Integrative HEALTH & WELLNESS
Living Your Personal Best

GENERAL INFORMATION

Name	*First*	*Middle*	*Last*	
Preferred Name				
Date of Birth				
Age				
Gender	☐ Male	☐ Female		
Genetic Background	☐ African	☐ European	☐ Native American	☐ Mediterranean
	☐ Asian	☐ Ashkenazi	☐ Middle Eastern	☐ ______________
Highest Education Level	☐ High School	☐ Under-Graduate	☐ Post-Graduate	
Job Title				
Nature of Business				
Primary Address	*Number, Street*			
	City		*State*	*Zip*
Alternate Address	*Number, Street*			
	City		*State*	*Zip*
Home Phone			Work Phone	
Cell Phone			Fax	
E-mail				
Emergency Contact	*Name*		*Phone Number*	
Relationship			*Cell Phone*	
	Address		*Work Number*	
	City		*State*	*Zip*
Primary Care Physician	*Name*		*Phone Number*	
	Fax			
Referred by	☐ Book	☐ Website	☐ Media	☐ Family or Friend
	☐PCP	☐ CC Physician	☐ Other	

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ALLERGIES

Medication / Supplement / Food	Reaction

COMPLAINTS CONCERNS

What do you hope to achieve in your visit with us?

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 trigger your change in health?

What makes you feel worse?

What makes you feel better?

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		

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MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

Past Condition	*Ongoing Condition*	
		GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome________
☐	☐	Inflammatory Bowel Disease________
☐	☐	Crohn's________
☐	☐	Ulcerative Colitis________
☐	☐	Gastritis or Peptic Ulcer Disease________
☐	☐	GERD (reflux)________
☐	☐	Celiac Disease________
☐	☐	Other ________
		CARDIOVASCULAR
☐	☐	Heart Attack________
☐	☐	Other Heart Disease________
☐	☐	Stroke________
☐	☐	Elevated Cholesterol________
☐	☐	Arrhythmia (irregular heart rate)________
☐	☐	Hypertension (high blood pressure)________
☐	☐	Rheumatic Fever________
☐	☐	Mitral Valve Prolapse________
☐	☐	Other ________
		METABOLIC/ENDOCRINE
☐	☐	Type 1 Diabetes________
☐	☐	Type 2 Diabetes________
☐	☐	Hypoglycemia________
☐	☐	Metabolic Syndrome________ (Insulin Resistance or Pre-Diabetes)
☐	☐	Hypothyroidism (low thyroid)________
☐	☐	Hyperthyroidism (overactive thyroid)________
☐	☐	Endocrine Problems________
☐	☐	Polycystic Ovarian Syndrome (POCS)________
☐	☐	Infertility________
☐	☐	Weight Gain________
☐	☐	Weight Loss________
☐	☐	Frequent Weight Fluctuations________
☐	☐	Bulimia________
☐	☐	Anorexia________
☐	☐	Binge Eating Disorder________
☐	☐	Night Eating Syndrome________
☐	☐	Eating Disorder (non-specific)________
☐	☐	Other ________
		CANCER
☐	☐	Lung Cancer________
☐	☐	Breast Cancer________
☐	☐	Colon Cancer________
☐	☐	Ovarian Cancer________
☐	☐	Prostate Cancer________
☐	☐	Skin Cancer________
☐	☐	Other ________

Past Condition	*Ongoing Condition*	
		GENITAL AND URINARY SYSTEM
☐	☐	Kidney Stones________
☐	☐	Gout________
☐	☐	Interstitial Cystitis________
☐	☐	Frequent Urinary Tract Infections________
☐	☐	Frequent Yeast Infections________
☐	☐	Erectile Dysfunction________ Or Sexual Dysfunction
☐	☐	Other ________
		MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis________
☐	☐	Fibromyalgia________
☐	☐	Chronic Pain________
☐	☐	Other ________
		INFLAMMATORY/AUTOIMMUNE
☐	☐	Chronic Fatigue Syndrome________
☐	☐	Autoimmune Disease________
☐	☐	Rheumatoid Arthritis________
☐	☐	Lupus SLE________
☐	☐	Immune Deficiency Disease________
☐	☐	Herpes-Genital________
☐	☐	Severe Infectious Disease________
☐	☐	Poor Immune Function________ (frequent infections)
☐	☐	Food Allergies________
☐	☐	Environmental Allergies________
☐	☐	Multiple Chemical Sensitivities________
☐	☐	Latex Allergy________
☐	☐	Other ________
		RESPIRATORY DISEASES
☐	☐	Asthma________
☐	☐	Chronic Sinusitis________
☐	☐	Bronchitis________
☐	☐	Emphysema________
☐	☐	Pneumonia________
☐	☐	Tuberculosis________
☐	☐	Sleep Apnea________
☐	☐	Other ________
		SKIN DISEASES
☐	☐	Eczema________
☐	☐	Psoriasis________
☐	☐	Acne________
☐	☐	Melanoma________
☐	☐	Skin Cancer________
☐	☐	Other ________

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MEDICAL HISTORY (continued)

NEUROLOGICAL

Past Condition	Ongoing Condition	Condition
☐	☐	Depression________
☐	☐	Anxiety________
☐	☐	Bipolar Disorder________
☐	☐	Schizophrenia________
☐	☐	Headaches________
☐	☐	Migraines________
☐	☐	ADD/ADHD________
☐	☐	Autism________
☐	☐	Mild Cognitive Impairment________
☐	☐	Memory Problems________
☐	☐	Parkinson's Disease________
☐	☐	Multiple Sclerosis________
☐	☐	ALS________
☐	☐	Seizures________
☐	☐	Other Neurological Problems________

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam________
- ☐ Bone Density________
- ☐ Colonoscopy________
- ☐ Cardiac Stress Test________
- ☐ EBT Heart Scan________
- ☐ EKG________
- ☐ Hemoccult Test-stool test for blood________
- ☐ MRI________
- ☐ CT Scan________
- ☐ Upper Endoscopy________
- ☐ Upper GI Series________
- ☐ Ultrasound________

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy________
- ☐ Hysterectomy +/- Ovaries________
- ☐ Gall Bladder________
- ☐ Hernia________
- ☐ Tonsillectomy________
- ☐ Dental Surgery________
- ☐ Joint Replacement – Knee/Hip________
- ☐ Heart Surgery - Bypass Valve________
- ☐ Angioplasty or Stent________
- ☐ Pacemaker________
- ☐ Other________
- ☐ None

INJURIES

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones
- ☐ Other________

BLOOD TYPE:

- ☐ A
- ☐ B
- ☐ AB
- ☐ O
- ☐ Rh+
- ☐ Unknown

HOSPITALIZATION ☐ None

Date	*Reason*

COMMENTS

____
____
____
____
____

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GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY *Check box if yes and provide number of*

☐ Pregnancies___________ ☐ Caesarean____________ ☐ Vaginal Deliveries____________

☐ Miscarriage___________ ☐ Abortion_____________ ☐ Living Children______________

☐ Post-Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby Over 8 Pounds

☐ Breast Feeding for how long?____________

MENSTRUAL HISTORY

Age at First Period:______ Menses Frequency:_____ Length:_____ Pain: ☐Yes ☐No Clotting: ☐Yes ☐No

Has you period ever skipped? _____ For how long?___________

Last Menstrual Period:____________

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?____________

Do you use contraception? ☐Yes ☐No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐ Painful Periods ☐ Heavy Periods ☐ PMS

Last Mammogram:______________ ☐ Breast Biopsy/Date:_____________

Last PAP Test:______________ ☐ Normal ☐ Abnormal

Last Bone Density:______________ Results: ☐High ☐Low ☐Within Normal Range

Are you in Menopause? ☐Yes ☐No

Age at Menopause:____________

☐Hot Flashes ☐Mood Swings ☐Concentration/Memory Problems ☐Vaginal Dryness ☐Decreased Libido

☐Heavy Bleeding ☐Joint Pains ☐Headaches ☐Weight Gain ☐Loss of Control of Urine ☐Palpitations

☐Use of hormone replacement therapy How long?______________________

MEN'S HISTORY (for men only)

Have you had a PSA done? ☐Yes ☐No

PSA Level: ☐0-2 ☐2-4 ☐4-10 ☐> 10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Nocturia (urination at night). How many times at night?____________

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel ☐Yes ☐ No Where?______________________________

Wilderness Camping ☐Yes ☐ No Where?______________________________

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐Yes ☐ No

Do you feel bloated after meals? ☐Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature

Pregnancy Complications:______________________________

Birth Complications:______________________________

☐ Breast Fed How long?_______________ ☐ Bottle Fed

Age at introduction of: Solid Foods:____________ Dairy:____________ Wheat:____________

Did you eat a lot of candy or sugar as a child? ☐Yes ☐ No

DENTAL HISTORY

☐ Silver Mercury Fillings How many?____________

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

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ☐Yes ☐ No

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MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS (*Last 10 years)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐Yes ☐ No

Describe:____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐Yes ☐ No

Have you had prolonged use of Tylenol? ☐Yes ☐ No

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) ☐Yes ☐ No

Frequent antibiotics ☐Yes ☐ No

Long term antibiotics ☐Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐Yes ☐ No

Use of oral contraceptives ☐Yes ☐ No

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FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

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SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐Yes ☐ No Describe:____________________

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

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism

☐ Specific Program for Weight Loss/Maintenance Type:______________________ ☐ Other________________________

Height (feet/inches)______________________________	Current Weight______________________________
Usual Weight Range +/- 5 lbs______________________	Desired Weight Range +/- 5 lbs______________________
Highest Adult Weight______________________________	Lowest Adult Weight______________________________
Weight Fluctuations (>10 lbs) ☐Yes ☐ No	Body Fat %______________________________

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐Yes ☐ No If yes, what was it?________________

Do you avoid any particular foods? ☐Yes ☐ No If yes, types and reason____

____

If you could only eat a few foods a week, what would they be?____

____

Do you grocery shop? ☐Yes ☐ No If no, who does the shopping?____

Do you read food labels? ☐Yes ☐ No

Do you cook? ☐Yes ☐ No If no, who does the cooking?____

How many meals to you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ > 5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

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

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SMOKING

Currently Smoking? ☐Yes ☐ No If yes, 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 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 | Tea cups/day: ☐ 1 ☐ 2-4 ☐ > 4

Caffeinated Sodas or Diet Sodas Intake: ☐Yes ☐ No

12-ounce can/bottle: ☐ 1 ☐ 2-4 ☐ > 4

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

Are you currently using any recreational drugs? ☐Yes ☐ No If yes, type:__________________________

Have you ever used IV or inhaled recreational drugs? ☐Yes ☐ No

EXERCISE

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

Activity	**Type**	**Frequency Per Week**	**Duration in Minutes**
Stretching			
Cardio/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

PSYCHOSOCIAL

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 1-10

Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? ☐Yes ☐ No 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 ☐ Long term partnership ☐ Widow

List Children: Child's Full Name	Age	Gender

Who is Living in Household? Number:________ Names:____

Their Employement/Occupations:____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other:____________________

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

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How well have things been going for you?	Very Well	Fine	Poorly	N/A
- Overall				
- At school				
- In your job				
- In your social life				
- With close friends				
- With sex				
- With your attitude				
- With your boyfriend/girlfriend				
- With your children				
- With your parents				
- With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

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:____ ☐ No

Do you have an adverse reaction to caffeine? ☐Yes ☐ No

When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Aches and Pains

Do you adversely react to *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. Sodium Benzoate)

☐ Other:____

Which of these significantly affect you? *(Check all that apply)*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other:____________________________

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐Yes ☐ No

Have you ever been told you have Gilbert's Syndrome or a liver disorder? ☐Yes ☐ No

Explain:____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other____

Chemical Name, Date, Length of Exposure:____

Do you dry clean your clothes frequently? ☐Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? ☐Yes ☐ No

Do you have pets or farm animals? ☐Yes ☐ No

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SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months

GENERAL

- ☐ Cold Hands & 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, EYES & 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 Loud Noises
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL

- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Twitches – around eyes
- ☐ Muscle Twitches – Arms or Legs
- ☐ Muscle Weakness
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- Difficulty
  - ☐ Concentrating
  - ☐ With Balance
  - ☐ With Thinking
  - ☐ With Judgment
  - ☐ With Speech
  - ☐ With Memory
- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pasta)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating of Lower Abdomen
- ☐ Bloating of Whole Abdomen
- ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/ Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Food "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting
- Intolerance to:
  - ☐ Lactose
  - ☐ All Dairy Products
  - ☐ Wheat
  - ☐ Gluten (Wheat, Rye, Barley)
  - ☐ Corn
  - ☐ Eggs
  - ☐ Fatty Foods
  - ☐ Yeast
- ☐ Liver Disease/Jaundice (yellow eyes/ skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

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SKIN PROBLEMS

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ 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

SKIN, DRYNESS OF

- ☐ Eyes
- ☐ Feet
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Hair
- ☐ Hair Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Any Dandruff?
- ☐ Skin in General

LYMPH NODES

- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of fingernails
- ☐ Thickening of toenails
- ☐ White Spots/Lines

RESPIRATORY

- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change of Season
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE

- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps in Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:

- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:

- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

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READINESS ASSESSMENT

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 nutrition 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 your 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, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐5 ☐4 ☐3 ☐2 ☐1

Comments____

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3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Describe the food or beverage as accurately as possible e.g., milk- what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ and ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY – DAY 1

Name:______________________________ Date:______________________________

Daily Exercise (Type of Activity / Time of Day / Duration): ______________________________

____

Daily Bowel Movements:______________________________

TIME	FOOD/ BEVERAGE / AMOUNT	COMMENTS

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DIET DIARY – DAY 2____

Name:____ Date:______________________________

Daily Exercise (Type of Activity / Time of Day / Duration): ____

____

Daily Bowel Movements:____

TIME	FOOD/ BEVERAGE / AMOUNT	COMMENTS

DIET DIARY – DAY 3____

Name:____ Date:______________________________

Daily Exercise (Type of Activity / Time of Day / Duration): ____

____

Daily Bowel Movements:____

TIME	FOOD/ BEVERAGE / AMOUNT	COMMENTS

OTHER COMMENTS / QUESTIONS/ CONCERNS:________________________

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Medical Symptoms Questionnaire

Name ____________________________________ **Date** _________________

Rate each of the following symptoms based upon your typical health profile for the p*ast 30 days*

Point Scale

0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD

________ Headaches
________ Faintness
________ Dizziness
________ Insomnia Total ________

EYES

________ Watery or itchy eyes
________ Swollen, reddened or sticky eyelids
________ Bags or dark circles under eyes
________ Blurred or tunnel vision
(does not include near or far-sightedness) Total ________

EARS

________ Itchy ears
________ Earaches, ear infections
________ Drainage from ear
________ Ringing in ears, hearing loss Total ________

NOSE

________ Stuffy nose
________ Sinus problems
________ Hay fever
________ Sneezing attacks
________ Excessive mucus formation Total ________

MOUTH/THROAT

________ Chronic coughing
________ Gagging, frequent need to clear throat
________ Sore throat, hoarseness, loss of voice
________ Swollen or discolored tongue, gums, lips
________ Canker sores Total ________

SKIN

________ Acne
________ Hives, rashes, dry skin
________ Hair loss
________ Flushing, hot flashes
________ Excessive sweating Total ________

HEART

________ Irregular or skipped heartbeat
________ Rapid or pounding heartbeat
________ Chest pain Total ________

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LUNGS	________	Chest congestion	
	________	Asthma, bronchitis	
	________	Shortness of breath	
	________	Difficulty breathing	Total ________
DIGESTIVE TRACT	________	Nausea, vomiting	
	________	Diarrhea	
	________	Constipation	
	________	Bloated feeling	
	________	Belching, passing gas	
	________	Heartburn	
	________	Intestinal/stomach pain	Total ________
JOINTS/MUSCLE	________	Pain or aches in joints	
	________	Arthritis	
	________	Stiffness or limitation of movement	
	________	Pain or aches in muscles	
	________	Feeling of weakness or tiredness	Total ________
WEIGHT	________	Binge eating/drinking	
	________	Craving certain foods	
	________	Excessive weight	
	________	Compulsive eating	
	________	Water retention	
	________	Underweight	Total ________
ENERGY/ACTIVITY	________	Fatigue, sluggishness	
	________	Apathy, lethargy	
	________	Hyperactivity	
	________	Restlessness	Total ________
MIND	________	Poor memory	
	________	Confusion, poor comprehension	
	________	Poor concentration	
	________	Poor physical coordination	
	________	Difficulty in making decisions	
	________	Stuttering or stammering	
	________	Slurred speech	
	________	Learning disabilities	Total ________
EMOTIONS	________	Mood swings	
	________	Anxiety, fear, nervousness	
	________	Anger, irritability, aggressiveness	
	________	Depression	Total ________
OTHER	________	Frequent illness	
	________	Frequent or urgent urination	
	________	Genital itch or discharge	
			Total ________
GRAND TOTAL			***TOTAL*** ________