you feel: □ Irritable or Wired □ Aches & Pains
Do you adversely react to (Check all that apply): □ No □ Monosodium glutamate (MSG) □ Aspartame (Nutrasweet) □ Caffeine □ Onion □ Cheese □ Citrus Foods □ Chocolate □Alcohol □ Red Wine □ Garlic □Bananas □ Sulfite Containing Foods (wine, dried fruit, salad bars) □ Preservatives (ex. sodium benzoate)
Other: _____

Yes	No	Is there anything special about your diet that we should know? If yes, explain. _____
Yes	No	Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.? Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea. **a)** _____ **b)** _____
Yes	No	Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? a) _____ b) _____
Yes	No	Do you feel much **worse** when you eat a lot of: _____high fat foods _____refined sugar (junk food) _____high protein foods _____fried foods _____high carbohydrate foods (breads, pastas, potatoes) _____1 or 2 alcoholic drinks _____other _____
Yes	No	Do you feel much **better** when you eat a lot of: _____high fat foods _____refined sugar (junk food) _____high protein foods _____fried foods _____high carbohydrate foods(breads, pastas, potatoes) _____1 or 2 alcoholic drinks _____other _____
Yes	No	Does skipping a meal greatly affect your symptoms?
Yes	No	Have you ever had a food that you craved or really "binged" on over a period of time? (Food craving may be an indicator that you may be allergic to that food.) If yes, what food(s)? _____
Yes	No	• Do you have an aversion to certain foods? If yes, what foods? _____ __

Relationship History

How well is our life going?					
	Very Well	**Fair**	**Poorly**	**Very Poorly**	**Does not apply**
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

Environmental and Detoxification Assessment

DENTAL SURGERY

□ Silver Mercury Fillings How many? _____

□ Gold Fillings □ Root Canals □ Implants □ Tooth Pain □ Bleeding Gums

□ Gingivitis □ Problems with Chewing

Do you floss regularly? □ Yes □ No

SMOKING

Currently Smoking? □ Yes □ No How many years? _____ Packs per day: ____ Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? ____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits

□ None □ 1-3 □ 4-6 □ 7-10 □>10 If "None," skip to Other Substances

Previous alcohol intake? □ Yes (□ Mild □ Moderate □ High) □ None

Have you ever been told you should cut down your alcohol intake? □ Yes □ No

Do you get annoyed when people ask you about your drinking? □ Yes □ No

Do you ever feel guilty about your alcohol consumption' □ Yes □ No

Do you ever take an eye-opener? □ Yes □ No

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

Have you ever been unable to remember what you did during a drinking episode? □ Yes □ No

Do you get into arguments or physical fights when you have been drinking? □ Yes □ No

Have you ever been arrested or hospitalized because of drinking? □ Yes □ No

Have you ever thought about getting help to control or stop your drinking? □ Yes □ No

OTHER SUBSTANCES

Caffeine Intake: □ Yes □ No | Coffee cups/day: 1 2-4 >4

Teacups/day: □ Yes □ No | Cups of Tea (circle) 1 2-4 >4

Caffeinated Sodas or Diet Sodas Intake: □ Yes □ No 12-ounce can/bottle (circle). 1 2-4 > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): _____

Are you currently using any recreational drugs? □ Yes □ No

Type

1. Amphetamines
2. Barbiturates
3. Bath Salts
4. Benzodiazepines
5. Cocaine
6. Narcotics (prescribed) eg. Morphine, Lorcet, Oxycodone/Percocet etc.
7. Narcotics (non-prescribed) eg. Heroine

Have you ever used IV or inhaled recreational drugs? □ Yes □ N

PSYCHOSOCIAL

1. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister

   _____

   _____

   _____

- Do you have any pets or farm animals? Yes____ No____
  If yes, where do they live? 1. _____ indoors 2. _____outdoors 3. _____both indoors and outdoors
- Have you lived or traveled outside of the United States? Yes____ No____
  If so, when and where? _____

  _____
- Have you or your family recently experienced any major life changes? Yes____ No____
  If yes, please comment: _____

  _____
- Have you experienced any major losses in life? Yes____ No____
  If so, please comment: _____
  - How important is religion (or spirituality) for you and your family's life?

  a. _____ not at all important

b. _____ somewhat important

c. _____ extremely important

- How much time have you lost from work or school in the past year?
  a. _____ 0-2 days

  b. _____ 3 –14 days

  c. _____ > 15 days

- Previous jobs: _____

- Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

- Please do your best to answer the following questions:
  a. Did you feel safe growing up?
     ☐ Yes ☐ No

  b. Have you been involved in abusive relationships in your life?
     ☐ Yes ☐ No

  c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
     ☐ Yes ☐ No

  d. Do you currently feel safe in your home?
     ☐ Yes ☐ No

  e. Do you feel safe, respected and valued in your current relationship?
     ☐ Yes ☐ No

  f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
     ☐ Yes ☐ No

  g. Would you feel safer discussing any of these issues privately?
     ☐ Yes ☐ No

PSYCHOSOMATIC

Do you feel significantly less vital than you did a year ago? □ Yes □ No

Are you happy? □ Yes □ No

Do you feel your life has meaning and purpose? □ Yes □ No

Do you believe stress is presently reducing the quality of your life? □ Yes □ No

Do you like the work you do? □ Yes □ No

Have you ever experienced major losses in your life? □ Yes □ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? □ Yes □ No

Would you describe your experience as a child in your family as happy and secure? □ Yes □ No

STRESS/COPING

Have you ever sought counseling? □ Yes □ No

Are you currently in therapy? □ Yes □ No Describe: _____

Do you feel you have an excessive amount of stress in your life? □ Yes □ No

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

Daily Stressors: Rate on scale of l-10

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

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: _____

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

SLEEP/REST

Average number of hours you sleep per night: >10 8-10 6-8 < 6

Do you have trouble falling asleep? □ Yes □ No Do you feel rested upon awakening? □ Yes □ No Do you have problems with insomnia? □ Yes □ No Do you snore? □ Yes □ No

Do you use sleeping aids? □ Yes □ No Explain: _____

ROLES/RELATIONSHIP

Marital status □ Single □ Married □ Divorced □ Gay/Lesbian □ Long Term Partnership □ Widow □ Separated

List Children-

Child's Name	Age	Gender

Who is living in Household? Number: _____ Name(s)/Employment: _____

_____

Resources for emotional support?

Check all that apply: □ Spouse □ Family □ Friends □ Religious/Spiritual □ Pets □ Other: _____

Are you satisfied with your sex life? □ Yes □ No

Symptom Review of Systems

Please Check all current symptoms present, or in the past six months

GENERAL
□Cold hand and feet
□Cold intolerance
□Low body temperature
□Low blood pressure
□Daytime sleepiness
□Difficulty falling asleep
□Early waking
□Fatigue
□Fever
□Flushing
□Heat intolerance
□Night waking
□Nightmares
□No dream recall

HEAD, EYE, EARS
□Conjunctivitis
□Distorted sense of smell
□Distorted taste
□Ear fullness
□Ear pain
□Ear ringing/buzzing
□Lid margin redness
□Eye crusting
□Eye pain
□Hearing loss
□Hearing problems
□Headache
□Migraine
□Sensitivity to noise
□Vision problem (-glasses)
□Macular degeneration
□Vitreous detachment
□Retinal detachment

CARDIOVASCULAR
□Angina/chest pain
□Breathlessness
□Heart murmur
□Irregular pulse
□Palpitations
□Phlebitis
□Swollen ankles/feet
□Varicose veins

GENITAL - FEMALE
□Breast cysts
□Breast lumps
□Breast tenderness
□Ovarian cyst
□Poor libido
□Vaginal discharge
□Vaginal odor
□Vaginal itch
□Vaginal pain with sex
□Premenstrual
  □Bloating breast tenderness
  □Carb cravings
  □Chocolate cravings
  □Constipation
  □Decreased sleep
  □Diarrhea
  □Fatigue
  □Increased sleep
  □Irritability
□Menstrual
  □Cramps
  □Heavy periods
  □Irregular periods
  □No periods
  □Scanty periods
  □Spotting between

GENITAL – MALE
□Discharge from penis
□Ejaculation problem
□Genital pain
□Impotence
□Prostate or urine infection
□Lumps in testicles
□Poor libido

MUSCULOSKELETAL
□Back muscle spasm
□Calf cramps
□Foot cramps
□Joint deformity
□Joint redness
□Joint stiffness
□Muscle pain
□Muscle spasms
□Muscle stiffness
□Muscle twitches
  □Around eyes
  □Arms or legs
□Muscle weakness
□Neck muscle spasm
□Tendonitis
□Tension headache
□TMJ problems

MOOD/NERVES
□Agoraphobia
□Anxiety
□Auditory hallucinations
□Black out
□Depression
□Difficulty
  □Concentrating
  □With balance
  □With thinking
  □With judgement
  □With speech
  □With memory
□Dizziness
□Fainting
□Fearfulness
□Irritability
□Light-headedness
□Numbness
□Other phobias
□Panic attacks
□Seizures
□Suicidal thoughts
□Tingling
□Tremor/Trembling
□Visual hallucinations

EATING
□Binge eating
□Bulimia
□Can't gain weight
□Can't lose weight
□Frequent dieting
□Poor appetite
□Carb cravings
□Sweet cravings
□Caffeine dependency

DIGESTION
□Abdominal pain
□Anal spasms
□Anal itching
□Bad teeth
□Bleeding gums
□Bloating and gas
□Bloody stools
□Burping
□Canker sores

□Cold sores
□Constipation
□Cracking of corners of lips
□Cramps
□Dentures and poor chewing
□Diarrhea
□Diarrhea and constipation
□Difficulty swallowing
□Dry mouth
□Excess flatulence
□Fissures
□Foods repeat (reflux)
□Gas
□Heartburn
□Hemorrhoids
□Indigestion
□Intolerance to:
    □Lactose
    □Dairy products
    □Wheat
    □Gluten (Wheat, rye, barley)
    □Corn
    □Eggs
    □Fatty foods
    □Yeast
□Liver disease/Jaundice
□Mucus in stools
□Nausea
□Periodontal disease
□Sore tongue
□Strong stool odor
□Undigested food in stools

SKIN PROBLEMS
□Acne on back (Bacne)
□Acne on chest
□Acne on face
□Acne on shoulders
□Athlete's foot
□Bumps on back of upper arms
□Cellulite
□Dark circles under eyes
□Different skin colors (2-toned)
□Ears get red
□Easy bruising
□Lack of sweating
□Eczema
□Hives
□Jack itch
□Lackluster skin
□Moles
□Oily skin
□Pale skin
□Patchy dullness
□Rash
□Red face
□Sensitivity to bites
□Sensitivity to poison ivy/oak
□Shingles
□Skin darkening
□Strong body odor
□Hair loss
□Vitiligo

ITCHING SKIN
□Skin in general
□Anus
□Arms
□Ear canals
□Eyes
□Feet
□Hands
□Legs
□Nipples
□Nose
□Penis
□Roof of mouth
□Scalp
□Throat

DRY SKIN
□Eyes
□Feet
    □Cracking?
    □Peeling?
□Hair
    □And unmanageable?
□Hands
    □Cracking
    □Peeling?
□Mouth/Throat
□Scalp
    □Dandruff?
□Skin in general

LYMPH NODES
□Enlarged neck
□Tender neck
□Swelling in groin
□Swelling in legs

NAILS
□Bitten
□Brittle
□Cracked nails
□Curved up
□Frayed
□Fungus nails (fingers/toes)
□Pitting
□Ragged cuticles
□Ridges
□Soft
□Thickening
    □Fingers
    □Toes
□White spots or lines

RESPIRATORY
□Bad breath
□Bad odor in nose
□Cough – dry
□Cough – productive
□Hoarseness
□Sore throat
□Hay fever
    □Seasonal _____
□Nasal stuffiness
□Nose bleeds
□Post nasal drip
□Sinus fullness
□□Sinus infection
□Snoring
□Wheezing
□Winter stuffiness

URINARY
□Bed wetting
□Hesitancy
□Infection
□Kidney disease
□Leaking/incontinence
□Pain/burning
□Urgency

READINESS ASSESSMENT	Name:

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet . . . . . (5) (4) (3) (2) (1)

Take several nutritional supplements each day…… (5) (4) (3) (2) (1)

Keep a record of everything you eat each day . . . . . (5) (4) (3) (2) (1)

Modify your lifestyle (e.g., work demands, sleep habits)..... (5) (4) (3) (2) (1)

Practice a relaxation technique . . . . . (5) (4) (3) (2) (1)

Engage in regular exercise . . . . . (5) (4) (3) (2) (1)

Have periodic lab tests to assess your progress..... (5) (4) (3) (2) (1)

Comments

_____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health related activities?

(5) (4) (3) (2) (1)

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?

_____

_____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? - (5) (4) (3) (2) (1)

Comments

_____

_____

_____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much on-going support and contact (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? – (5) (4) (3) (2) (1)

Comments.

_____

_____

_____

ANTHROPOMETRICS

Temperature: _____ Pulse: _____ Pulse Oximetry: _____

SBP: _____ DBP: _____ Body Fat Percent: _____

Height: _____ (in) Weight: _____ (lb) Body Mass Index: _____

Waist Circ: _____ (in) Hip Circ: _____ (in) Waist/Hip: _____