# Male 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: Mild | Moderate | Severe | Prior Treatment/Approach | Success: Excellent | Good | Fair |
|---|---|---|---|---|---|---|---|
| *Example: Post Nasal Drip* | *X* | | | *Elimination Diet* | *X* | | |
| **1.** | | | | | | | |
| **2.** | | | | | | | |
| **3.** | | | | | | | |
| **4.** | | | | | | | |
| **5.** | | | | | | | |
| **7.** | | | | | | | |
| **8.** | | | | | | | |
| **9.** | | | | | | | |
| **9.** | | | | | | | |
| **10.** | | | | | | | |

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## 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:________________________________________


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## 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:

☐ Fast eater
☐ Eat too much
☐ Late-night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Travel frequently
☐ Eat more than 50% of meals away from home
☐ Healthy foods not readily available
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods

☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, bored, etc.)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Confused about nutrition advice


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## 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


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### 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 | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At school | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| In your job | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| In your social life | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With close friends | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With sex | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your attitude | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your boyfriend/girlfriend | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your children | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your parents | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your spouse | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |


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## 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

### Men's History

*(Check box if applicable)*

☐ Testicular mass ☐ Testicular pain ☐ Prostate enlargement ☐ Prostate infection
☐ Change in sex drive ☐ Impotence ☐ Premature ejaculation ☐ Difficulty obtaining an erection
☐ Difficulty maintaining an erection ☐ Loss of control of urine ☐ Urinary urgency/hesitancy/change in stream
☐ Vasectomy ☐ Nocturia (urination at night) # of times per night ______
☐ Sexually transmitted diseases (describe) ______


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### Men's History *(cont.)*

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

Last PSA test:______________________ PSA Level: ☐ 0–2 ☐ 2–4 ☐ 4–10 ☐ >10

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 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obesity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures/epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Psychiatric disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ADHD | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Autism | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dementia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Substance abuse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Genetic disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other: ________________ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |



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## 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 | ☐ | ☐ |
| GERD (reflux) | ☐ | ☐ |
| Crohn's disease/ulcerative colitis | ☐ | ☐ |
| Peptic ulcer disease | ☐ | ☐ |
| Celiac disease | ☐ | ☐ |
| Gallstones | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Respiratory** | | |
| Bronchitis | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Pneumonia | ☐ | ☐ |
| Sinusitis | ☐ | ☐ |
| Sleep apnea | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Urinary/Genital** | | |
| Kidney stones | ☐ | ☐ |
| Gout | ☐ | ☐ |
| Interstitial cystitis | ☐ | ☐ |
| Frequent yeast infections | ☐ | ☐ |
| Frequent urinary tract infections | ☐ | ☐ |
| Sexual dysfunction | ☐ | ☐ |
| Sexually transmitted diseases | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Endocrine/Metabolic** | | |
| Diabetes | ☐ | ☐ |
| Hypothyroidism (low thyroid) | ☐ | ☐ |
| Hyperthyroidism (overactive thyroid) | ☐ | ☐ |
| Infertility | ☐ | ☐ |
| Metabolic syndrome/insulin resistance | ☐ | ☐ |
| Eating disorder | ☐ | ☐ |
| Hypoglycemia | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Inflammatory/Immune** | | |
| Rheumatoid arthritis | ☐ | ☐ |
| Chronic fatigue syndrome | ☐ | ☐ |
| Food allergies | ☐ | ☐ |
| Environmental allergies | ☐ | ☐ |
| Multiple chemical sensitivities | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ |
| Immune deficiency | ☐ | ☐ |
| Mononucleosis | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Other: | ☐ | ☐ |

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


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## 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 | | |
| Tonsillectomy | | |
| Joint replacement | | |
| Heart surgery | | |
| Other: | | |
| **Hospitalizations** | **Date** | **Reason** |
| | | |
| | | |
| | | |
| | | |
| | | |


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## 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 | ☐ | ☐ | ☐ |
| Cold intolerance | ☐ | ☐ | ☐ |
| Daytime sleepiness | ☐ | ☐ | ☐ |
| Difficulty falling asleep | ☐ | ☐ | ☐ |
| Early waking | ☐ | ☐ | ☐ |
| Fatigue | ☐ | ☐ | ☐ |
| Fever | ☐ | ☐ | ☐ |
| Flushing | ☐ | ☐ | ☐ |
| Heat intolerance | ☐ | ☐ | ☐ |
| Night waking | ☐ | ☐ | ☐ |
| Nightmares | ☐ | ☐ | ☐ |
| Can't remember dreams | ☐ | ☐ | ☐ |
| Low body temperature | ☐ | ☐ | ☐ |
| **Head, Eyes, and Ears** | | | |
| Conjunctivitis | ☐ | ☐ | ☐ |
| Distorted sense of smell | ☐ | ☐ | ☐ |
| Distorted taste | ☐ | ☐ | ☐ |
| Ear fullness | ☐ | ☐ | ☐ |
| Ear ringing/buzzing | ☐ | ☐ | ☐ |
| Eye crusting | ☐ | ☐ | ☐ |
| Eye pain | ☐ | ☐ | ☐ |
| Eyelid margin redness | ☐ | ☐ | ☐ |
| Headache | ☐ | ☐ | ☐ |
| Hearing loss | ☐ | ☐ | ☐ |
| Hearing problems | ☐ | ☐ | ☐ |
| Migraine | ☐ | ☐ | ☐ |
| Sensitivity to loud noises | ☐ | ☐ | ☐ |
| Vision problems | ☐ | ☐ | ☐ |
| **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 | ☐ | ☐ | ☐ |
| Arms or legs | ☐ | ☐ | ☐ |
| Muscle weakness | ☐ | ☐ | ☐ |

| Musculoskeletal *(cont.)* | Mild | Moderate | Severe |
|---|---|---|---|
| Neck muscle spasm | ☐ | ☐ | ☐ |
| Tendonitis | ☐ | ☐ | ☐ |
| Tension headache | ☐ | ☐ | ☐ |
| TMJ problems | ☐ | ☐ | ☐ |
| **Mood/Nerves** | | | |
| Agoraphobia | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ |
| Auditory hallucinations | ☐ | ☐ | ☐ |
| Blackouts | ☐ | ☐ | ☐ |
| 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 | ☐ | ☐ | ☐ |
| **Cardiovascular** | | | |
| Angina/chest pain | ☐ | ☐ | ☐ |
| Breathlessness | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Irregular pulse | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Palpitations | ☐ | ☐ | ☐ |
| Phlebitis | ☐ | ☐ | ☐ |
| Swollen ankles/feet | ☐ | ☐ | ☐ |
| Varicose veins | ☐ | ☐ | ☐ |


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## Symptom Review *(cont.)*

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

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

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


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## Symptom Review *(cont.)*

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

| Nails | Mild | Moderate | Severe |
|---|---|---|---|
| Bitten | ☐ | ☐ | ☐ |
| Brittle | ☐ | ☐ | ☐ |
| Curve up | ☐ | ☐ | ☐ |
| Frayed | ☐ | ☐ | ☐ |
| Fungus – fingers | ☐ | ☐ | ☐ |
| Fungus – toes | ☐ | ☐ | ☐ |
| Pitting | ☐ | ☐ | ☐ |
| Ragged cuticles | ☐ | ☐ | ☐ |
| Ridges | ☐ | ☐ | ☐ |
| Soft | ☐ | ☐ | ☐ |
| Thickening of: | ☐ | ☐ | ☐ |
| Finger nails | ☐ | ☐ | ☐ |
| Toenails | ☐ | ☐ | ☐ |
| White spots/lines | ☐ | ☐ | ☐ |
| **Lymph Nodes** | | | |
| Enlarged/neck | ☐ | ☐ | ☐ |
| Tender/neck | ☐ | ☐ | ☐ |
| Other enlarged/tender | ☐ | ☐ | ☐ |
| lymph nodes | | | |
| **Skin, Dryness of** | | | |
| Eyes | ☐ | ☐ | ☐ |
| Feet | ☐ | ☐ | ☐ |
| Any cracking? | ☐ | ☐ | ☐ |
| Any peeling? | ☐ | ☐ | ☐ |
| Hair | ☐ | ☐ | ☐ |
| And unmanageable? | ☐ | ☐ | ☐ |
| Hands | ☐ | ☐ | ☐ |
| Any cracking? | ☐ | ☐ | ☐ |
| Any peeling? | ☐ | ☐ | ☐ |
| Mouth/throat | ☐ | ☐ | ☐ |
| Scalp | ☐ | ☐ | ☐ |
| Any dandruff? | ☐ | ☐ | ☐ |
| Skin in general | ☐ | ☐ | ☐ |
| **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 | ☐ | ☐ | ☐ |

| Skin Problems *(cont.)* | Mild | Moderate | Severe |
|---|---|---|---|
| Easy bruising | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ |
| Herpes – genital | ☐ | ☐ | ☐ |
| Hives | ☐ | ☐ | ☐ |
| Jock itch | ☐ | ☐ | ☐ |
| Lackluster skin | ☐ | ☐ | ☐ |
| Moles w color/size change | ☐ | ☐ | ☐ |
| Oily skin | ☐ | ☐ | ☐ |
| Pale skin | ☐ | ☐ | ☐ |
| Patchy dullness | ☐ | ☐ | ☐ |
| Psoriasis | ☐ | ☐ | ☐ |
| Rash | ☐ | ☐ | ☐ |
| Red face | ☐ | ☐ | ☐ |
| Sensitive to bites | ☐ | ☐ | ☐ |
| Sensitive to poison ivy/oak | ☐ | ☐ | ☐ |
| Shingles | ☐ | ☐ | ☐ |
| Skin cancer | ☐ | ☐ | ☐ |
| Skin darkening | ☐ | ☐ | ☐ |
| Strong body odor | ☐ | ☐ | ☐ |
| Thick calluses | ☐ | ☐ | ☐ |
| Vitiligo | ☐ | ☐ | ☐ |
| **Itching Skin** | | | |
| Anus | ☐ | ☐ | ☐ |
| Arms | ☐ | ☐ | ☐ |
| Ear canals | ☐ | ☐ | ☐ |
| Eyes | ☐ | ☐ | ☐ |
| Feet | ☐ | ☐ | ☐ |
| Hands | ☐ | ☐ | ☐ |
| Legs | ☐ | ☐ | ☐ |
| Nipples | ☐ | ☐ | ☐ |
| Nose | ☐ | ☐ | ☐ |
| Genitals | ☐ | ☐ | ☐ |
| Roof of mouth | ☐ | ☐ | ☐ |
| Scalp | ☐ | ☐ | ☐ |
| Skin in general | ☐ | ☐ | ☐ |
| Throat | ☐ | ☐ | ☐ |
| **Male Reproductive** | | | |
| Discharge from penis | ☐ | ☐ | ☐ |
| Ejaculation problem | ☐ | ☐ | ☐ |
| Genital pain | ☐ | ☐ | ☐ |
| Impotence | ☐ | ☐ | ☐ |
| Infection | ☐ | ☐ | ☐ |
| Lumps in testicles | ☐ | ☐ | ☐ |
| Poor libido (low sex drive) | ☐ | ☐ | ☐ |


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## 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 | | | |


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## 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 | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Take several nutritional supplements each day | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Keep a record of everything you eat each day | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Modify your lifestyle (e.g., work demands, sleep habits) | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Practice a relaxation technique | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Engage in regular exercise | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |

***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 ______________________________________________________

______________________________________________________________


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## 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? ______________________


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# 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

_____ 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** _____

## MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

### 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** ________

# Exposure History Form

## Part 1. Exposure Survey

*Please circle the appropriate answer.*

**Name:** ______________________ **Date:** __________

**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 →

If *yes*, list them below

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 →

If *yes*, list the protective equipment used

10. Have you been advised to use protective equipment? no yes

11. Have you been instructed in the use of protective equipment? no yes

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.

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

### 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?
   *Please circle those that apply.*
   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.**

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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 | |

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# 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**__________



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# 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?**

| ☐ General Intensity | ☐ Talk Test | ☐ Perceived Exertion | ☐ 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

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**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 ______________________________

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# <u>How Healthy Is Your Diet?</u>

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

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# Sleep Questionnaire

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? ________________________________



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**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? *(Please specify)* ________________ | | | | |

**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

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### 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? ______________________________

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### 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? ______

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# 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 |

From: Lovibond, SH and Lovibond PF. (1995) Manual for the Depression Anxiety Stress Scales (2nd Ed.). Sydney: Psychology Foundation

*Please turn the page*

**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 |

From: Lovibond, SH and Lovibond PF. (1995) Manual for the Depression Anxiety Stress Scales (2nd Ed.). Sydney: Psychology Foundation

# 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 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 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:______