

Female Intake Questionnaire

General Information

Name _____ Age _____ Today's Date _____

Date of Birth _____ Email _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____ (Work) _____

Genetic Background: African American Hispanic Mediterranean Asian
 Native American Caucasian Northern European
 Other _____

When, where and from whom did you last receive medical or health care? _____

Emergency Contact: _____ Relationship _____

Phone (Home) _____ (Cell) _____ (Work) _____

How did you hear about our practice?

Clinic website IFM website Referral from doctor Referral from friend/family member
 Social media Other _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Severity			Prior Treatment/Approach	Success	Success		
		Mild	Moderate	Severe			Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X			<i>Elimination Diet</i>		X		
1.									
2.									
3.									
4.									
5.									
7.									
8.									
9.									
9.									
10.									

Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? Yes No Staying asleep? Yes No

Do you have problems with insomnia? Yes No Do you snore? Yes No

Do you feel rested upon awakening? Yes No

Do you use sleeping aids? Yes No

If yes, explain: _____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? Yes A little No

Are there any problems that limit exercise? Yes No

If yes, explain: _____

Do you feel unusually fatigued or sore after exercise? Yes No

If yes, explain: _____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

- Vegetarian Vegan Allergy Elimination Low Fat Low Carb High Protein
 Blood Type Low sodium No Dairy No Wheat Gluten Free
 Other: _____

Do you have sensitivities to certain foods? Yes No

If yes, list food and symptoms: _____

Do you have an aversion to certain foods? Yes No

If yes, explain: _____

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

- Monosodium glutamate (MSG) Artificial sweeteners Garlic/onion Cheese Citrus foods
 Chocolate Alcohol Red wine Sulfite-containing foods (wine, dried fruit, salad bars)
 Preservatives Food colorings Other food substances: _____

Are there any foods that you crave or binge on? Yes No

If yes, what foods? _____

Do you eat 3 meals a day? Yes No If no, how many _____

Does skipping a meal greatly affect you? Yes No

How many meals do you eat out per week? 0–1 1–3 3–5 >5 meals per week

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

- | | |
|---|---|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Significant other or family members have special dietary needs |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Love to eat |
| <input type="checkbox"/> Late-night eating | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Dislike healthy foods | <input type="checkbox"/> Have negative relationship to food |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Struggle with eating issues |
| <input type="checkbox"/> Travel frequently | <input type="checkbox"/> Emotional eater (eat when sad, lonely, bored, etc.) |
| <input type="checkbox"/> Eat more than 50% of meals away from home | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Healthy foods not readily available | <input type="checkbox"/> Eat too little under stress |
| <input type="checkbox"/> Poor snack choices | <input type="checkbox"/> Don't care to cook |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | <input type="checkbox"/> Confused about nutrition advice |

Diet

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

How many servings do you eat in a typical week of these foods:

Fruits (not juice) _____ Vegetables (not including white potatoes) _____

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages? Yes No If yes, check amounts:

Coffee (cups per day) 1 2-4 >4 Tea (cups per day) 1 2-4 >4

Caffeinated sodas—regular or diet (cans per day) 1 2-4 >4

Do you have adverse reactions to caffeine? Yes No

If yes, explain: _____

When you drink caffeine do you feel: Irritable or wired Aches or pains

Smoking

Do you smoke currently? Yes No Packs per day: _____ Number of years _____

What type? Cigarettes Smokeless Pipe Cigar E-Cig

Have you attempted to quit? Yes No

If yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years _____

Are you regularly exposed to second-hand smoke? Yes No

Alcohol

How many alcoholic beverages do you drink in a week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)

1-3 4-6 7-10 >10 None

Previous alcohol intake? Yes (Mild Moderate High) None

Have you ever had a problem with alcohol? Yes No

If yes, when? _____

Explain the problem: _____

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

Other Substances

Are you currently using any recreational drugs? Yes No

If yes, type: _____

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

Stress

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

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you use relaxation techniques? Yes No

If yes, how often? _____

Which techniques do you use? *(Check all that apply)*

Meditation Breathing Tai Chi Yoga Prayer Other: _____

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No

If yes, describe: _____

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

What are your hobbies or leisure activities? _____

Relationships

Marital status: Single Married Divorced Gay/Lesbian Long-Term Partner Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) _____

Current occupation: _____

Previous occupations: _____

Do you have resources for emotional support? Yes No *(Check all that apply)*

Spouse/Partner Family Friends Religious/Spiritual Pets Other: _____

Do you have a religious or spiritual practice? Yes No

If yes, what kind? _____

How well have things been going for you? *(Mark on scale of 1–10, or N/A if not applicable)*

	N/A	Poorly			Fine			Very Well			
Overall	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At school	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your spouse	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10

History

Patient's Birth/Childhood History:

You were born: Term Premature Don't know

Were there any pregnancy or birth complications? Yes No

If yes, explain: _____

You were: Breast-fed/How long? _____ Bottle-fed/Type of formula: _____ Don't know

Age of introduction of: Solid food: _____ Wheat _____ Dairy _____

As a child, were there any foods that were avoided because they gave you symptoms? Yes No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

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

Dental History:

Check if you have any of the following, and provide number if applicable:

- Silver mercury fillings _____ Gold fillings _____ Root canals _____ Implants _____
- Caps/Crowns _____ Tooth pain _____ Bleeding gums _____ Gingivitis _____
- Problems with chewing _____ Other dental concerns (explain): _____

Have you had any mercury fillings removed? Yes No If yes, when: _____

How many fillings did you have as a kid? _____

Do you brush regularly? Yes No Do you floss regularly? Yes No

Environmental/Detoxification History

Do any of these significantly affect you?

- Cigarette smoke Perfume/colognes Auto exhaust fumes Other: _____

In your work or home environment are you regularly exposed to: (Check all that apply)

- Mold Water leaks Renovations Chemicals Electromagnetic radiation
- Damp environments Carpets or rugs Old paint Stagnant or stuffy air Smokers
- Pesticides Herbicides Harsh chemicals (solvents, glues, gas, acids, etc) Cleaning chemicals
- Heavy metals (lead, mercury, etc.) Paints Airplane travel Other _____

Have you had a significant exposure to any harmful chemicals? Yes No

If yes: Chemical name, length of exposure, date: _____

Do you have any pets or farm animals? Yes No

If yes, do they live: Inside Outside Both inside and outside

Women's History

Obstetric History: *(Check box and provide number if applicable)*

- Pregnancies _____ Miscarriages _____ Abortions _____ Living children _____
 Vaginal deliveries _____ Cesarean _____ Term births _____ Premature birth _____

Birth weight of largest baby _____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? Yes No

If yes, please explain _____

Menstrual History:

Age at first period _____ Date of last menstrual period _____

Length of cycle _____ Time between cycles _____

Cramping? Yes No Pain? Yes No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? Yes No

If yes, please describe: _____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? Yes No

If yes, please describe: _____

Use of hormonal birth control: Birth control pills Patch Nuva ring

Other _____ How Long _____

Any problems with hormonal birth control? Yes No

If yes, explain _____

Use of other contraception? Yes No Condoms Diaphragm IUD Partner vasectomy

Are you in menopause? Yes No If yes, age at last period: _____

Was it surgical menopause? Yes No If yes, explain surgery: _____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

- Hot flashes Mood swings Concentration/memory problems Headaches Joint pain
 Vaginal dryness Weight gain Decreased libido Loss of control of urine Palpitations

Are you on hormone replacement therapy? Yes No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? _____

Other Gynecological Symptoms: *(Check if applicable)*

- Endometriosis Infertility Fibrocystic breasts Vaginal infection Fibroids
 Ovarian cysts Pelvic inflammatory disease Reproductive cancer
 Sexually transmitted disease (describe) _____

Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: _____ Normal Abnormal

Last mammogram: _____ Normal Abnormal

Last bone density: _____ Results: High Low Within Normal Range

Other tests/procedures (list type and dates) _____

Family History:

Check family members that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History: Illnesses/Conditions

Check YES = a condition you currently have, **Check PAST** = a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
GERD (reflux)	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease/ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Urinary/Genital		
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial cystitis	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine/Metabolic		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism (low thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism (overactive thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Ovarian Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Metabolic syndrome/insulin resistance	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory/Immune		
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
Multiple chemical sensitivities	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal	Yes	Past
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Skin		
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular		
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High blood fats (cholesterol, triglycerides)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia (irregular heart rate)	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic/Emotional		
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cancer		
Lung	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>
Colon	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

Medical History *(cont.)*

Diagnostic Studies	Date	Comments
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		
Injuries		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalizations	Date	Reason

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't remember dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low body temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head, Eyes, and Ears			
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear ringing/buzzing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye crusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid margin redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to loud noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal			
Back muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calf cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle twitches:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal (cont.)	Mild	Moderate	Severe
Neck muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood/Nerves			
Agoraphobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auditory hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness (spinning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fearfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light-headedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor/trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			
Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaking/incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestion			
Anal spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canker sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cracking at corner of lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures w/poor chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Farting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foods "repeat" (reflux)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gluten (wheat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease/jaundice (yellow eyes or skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucus in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Digestion <i>(cont.)</i>	Mild	Moderate	Severe
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong stool odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undigested food in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating			
Binge eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't gain weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent dieting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad odor in nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough - dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough - productive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change of season	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Nails	Mild	Moderate	Severe
Bitten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Curve up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frayed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus - fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus - toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ragged cuticles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ridges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thickening of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toenails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White spots/lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymph Nodes			
Enlarged/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tender/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other enlarged/tender lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin, Dryness of			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
And unmanageable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any dandruff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems			
Acne on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athlete's foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bumps on back of upper arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cellulite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Skin Problems <i>(cont.)</i>	Mild	Moderate	Severe
Ears get red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes - genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jock itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lackluster skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moles w color/size change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pale skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patchy dullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to poison ivy/oak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin darkening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong body odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thick calluses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching Skin			
Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear canals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nipples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roof of mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive	Mild	Moderate	Severe
Breast cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor libido (sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premenstrual:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scanty periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spotting between	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

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

If yes, describe: _____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? Yes No Tylenol (acetaminophen)? Yes No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? Yes No

How many times have you taken antibiotics?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? Yes No

If yes, explain: _____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Readiness Assessment and Health Goals

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 | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Take several nutritional supplements each day | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Keep a record of everything you eat each day | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Modify your lifestyle (e.g., work demands, sleep habits) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Practice a relaxation technique | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Engage in regular exercise | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |

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 follow through? _____

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

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

How much ongoing support (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 _____

Health Goals

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

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel better? _____

What makes you feel worse? _____

How does your condition affect you? _____

What do you think is happening and why? _____

What do you feel needs to happen for you to get better? _____



Medical Symptoms Questionnaire (MSQ)

Patient Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past 14 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	<input type="text"/> Headaches <input type="text"/> Faintness <input type="text"/> Dizziness <input type="text"/> Insomnia	Total _____
-------------	---	--------------------

EYES	<input type="text"/> Watery or itchy eyes <input type="text"/> Swollen, reddened or sticky eyelids <input type="text"/> Bags or dark circles under eyes <input type="text"/> Blurred or tunnel vision <i>(Does not include near or far-sightedness)</i>	Total _____
-------------	---	--------------------

EARS	<input type="text"/> Itchy ears <input type="text"/> Earaches, ear infections <input type="text"/> Drainage from ear <input type="text"/> Ringing in ears, hearing loss	Total _____
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NOSE	<input type="text"/> Stuffy nose <input type="text"/> Sinus problems <input type="text"/> Hay fever <input type="text"/> Sneezing attacks <input type="text"/> Excessive mucus formation	Total _____
-------------	--	--------------------

MOUTH/THROAT	<input type="text"/> Chronic coughing <input type="text"/> Gagging, frequent need to clear throat <input type="text"/> Sore throat, hoarseness, loss of voice <input type="text"/> Swollen or discolored tongue, gums, lips <input type="text"/> Canker sores	Total _____
---------------------	---	--------------------

SKIN	<input type="text"/> Acne <input type="text"/> Hives, rashes, dry skin <input type="text"/> Hair loss <input type="text"/> Flushing, hot flashes <input type="text"/> Excessive sweating	Total _____
-------------	--	--------------------

HEART	<input type="text"/> Irregular or skipped heartbeat <input type="text"/> Rapid or pounding heartbeat <input type="text"/> Chest pain	Total _____
--------------	--	--------------------

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloating 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 _____

Exposure History Form

Part 1. Exposure Survey

Name: _____ Date: _____

Please circle the appropriate answer.

Birth date: _____ Sex (circle one): Male Female

- | | | | | |
|----|---|----|-----|--|
| 1. | Are you currently exposed to any of the following? | | | |
| | metals | no | yes | |
| | dust or fibers | no | yes | |
| | chemicals | no | yes | |
| | fumes | no | yes | |
| | radiation | no | yes | |
| | biologic agents | no | yes | |
| | loud noise, vibration, extreme heat or cold | no | yes | |
| 2. | Have you been exposed to any of the above in the past? | no | yes | |
| 3. | Do any household members have contact with metals, dust, fibers, chemicals, fumes, radiation, or biologic agents? | no | yes | |

If you answered *yes* to any of the items above, describe your exposure in detail—how you were exposed, to what you were exposed. If you need more space, please use a separate sheet of paper.

- | | | | | |
|-----|--|----|-----|--|
| 4. | Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to? | | | |
| | | no | yes | |
| 5. | Do you get the material on your skin or clothing? | no | yes | |
| 6. | Are your work clothes laundered at home? | no | yes | |
| 7. | Do you shower at work? | no | yes | |
| 8. | Can you smell the chemical or material you are working with? | no | yes | |
| 9. | Do you use protective equipment such as gloves, masks, respirator, or hearing protectors? | no | yes | |
| 10. | Have you been advised to use protective equipment? | no | yes | |
| 11. | Have you been instructed in the use of protective equipment? | no | yes | |

If *yes*, list them below

If *yes*, list the protective equipment used

- | | | | | |
|--|--------------|-----|----------|--------|
| 12. Do you wash your hands with solvents? | no | yes | | |
| 13. Do you smoke at the workplace? | no | yes | At home? | no yes |
| 14. Are you exposed to secondhand tobacco smoke at the workplace? | no | yes | At home? | no yes |
| 15. Do you eat at the workplace? | no | yes | | |
| 16. Do you know of any co-workers experiencing similar or unusual symptoms? | no | yes | | |
| 17. Are family members experiencing similar or unusual symptoms? | no | yes | | |
| 18. Has there been a change in the health or behavior of family pets? | no | yes | | |
| 19. Do your symptoms seem to be aggravated by a specific activity? | no | yes | | |
| 20. Do your symptoms get either worse or better at work? | no | yes | | |
| | at home? | no | yes | |
| | on weekends? | no | yes | |
| | on vacation? | no | yes | |
| 21. Has anything about your job changed in recent months (such as duties, procedures, overtime)? | no | yes | | |
| 22. Do you use any traditional or alternative medicines? | no | yes | | |

If you answered *yes* to any of the questions, please explain.

Part 2. Work History

A. Occupational Profile

Name: _____

Birth date: _____ **Sex:** Male Female

The following questions refer to your current or most recent job:

Job title: _____ Describe this job: _____

Type of industry: _____

Name of employer: _____

Date job began: _____

Are you still working in this job? yes no _____

If no, when did this job end? _____

Fill in the table below listing all jobs you have worked including short-term, seasonal, part-time employment, and military service. Begin with your most recent job. Use additional paper if necessary.

Dates of Employment	Job Title and Description of Work	Exposures*	Protective Equipment

*List the chemicals, dusts, fibers, fumes, radiation, biologic agents (i.e., molds or viruses) and physical agents (i.e., extreme heat, cold, vibration, or noise) that you were exposed to at this job.

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)? If yes, please check the box beside the name.

- | | | | |
|--|---|--|---|
| <input type="radio"/> Acids | <input type="radio"/> Chloroprene | <input type="radio"/> Methylene chloride | <input type="radio"/> Styrene |
| <input type="radio"/> Alcohols (industrial) | <input type="radio"/> Chromates | <input type="radio"/> Nickel | <input type="radio"/> Talc |
| <input type="radio"/> Alkalies | <input type="radio"/> Coal dust | <input type="radio"/> PBBs | <input type="radio"/> Toluene |
| <input type="radio"/> Ammonia | <input type="radio"/> Dichlorobenzene | <input type="radio"/> PCBs | <input type="radio"/> TDI or MDI |
| <input type="radio"/> Arsenic | <input type="radio"/> Ethylene dibromide | <input type="radio"/> Perchloroethylene | <input type="radio"/> Trichloroethylene |
| <input type="radio"/> Asbestos | <input type="radio"/> Ethylene dichloride | <input type="radio"/> Pesticides | <input type="radio"/> Trinitrotoluene |
| <input type="radio"/> Benzene | <input type="radio"/> Fiberglass | <input type="radio"/> Phenol | <input type="radio"/> Vinyl chloride |
| <input type="radio"/> Beryllium | <input type="radio"/> Halothane | <input type="radio"/> Phosgene | <input type="radio"/> Welding fumes |
| <input type="radio"/> Cadmium | <input type="radio"/> Isocyanates | <input type="radio"/> Radiation | <input type="radio"/> X-rays |
| <input type="radio"/> Carbon tetrachloride | <input type="radio"/> Ketones | <input type="radio"/> Rock dust | <input type="radio"/> Other (specify) |
| <input type="radio"/> Chlorinated naphthalenes | <input type="radio"/> Lead | <input type="radio"/> Silica powder | |
| <input type="radio"/> Chloroform | <input type="radio"/> Mercury | <input type="radio"/> Solvents | |

B. Occupational Exposure Inventory

Please circle the appropriate answer.

1. Have you ever been off work for more than 1 day because of an illness related to work?	no	yes
2. Have you ever been advised to change jobs or work assignments because of any health problems or injuries?	no	yes
3. Has your work routine changed recently?	no	yes
4. Is there poor ventilation in your workplace?	no	yes

Part 3. Environmental History

Please circle the appropriate answer.

1. Do you live next to or near an industrial plant, commercial business, dump site, or nonresidential property?	no	yes
2. Which of the following do you have in your home? <i>Please circle those that apply.</i>		
Air conditioner	Air purifier	Central heating (gas or oil?)
Gas stove	Electric stove	
Fireplace	Wood stove	Humidifier
3. Have you recently acquired new furniture or carpet, refinished furniture, or remodeled your home?	no	yes
4. Have you weatherized your home recently?	no	yes
5. Are pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets?	no	yes
6. Do you (or any household member) have a hobby or craft?	no	yes
7. Do you work on your car?	no	yes
8. Have you ever changed your residence because of a health problem?	no	yes
9. Does your drinking water come from a private well, city water supply, or grocery store?		
10. Approximately what year was your home built? _____		

If you answered *yes* to any of the questions, please explain.

ENVIRONMENTAL SENSITIVITY QUESTIONNAIRE

1. Do you have or use any of the following at/near home or work?

Exposure:	Home	Work	Exposure	Home	Work
a. Spring water			u. Foam rubber pillows		
b. Well water			v. Feather/down Comforter		
c. Water purifier			w. Coat/jacket		
d. Damp cellar			x. Stuffed upholstery		
e. Wooded area			y. Animals		
f. Swamp			z. Polyester blend in: Sheets		
g. Power lines			aa. Pillow case		
h. Microwave transmitter			ab. Pajamas		
i. Smoke stacks			ac. Shirts		
j. Dump			ad. Skirts		
k. Gas stove			ae. Pants		
l. Gas furnace			af. Exterminator		
m. Gas hot water heater			ag. Moth balls		
n. Gas dryer			ah. Mold on: Shower curtain		
o. Wood stove			ai. Basement walls		
p. Coal stove			aj. First story walls		
q. Kerosene space heater			ak. Second story walls		
r. Forced hot air heat			al. Garage under living space		
s. Electric blankets			am. Urea formaldehyde insulation		
t. Feather pillows			an. Other:		

PLEASE TURN PAGE OVER AND COMPLETE THE OTHER SIDE.

2. Are you bothered by: (check appropriate selections)

a. Gasoline fumes		l. Fabric stores	
b. Diesel exhaust		m. New car smell	
c. Soaps		n. Air conditioners	
d. Detergents		o. Newsprint	
e. Chlorinated water		p. Tobacco smoke	
f. Moth balls		q. Cats	
g. Asphalt/tar		r. Dogs	
h. Hair spray		s. Mold	
i. Cosmetics		t. Tree pollen	
j. Perfume		u. Grass pollen	
k. Dust		v. Ragweed pollen	

3. Please check appropriate selections about carpeting in your home.

	BEDROOM	√	LIVING ROOM	√	FAMILY ROOM	√
a.	None		h. None		r. None	
b.	Area rugs		i. Area rugs		s. Area rugs	
c.	Wall to wall		j. Wall to wall		t. Wall to wall	
d.	Wool		k. Wool		u. Wool	
e.	Synthetic pad		l. Synthetic pad		v. Synthetic pad	
f.	Glued down		m. Glued down		w. Glued down	
g.	How old is carpeting?		n. How old is carpeting?		x. How old is carpeting?	
			o. On slab		y. On slab	
			p. Ever damp?		z. Ever damp?	
			q. Moldy		aa. Moldy	



Daily Activity Questionnaire

Patient Name _____ Date _____

Please check the one best response for each activity described below:

SEDENTARY BEHAVIOR

Sitting while watching TV, at a computer, driving, talking on the phone, or reading

- 1 Most of the day
- 2 Half of the day
- 3 Some of the day
- 4 Rarely

Total _____

ACTIVITIES OF DAILY LIVING

Bathing, dressing, feeding self, toilet

- 1 Need some assistance
- 2 Slight difficulty
- 3 Minimal difficulty
- 4 No problem

Total _____

LAUNDRY

- 1 Unable
- 2 Occasionally
- 3 Regularly in small steps or with help
- 4 Regularly without help

Total _____

COOKING

- 1 Unable
- 2 Take-out, breakfast, or simple lunch only
- 3 Simple microwave or crockpot meal
- 4 Regular meals

Total _____

HOUSEKEEPING

- 1 Unable
- 2 Light dusting, straighten up
- 3 Regular housekeeping in small steps or with help
- 4 Fully capable

Total _____

GROCERY SHOPPING

- 1 Unable
- 2 Occasional (once or twice per month)
- 3 Frequent, but with assistance
- 4 No problem

Total _____

SOCIAL ACTIVITIES

Church, temple, family and friends

- 1 Unable
- 2 Infrequently
- 3 Occasionally (once or twice per month)
- 4 Frequently (weekly or more often)

Total _____

DRIVING

- 1 Unable
- 2 Very limited
- 3 Cautious, local trips
- 4 Distant trips or traffic

Total _____

ERRANDS OR LIGHT CHORES

Post office, drop off a child

- 1 None
- 2 0-1 per day
- 3 2-3 per day
- 4 No or few restrictions

Total _____

Grand Total _____



Exercise History Questionnaire

Patient Name _____ Date _____

1. **Have you been cleared for exercise?** Yes No

2. **What are you doing on a regular basis that gets you moving and gets your heart rate up?**

Cardio/Aerobic exercise: (e.g., walking, jogging, running, dancing)

Activity 1 _____ x per week for _____ minutes

Activity 2 _____ x per week for _____ minutes

Strength/Resistance exercise: (e.g., resistance machines, kettle bell, pilates, weightlifting)

Activity 1 _____ x per week for _____ minutes

Activity 2 _____ x per week for _____ minutes

Flexibility/Stretching exercise: (e.g., yoga, pilates, matwork, stretches)

Activity 1 _____ x per week for _____ minutes

Activity 2 _____ x per week for _____ minutes

Balance exercise: (e.g., tai chi, qi gong, bosu ball, dancing)

Activity 1 _____ x per week for _____ minutes

Activity 2 _____ x per week for _____ minutes

3. **How do you monitor your exercise intensity?**

<input type="checkbox"/> General Intensity	<input type="checkbox"/> Talk Test	<input type="checkbox"/> Perceived Exertion	<input type="checkbox"/> Heart Rate*
Light	Able to talk and/or sing	< 3 (10 point scale)	< 64% HR _{max}
Moderate	Able to talk but not sing	3-4 (10 point scale)	64-76% HR _{max}
Vigorous/hard	Difficulty talking	≥ 5 (10 point scale)	>76% HR _{max}

4. **Are you satisfied with your current exercise program?** Yes No

If no, explain _____

5. **What are your motivators for exercise? (Check all that apply)**

Prevent cardiac disease and stroke

Reduce blood pressure

Control blood glucose

Prevent bone loss

Increase energy

Increase self esteem

Improve mood

Decrease stress

Improve sleep

Weight reduction

Increase mental alertness

Better endurance

Increase interest in sex

Other _____

6. **What types of aerobic exercise do you prefer? (Circle all that apply)**

Walking, hiking, blading, jogging, treadmill, bicycling indoors/outdoors, EFX elliptical, stair climbers, swimming, rowing, water aerobics, aerobics classes, cross country skiing, downhill skiing/snowboarding, snowshoeing, other _____

7. **What do you like most about exercising?**

*Not an appropriate measure of intensity if taking a Beta Blocker

EXERCISE HISTORY QUESTIONNAIRE

8. Do you have an exercise partner? Yes No

9. Do you enjoy group exercise or classes? Yes No

10. Are you a member of a gym or fitness center? Yes No

11. Are there any obstacles you have to engaging in movement and physical activity? Yes No

a. If yes, what are they?

b. If yes, do you have control over the circumstances surrounding your obstacles? How can you overcome them?

c. Are any of your obstacles out of your control? If yes, which ones?

d. What are some possible solutions around these obstacles? What has worked before?

12. What is the best time of day for you to exercise? _____

13. When do you have the most energy and time? _____

14. Are you ready to take action to make your exercise program work for you and your goals? Yes No

15. Do you have any goals related to you strength, tone, body composition, or fitness level? Yes No

If yes, explain: _____

16. Do you experience any pain or breathing problems while exercising? Yes No

If yes, explain: _____

17. Do you have any joint or musculoskeletal problems that might flare up during exercise? Yes No

If yes, explain: _____

18. Have you had any injuries while exercising? Yes No

If yes, explain: _____

19. Have you experienced a loss of muscle tissue or a decline in strength over the last few years? Yes No

20. Have you fallen in the past few months? Yes No

21. Do you notice any balance problems? Yes No

If yes, explain: _____

22. Do you have any of the following exercise contraindications? (Check all that apply)

Acute systemic infection (i.e., fever, body aches, swollen lymph nodes, etc.)

Arrhythmias

Recent heart attack

Severe congestive heart failure

Uncontrolled angina/chest pain

Other _____



How Healthy Is Your Diet?

Circle your answers after careful thought, then add up your points (numbers in parentheses).

1. **How many fruits do you *normally* eat each day (1/2 cup fresh or dried fruit, 1 medium piece, 1 cup *unsweetened* juice)?**
 - A. 0 (-2)
 - B. 1 (0)
 - C. 2 to 3 (+2)
 - D. 4 or more (+3)(score) _____

2. **How many vegetable servings do you *normally* eat each day (1 cup leafy greens, 1/2 cup any other veggie, raw or cooked)?**
 - A. 0 (-4)
 - B. 1 (0)
 - C. 2 (+1)
 - D. 3 (+2)
 - E. 4 or more (+3)(score) _____

3. **How many different varieties of vegetables do you eat in a normal month?**
 - A. 2 or less (-4)
 - B. 3 to 4 (0)
 - C. 5 to 6 (+1)
 - D. 7 to 8 (+3)
 - E. 9 or more (+4)(score) _____

4. **How many times do you eat dried beans or peas (legumes, lentils, chickpeas, kidney beans, green peas, etc.) in a normal week?**
 - A. 0 (-2)
 - B. 1 to 2 (0)
 - C. 3 to 4 (+1)
 - D. 5 to 6 (+2)
 - E. 7 or more (+3)(score) _____

5. **How many times do you eat red meat in a normal week?**
 - A. 6 or more (-4)
 - B. 4 to 5 (-3)
 - C. 1 to 3 (-1)
 - D. Less than once a week (+2)
 - E. 0 (+3)(score) _____

6. **How many times do you eat in a fast food restaurant in a normal week?**
 - A. 6 or more (-5)
 - B. 4 to 5 (-4)
 - C. 1 to 3 (-3)
 - D. Less than once a week (-2)
 - E. 0 (0)(score) _____

7. **In a typical day, what do you drink *most* often?**
 - A. Soda (regular or diet) (-4)
 - B. Caffeinated coffee or tea (-1)
 - C. Decaffeinated coffee or tea (0)
 - D. Milk or fruit juice (0)
 - E. Herbal tea or water (+3)(score) _____

8. How many 12 oz. cans of soda do you drink in a normal day?

- A. 6 or more (-5)
- B. 4 to 5 (-4)
- C. 2 to 3 (-3)
- D. 1 (-2)
- E. Less than 1 (-1)
- F. 0 (0)

(score) _____

9. How often do you eat fish in a typical week?

- A. Never (-2)
- B. Once (+1)
- C. Twice (+2)
- D. 3 to 5 times (+3)

(score) _____

10. In a typical week, how often do you eat whole grains (100% whole grain bread, whole oats, brown rice, quinoa, whole rye crackers)?

- A. Never (-3)
- B. 1 to 2 times a week (-1)
- C. 3 to 4 times a week (0)
- D. 5 to 6 times a week (+1)
- E. 1 or more times a day (+3)

(score) _____

11. How often do you eat sweets such as cookies, cakes, or ice cream?

- A. 1 or more times a day (-3)
- B. Every other day (-2)
- C. Twice a week (-1)
- D. Once a week (0)
- E. 2 to 3 times a month (+1)
- F. Rarely (+3)

(score) _____

Your Total Score _____

Scoring:

22–28 – Great eating habits

17–21 – Pretty good eating habits

10–16 – Needs some improvement

9 or less – Needs much improvement; try to change one habit at a time

Patient Name _____ Date _____

Sleep is important for musculoskeletal healing and for healthy immune function, mood, cognitive and brain function, and for many physiological functions.

Please answer the following questions as accurately and fully as possible. For Yes / No questions, please check the correct answer and provide an explanation if one is requested. The information will help to determine whether you are getting the sleep you need and to identify possible strategies to help you sleep better.

Sleep Problems:

1 Do you have a sleep problem that has been diagnosed? Yes No
If yes, what? _____

2 Do you feel that you have a sleep problem? Yes No
If yes, how would you describe it? _____

Sleepiness Questions:

3 Do you feel well rested in the morning? Yes No
Please explain _____

4 Are there times during the day or evening that you feel sleepy? Yes No
If yes, what times are these? _____

5 What do you do to wake up when you feel sleepy? _____

6 Have you ever had an accident at work, at home or on your job because you were sleepy? Yes No
If yes, please explain _____

7 Do you take naps? Yes No
If yes, for how many minutes and at what time of day? _____

8 Do you feel well rested after a nap? Yes No

Insomnia Questions:

9 Can you usually fall asleep within 20 minutes of lying in bed? Yes No

10 How long does it usually take you to fall asleep? _____

11 Do you ever feel so wired at night that it is difficult to fall asleep? Yes No

12 Have you had a saliva cortisol test? Yes No
If yes, what was your night time level? _____

Insomnia Questions:

- 13** Do you currently take, or have you tried, any of the following sleep aids to fall asleep? Yes No
 If yes, how many times per week do you take them? Please answer with an **E** for effective or an **N** for not effective in helping you to sleep:

Sleep Aids	Tried in the past?	Taking now?	Dosage?	E or N?
Ambien (zolpidem)				
Sonata (zaleplon)				
Valium (diazepam)				
Ativan (lorazepam)				
Restoril (temazepam)				
Tylenol PM				
Benadryl				
Calcium/Magnesium				
Valerian				
Kava				
Melatonin				
L-Tryptophan				
Other? <i>(Please specify)</i> _____				

- 14** Do you wake up in the middle of the night? Yes No
 If yes, how many times times and for what reasons? _____
- 15** Do you have any trouble falling back asleep when you wake up? Yes No
 If yes, how long does it usually take you? _____
- 16** Does feeling the need to move your feet or legs at night keep you awake or have you been diagnosed with Restless Legs Syndrome? Yes No
- 17** Do you have disturbing dreams at night? Yes No

Caffeine and Other Stimulants:

18 If you drink or eat any of the following, please indicate how much (number of ounces, cups, glasses, etc.), how often per day, and at what times per day?

Do you use...	How much?	How often per day?	When during the day?
Coffee			
Caffeinated sodas (Coke, Pepsi, Mountain Dew, etc.)			
Caffeinated water			
Green tea			
Black tea			
Other tea			
Chocolate			
Coffee or espresso ice creams			
Sudafed or other OTC cold medications			
Alcohol			

19 What medications are you on and what time do you take them?

Stress and Stress Reduction:

20 What kind of stress have you been under in the past few months? _____

21 What do you do for stress management? _____

22 Do you have a journal to write in that is near your bed? Yes No

23 Do you exercise aerobically? Yes No
If yes, what do you do, how often do you exercise, and at what time of day? _____

Sleep Hygiene:

24 What time do you usually go to bed? _____

25 What time do you usually wake up? _____

26 Do you feel that you go to bed too late? Yes No
If yes, what time would you like to go to bed? _____

27 Do you watch TV in the evenings Yes No
If yes, what hours do you watch it? _____

28 Is the TV in your bedroom or in a family room? _____

29 On the weekend or days off do you vary your sleep schedule? Yes No

30 How many hours are you physically in your bed? _____

Sleep Hygiene:

- 31 How many hours of the time spent in bed are you actually asleep? _____
- 32 Do you have much light coming into your bedroom? Yes No
- 33 What can you see at night without any lights on? _____
- 34 Do you have little children who wake you up? Yes No

Bedroom, Breathing and Environment:

- 35 Is the air in your bedroom clean or dirty? _____
- 36 Are there any unusual smells in your bedroom? Yes No
If yes, please describe _____
- 37 Do you snore, stop breathing, or have trouble breathing at night? Yes No
- 38 Do you use Breathe-Easy strips on your nose? Yes No If yes, do they help you to breath? Yes No
- 39 Do you have carpets or hardwood floors in your bed room? _____
- 40 How many rooms in your home have carpets and how old are the carpets? _____
- 41 What type of heat is in your home: forced air or radiant? _____
- 42 How often do you change the furnace filter in your home? _____
- 43 Have you seen any black mold in your window sills or in a basement? Yes No
- 44 Do you have a HEPA air filter for your bedroom? Yes No
If yes, what brand is it and how long do you run it each day? _____
- 45 What type of vacuum cleaner do you use and does it have a HEPA filter in it? _____
- 46 How often do you clean the dust in your bedroom? _____
- 47 Do you sleep with an animal that snores or moves around and disturbs you? Yes No
- 48 Do you sleep with a bed partner who snores, moves around at night or disturbs you when you are trying to sleep?
 Yes No
- 49 Do noises wake you up? Yes No
If yes, what are they? _____
- 50 Do you live on a noisy street? Yes No
- 51 Do you feel safe in your bed at night? Yes No
If not, explain _____

Bed, Pillows, and Pain:

- 52 What type of bed do you have and what size is it? _____
- 53 Do you wake up because of pain? Yes No
If yes, at what time and where is the pain? _____
- 54 What type of pillow is most comfortable for you and what type have you tried that did not work?

- 55 Do you use body pillows? Yes No
If yes, how many and how do you use them? _____



Depression Anxiety Stress Scales

Patient Name _____ Date _____

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 – *Did not apply* to me at all
 1 – *Applied to me to some degree*, or some of the time
 2 – *Applied to me to a considerable degree*, or a good part of time
 3 – *Applied to me very much*, or most of the time

SYMPTOMS	Rating Scale			
1 I found myself getting upset by quite trivial things	0	1	2	3
2 I was aware of dryness of my mouth	0	1	2	3
3 I couldn't seem to experience any positive feeling at all	0	1	2	3
4 I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 I just couldn't seem to get going	0	1	2	3
6 I tended to over-react to situations	0	1	2	3
7 I had a feeling of shakiness (e.g., legs going to give way)	0	1	2	3
8 I found it difficult to relax	0	1	2	3
9 I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10 I felt that I had nothing to look forward to	0	1	2	3
11 I found myself getting upset rather easily	0	1	2	3
12 I felt that I was using a lot of nervous energy	0	1	2	3
13 I felt sad and depressed	0	1	2	3
14 I found myself getting impatient when I was delayed in any way (e.g., elevators, traffic lights, being kept waiting)	0	1	2	3
15 I had a feeling of faintness	0	1	2	3
16 I felt that I had lost interest in just about everything	0	1	2	3
17 I felt I wasn't worth much as a person	0	1	2	3
18 I felt that I was rather touchy	0	1	2	3
19 I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20 I felt scared without any good reason	0	1	2	3
21 I felt that life wasn't worthwhile	0	1	2	3

The rating scale is as follows:

- 0 – *Did not apply* to me at all
 1 – *Applied to me to some degree*, or some of the time
 2 – *Applied to me to a considerable degree*, or a good part of time
 3 – *Applied to me very much*, or most of the time

SYMPTOMS (continued)	Rating Scale			
22 I found it hard to wind down	0	1	2	3
23 I had difficulty in swallowing	0	1	2	3
24 I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25 I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
26 I felt down-hearted and blue	0	1	2	3
27 I found that I was very irritable	0	1	2	3
28 I felt I was close to panic	0	1	2	3
29 I found it hard to calm down after something upset me	0	1	2	3
30 I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31 I was unable to become enthusiastic about anything	0	1	2	3
32 I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33 I was in a state of nervous tension	0	1	2	3
34 I felt I was pretty worthless	0	1	2	3
35 I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36 I felt terrified	0	1	2	3
37 I could see nothing in the future to be hopeful about	0	1	2	3
38 I felt that life was meaningless	0	1	2	3
39 I found myself getting agitated	0	1	2	3
40 I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41 I experienced trembling (e.g., in the hands)	0	1	2	3
42 I found it difficult to work up the initiative to do things	0	1	2	3

General Office Policies

Please review carefully. Sign and date.

- Patient Responsibility: You are encouraged to ask questions on any health-related topic and to take an active role in your health-care.
- Confidentiality: Information revealed during office visits is confidential. Your record and the information contained within it will not be disclosed to others unless you direct us to do so in writing. Exceptions to this confidentiality include disclosure of the intent to harm yourself or others and subpoena from specific government agencies (as outlined in the HIPAA Privacy Rule).
- Treatment Plan: Each treatment plan and/or procedure possesses both risks and benefits. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and customized to your individual personal goals and health status, no guarantees can be assured regarding the outcomes of treatment plan(s) or procedure(s).
- Office Visits: Office visits are billed at \$200.00 per hour. The first office visit is \$400.00 and is typically 2 hours long. This length may vary. If a longer visit is necessary, you will be notified of this prior to your appointment. Subsequent follow-up visits are a minimum of 30 minutes. There is no refund for services provided. You may be eligible for out-of-network insurance reimbursement or tax deduction for medical services.
- Insurance: We do not accept any insurance. All fees are settled directly between patient and provider. At the patient's request, we will provide you with the necessary forms and diagnostic codes needed for you to submit an out-of-network claim to your insurance. Please note that we are not Medicare providers and are opted out of the Medicare program. Our services can not be submitted to Medicare for reimbursement.
- Payment: We accept cash, money orders and most major credit cards. Checks are not accepted.
- Cancellation policy: When an appointment is scheduled, time is reserved especially for you and no one else. Since our appointments are much longer than standard office visits, cancellations are significant interruptions to the Clinic. Thus, a minimum of 3 days' notice is required for cancellations of new patient visits and 1 day notice for existing patients. There will be a 100% office visit charge for "no-shows" or late cancellations.

- Specialty Laboratory Testing: Our clinic frequently uses specialty testing. These are usually an out-of-pocket expense. Occasionally, there is some insurance coverage. We will guide you through identifying the costs associated with your testing.
- Treatment Plan Questions: We encourage patients to call or e-mail with questions regarding their treatment plan. If there is a need for longer discussion regarding new symptoms or new concerns, then we recommend you schedule an additional follow-up appointment. Questions that require longer than 5-minute responses fit this scenario. Additionally, if it has been longer than 8 weeks since your last appointment, schedule an appointment rather than email.
- Emergencies and after-hours care: The Clinic is not a primary care clinic - we offer consultative services only. **You must have a primary care doctor with whom you can consult in the event of an emergency or urgent problem.** If you notice an adverse effect from one of the components of your Clinic treatment plan, you should discontinue it then email or call the Clinic during normal business hours. If you have a serious health problem that requires immediate attention, you should call your other doctors(s), call 911, or have someone take you to the nearest hospital emergency room.
- Please email us at info@swfunctionalmedicine.com for any questions regarding this policy.

I agree to all terms and conditions of these General Office Policies.

Signature:

Date:

I agree to allow Armen E. Nikogosian, MD to use or to describe my anonymous medical history and laboratory data for educational purposes in lectures, blogs, case reports, and other publications that are communicated to other professionals, but may include members of the public. This medical history and laboratory data might include photographs and/or other images of parts of my body other than my face (nutrition/physical exam findings only). Armen E. Nikogosian, MD will never publish any information that uses my name or that identifies me as the source of any of the information, data, or images that it publishes. If you **do not** wish to participate, initial here: _____