Health Questionnaires

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GENERAL INFORMATION

Name ______________________________

Preferred Name ______________________________

Date of Birth ______________________________ Age ____________

Gender ☐ Male ☐ Female

Genetic Background ☐ African ☐ European ☐ Native American ☐ Mediterranean
☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐ ____________

Highest Education Level ☐ High School ☐ College ☐ Post Graduate

Job Title ______________________________

Nature of Business ______________________________

Primary Address *Number, Street* ______________________________
City, State, Zip ______________________________

Secondary Address *Number, Street* ______________________________
City, State, Zip ______________________________

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________ Fax ____________________

Email ______________________________

Emergency Contact *Name* ____________________ *Phone* ____________
Address ______________________________
City, State, Zip ______________________________

Physician *Name* ____________________ *Phone* ____________
Address ______________________________
City, State, Zip ______________________________

Referred by ☐ Book ☐ Website ☐ Media ☐ Friend or Family Member
☐ Other ______________________________

MEDICAL QUESTIONNAIRE

ALLERGIES:

Medication/Supplement/Food **Reaction**

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

COMPLAINTS/CONCERNS:

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

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

When was the last time you felt well? ______________________________
____

Did something trigger your change in health? ______________________________
____

What makes you feel worse? ______________________________
____

What makes you feel better? ______________________________
____

Please list current and ongoing problems in order of priority:

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

MEDICAL HISTORY

☐ = Past Condition ■ = Ongoing Condition

GASTROINTESTINAL

- Irritable Bowel Syndrome ____________
- Inflammatory Bowel Disease ____________
- Crohn's ____________
- Ulcerative Colitis____________
- Gastritis or Peptic Ulcer Disease ____________
- GERD (reflux) ____________
- Celiac Disease ____________
- Other ____________

CARDIOVASCULAR

- Heart Attack ____________
- Other Heart Disease ____________
- Stroke ____________
- Elevated Cholesterol ____________
- Arrhythmia (irregular heart rate) ____________
- Hypertension (high blood pressure) ____________
- Rheumatic Fever ____________
- Mitral Valve Prolapse ____________
- Other ____________

METABOLIC/ENDOCRINE

- Type 1 Diabetes ____________
- Type 2 Diabetes ____________
- Hypoglycemia ____________
- Metabolic Syndrome____________
  (Insulin Resistance or Pre-Diabetes)
- Hypothyroidism (low thyroid) ____________
- Hyperthyroidism (overactive thyroid) ____________
- Endocrine Problems ____________
- Polycystic Ovarian Syndrome (PCOS) ____________
- Infertility ____________
- Weight Gain ____________
- Weight Loss ____________
- Frequent Weight Fluctuations ____________
- Bulimia ____________
- Anorexia ____________
- Binge Eating Disorder ____________
- Night Eating Syndrome ____________
- Eating Disorder (non-specific)____________
- Other ____________

CANCER

- Lung Cancer ____________
- Breast Cancer ____________
- Colon Cancer ____________
- Ovarian Cancer ____________
- Prostate Cancer ____________
- Skin Cancer____________
- Other ____________

GENITAL AND URINARY SYSTEMS

- Kidney Stones ____________
- Gout____________
- Interstitial Cystitis____________
- Frequent Urinary Tract Infections____________
- Frequent Yeast Infections____________
- Erectile Dysfunction
  Or Sexual Dysfunction____________
- Other____________

MUSCULOSKELETAL/PAIN

- Osteoarthritis ____________
- Fibromyalgia ____________
- Chronic Pain ____________
- Other ____________

INFLAMMATORY/AUTOIMMUNE

- Chronic Fatigue Syndrome____________
- Autoimmune Disease ____________
- Rheumatoid Arthritis ____________
- Lupus SLE ____________
- Immune Deficiency Disease ____________
- Herpes-Genital ____________
- Severe Infectious Disease____________
- Poor Immune Function
  (frequent infections)____________
- Food Allergies____________
- Environmental Allergies____________
- Multiple Chemical Sensitivities____________
- Latex Allergy____________
- Other____________

RESPIRATORY DISEASES

- Asthma ____________
- Chronic Sinusitis ____________
- Bronchitis____________
- Emphysema____________
- Pneumonia____________
- Tuberculosis____________
- Sleep Apnea____________
- Other____________

SKIN DISEASES

- Eczema____________
- Psoriasis____________
- Acne____________
- Melanoma____________
- Skin Cancer____________
- Other____________

MEDICAL HISTORY (CONTINUED)

☐ = Past Condition ▣ = Ongoing Condition

NEUROLOGIC/MOOD

- ☐ ▣ Depression________________________
- ☐ ▣ Anxiety ________________________
- ☐ ▣ Bipolar Disorder________________________
- ☐ ▣ Schizophrenia________________________
- ☐ ▣ Headaches________________________
- ☐ ▣ Migraines________________________
- ☐ ▣ ADD/ADHD________________________
- ☐ ▣ Autism________________________
- ☐ ▣ Mild Cognitive Impairment________________________
- ☐ ▣ Memory Problems________________________
- ☐ ▣ Parkinson's Disease________________________
- ☐ ▣ Multiple Sclerosis________________________
- ☐ ▣ ALS________________________
- ☐ ▣ Seizures________________________
- ☐ ▣ Other Neurological Problems________________________

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam________________________
- ☐ Bone Density________________________
- ☐ Colonoscopy________________________
- ☐ Cardiac Stress Test________________________
- ☐ EBT Heart Scan________________________
- ☐ EKG________________________
- ☐ Hemoccult Test (stool test for blood)____________
- ☐ MRI ________________________
- ☐ CT Scan________________________
- ☐ Upper Endoscopy________________________
- ☐ Upper GI Series________________________
- ☐ Ultrasound________________________

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy________________________
- ☐ Hysterectomy +/- Ovaries________________________
- ☐ Gall Bladder________________________
- ☐ Hernia________________________
- ☐ Tonsillectomy________________________
- ☐ Dental Surgery________________________
- ☐ Joint Replacement – Knee/Hip________________________
- ☐ Heart Surgery – Bypass Valve________________________
- ☐ Angioplasty or Stent________________________
- ☐ Pacemaker________________________
- ☐ Other________________________
- ☐ None________________________

INJURIES

Check box if yes

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

BLOOD TYPE: ☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ Unknown

HOSPITALIZATIONS ☐ None

Date	Reason
____________	________________________________
____________	________________________________
____________	________________________________
____________	________________________________
____________	________________________________

COMMENTS

____

____

____

____

____

GYNECOLOGIC HISTORY (*for women only)*

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

☐ Pregnancies___________ ☐Caesarean __________ ☐Vaginal deliveries_________
☐ Miscarriage _____________ ☐ Abortion ___________ ☐ Living Children:_________________________________
☐ Post Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby over 8 pounds
☐ Breast Feeding For how long? ________

MENSTRUAL HISTORY

Age at first period: ____ Menses Frequency:_______ Length:______ Pain: ☐Yes ☐ No Clotting: ☐Yes ☐No
Has your period ever skipped? ___________________ For how long? ___________________
Last Menstrual Period ___________________
Use of hormonal contraception such as: ☐Birth Control Pills ☐Patch ☐ Nuva Ring How long?_______
Do you use contraception? ☐Yes ☐No ☐Condom ☐Diaphragm ☐IUD ☐Partner vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐Fibrocystic Breasts ☐Endometriosis ☐Fibroids ☐Infertility
☐Painful Periods ☐Heavy periods ☐PMS
Last Mammogram:___________ ☐ Breast Biopsy/Date________________
Last PAP test: ____________ ☐Normal ☐Abnormal
Date of Last Bone Density_________ Results: ☐High ☐Low ☐Within Normal Range
Are you in menopause? ☐Yes ☐No
Age at Menopause __________
☐Hot Flashes ☐Mood Swings ☐Concentration/Memory Problems ☐Vaginal Dryness ☐Decreased Libido
☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐Loss of Control of Urine ☐ Palpitations
☐ Use of hormone replacement therapy? How long?

MEN'S HISTORY (*for men only*)

Have you had a PSA done? ☐Yes ☐No
PSA Level: ☐0-2 ☐2-4 ☐4-10 ☐>10
☐Prostate Enlargement ☐Prostate infection ☐Change in libido ☐Impotence
☐Difficulty Obtaining an Erection ☐Difficulty Maintaining an Erection
☐Nocturia (urination at night) How many times at night? ________
☐Urgency/Hesitancy/Change in Urinary Stream ☐Loss of Control of Urine

GI HISTORY

Foreign travel? ☐ Yes ☐ No Where? ______________________________

Wilderness Camping? ☐ Yes ☐ No Where? ______________________________

Have you ever had severe ☐ Gastroenteritis ☐ Diarrhea

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

Do you feel bloated after meals? ☐ Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature

Pregnancy complications: ______________________________

Birth Complications: ______________________________

☐ Breast-fed How long? ______________ ☐ Bottle-fed

Age at introduction of Solid foods: __________ Dairy: __________ Wheat: __________

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

DENTAL HISTORY

☐ Silver Mercury Fillings How many? ______________

☐ Gold Fillings ☐ Root canals ☐ Implants ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis

☐ Problems with chewing

Do you floss regularly? ☐ Yes ☐ No

MEDICATIONS

CURRENT MEDICATIONS:

Medication	Dose	Frequency	Start Date (mm/yy)	Reason for Use

PREVIOUS MEDICATIONS: *Last 10 years*

Medication	Dose	Frequency	Start Date (mm/yy)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY):

Supplement/Brand	Dose	Frequency	Start Date (mm/yy)	Reason for Use

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

Describe ____

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

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

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

Frequent antibiotics? > 3 times/year ☐ Yes ☐ No   Long term antibiotics? ☐ Yes ☐ No

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

Use of oral contraceptives? ☐ Yes ☐ No

FAMILY HISTORY

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

SOCIAL HISTORY

NUTRITION HISTORY

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

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

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

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy
☐ No Wheat ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism
☐ Specific Program for Weight Loss/Maintenance Type________________ ☐ Other _____________________

Height (feet/inches) _________________________	Current Weight ___________________________________
Usual Weight Range =/- 5 lbs. _______________	Desired Weight Range =/- 5 lbs. ___________________
Highest Adult Weight ________________________	Lowest Adult Weight ______________________________
Weight Fluctuations (> 10 lbs.) ☐ Yes ☐ No	Body Fat % _______________________________________

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

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

Do you avoid any particular foods? ☐ Yes ☐ No If yes, types and reason ____________________________
____

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

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

Do you read food labels? ☐ Yes ☐ No

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

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

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

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

The most important thing I should change about my diet to improve my health is _________________________
____

SMOKING

Currently Smoking? ☐Yes ☐No How many years? ____________ Packs per day ______________

Attempts to quit: _________

Previous Smoking: How many years?__________ Packs per day? _________

2nd Hand Smoke Exposure? ☐ Yes ☐ No

ALCOHOL INTAKE

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

☐ None ☐1-3 ☐4-6 ☐7-10 ☐>10 *If none, skip to Other Substances*

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

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

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

Do you ever feel guilty about your alcohol consumption? ☐Yes ☐ No

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

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

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

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

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

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

OTHER SUBSTANCES

Caffeine intake ☐ Yes ☐ No Cups/day: ☐Coffee ☐Tea ☐1 ☐2-4 ☐4 a day

Caffeinated Sodas or Diet Sodas Intake: ☐ Yes ☐ No

12-ounce can/bottle/day ☐1 ☐2-4 ☐>4 a day

List favorite type: (*such as Diet Coke, Pepsi, etc*) ____

Are you currently using any recreational drugs? ☐ Yes ☐ No Type ____________________________________

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

EXERCISE

Current Exercise Program:

Activity	Type	Frequency per week	Duration in minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, Pilates, etc)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc)			

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

List problems that limit activity: ____

____

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

If yes, please describe ____

____

Do you usually sweat when exercising? ☐ Yes ☐ No

PSYCHOSOCIAL

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

Are you happy? ☐Yes ☐No

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

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

Do you like the work you do? ☐Yes ☐No

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

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

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

STRESS/COPING

Have you ever sought counseling? ☐Yes ☐No

Are you currently in therapy? ☐Yes ☐No Describe:____

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

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

Daily Stressors: Rate on scale of 1-10

Work ______ Family ______ Social ___ Finances ________ Health_______ Other ______

Do you practice meditation or relaxation technique? ☐Yes ☐ No How often?___________

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

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

SLEEP/REST

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

Do you have trouble falling asleep? ☐Yes ☐No

Do you feel rested upon awakening? ☐Yes ☐ No

Do you have problems with insomnia? ☐Yes ☐ No

Do you snore? ☐Yes ☐No

Do you use sleeping aids? ☐ Yes ☐No Explain____

ROLES/RELATIONSHIP

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

List children:

Child's Name	Age	Gender

Who is living in Household? Number ____________ Names ____

Their employment/occupation: ____

Resources for emotional support? ____

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

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

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At school				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐Yes ☐No If yes, describe symptoms______________

____

Do you have any food allergies or sensitivities? ☐Yes List: ____ ☐No

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

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

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

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

☐Cheese ☐Citrus foods ☐Chocolate ☐Alcohol ☐Red Wine

☐Sulfite containing foods (wine, dried fruit, salad bars) ☐Preservatives (ex. sodium benzoate) ☐Other:

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

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

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

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

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

Explain ____

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

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

☐Heavy Metals ☐Other ____

Chemical Name, Date, Length of Exposure ____

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

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

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

SYMPTOM REVIEW

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

GENERAL

- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty falling asleep
- ☐ Early waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No dream recall

HEAD, EYES & EARS

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision problems -other than glasses
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL

- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm

Muscles Twitches:

- ☐ Around Eyes
- ☐ Arms or Legs

- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-outs
- ☐ Depression

Difficulty with:

- ☐ Concentrating
- ☐ Balance
- ☐ Thinking
- ☐ Judgment
- ☐ Speech
- ☐ Memory

- ☐ Dizziness (spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING

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

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
- ☐ Cramps
- ☐ Dentures with Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:

- ☐ Lactose
- ☐ All Dairy Products
- ☐ Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

- ☐ Liver Disease/Jaundice (yellow eyes or skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

SKIN PROBLEMS

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/color/size change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitive to Bites
- ☐ Sensitive to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN

- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF

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

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus – Fingers
- ☐ Fungus – Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of: ☐ Finger Nails ☐ Toenails

- ☐ White Spots/Lines

RESPIRATORY

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

Hay Fever: ☐ Spring ☐ Summer ☐ Fall ☐ Change of Season

- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR

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

LYMPH NODES

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

URINARY

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

MALE REPRODUCTIVE

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

FEMALE REPRODUCTIVE

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

Premenstrual:

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

Menstrual:

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

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 (i.e., work demands, sleep habits)? ☐5 ☐4 ☐3 ☐2 ☐1

Practice a relaxation technique? ☐5 ☐4 ☐3 ☐2 ☐1

Engage in regular exercise? ☐5 ☐4 ☐3 ☐2 ☐1

Have periodic lab tests to assess your progress? ☐5 ☐4 ☐3 ☐2 ☐1

Comments

____

____

____

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

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

☐5 ☐4 ☐3 ☐2 ☐1

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

____

____

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

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

Comments ____

____

____

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

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

Comments ____

____

____

3 DAY DIET DIARY INSTRUCTIONS

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

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible i.e., milk - what kind? (whole, 2%, nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), coffee - (decaffeinated with sugar and 1/2 & 1/2).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).

Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name ______________________________ Date ______________

DAY 1

Time	Food/Beverage/Amount	Comments

Bowel Movements (#, form, color) ______________________________

Stress/Mood/Emotions ______________________________

Other Comments ______________________________

DAY 2

Time	Food/Beverage/Amount	Comments

Bowel Movements (#, form, color) ______________________________
Stress/Mood/Emotions ______________________________
Other Comments ______________________________

DAY 3

Time	Food/Beverage/Amount	Comments

Bowel Movements (#, form, color) ______________________________
Stress/Mood/Emotions ______________________________
Other Comments ______________________________

MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME ____ **DATE** _________________

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

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

DIGESTIVE TRACT
_____ Nausea or vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching or passing gas
_____ Heartburn
_____ Intestinal/Stomach pain
Total ___________

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
Total ___________

EMOTIONS
_____ Mood swings
_____ Anxiety, fear or nervousness
_____ Anger, irritability, aggression
_____ Depression
Total ___________

ENERGY/ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
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 _____________

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total ________

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

JOINTS/MUSCLES
_____ Pain or aches in joints
_____ Arthritis
_____Stiffness/limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total ________

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficult breathing
Total ________

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total ________

MOUTH/THROAT
_____ Chronic coughing
_____ Gagging, frequent throat clearing
_____ Sore throat, hoarseness, loss of voice
_____Swollen/discolored tongue,gum,lips
_____ Canker sores
Total ________

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

SKIN
_____ Acne
_____ Hives, rashes, or dry skin
_____ Hair loss
_____ Flushing or hot flushes
_____ Excessive sweating
Total ________

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
Total ________

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
Total ________

GRAND TOTAL ________

KEY TO QUESTIONNAIRE: Add individual scores and total each group. Add each group score to get Grand Total.
Optimal is less than 10 Mild Toxicity: 10-50 Moderate Toxicity: 50-100 Severe Toxicity: over 100

SF-36 QUALITY OF LIFE ASSESSMENT

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

In general, would you say your health is: (*Please tick one box.*)
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health in general now? (*Please tick one box.*)

- Much better than one year ago ☐
- Somewhat better now than one year ago ☐
- About the same as one year ago ☐
- Somewhat worse now than one year ago ☐
- Much worse than one year ago ☐

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (*Please circle one number on each line.*)

Activities	**Limited a Lot**	**Limited a Little**	**Not Limited at All**
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing several flights of stairs	1	2	3
Climbing one flight of stairs	1	2	3
Bending, kneeling, or stooping	1	2	3
Walking more than a mile	1	2	3
Walking several blocks	1	2	3
Walking one block	1	2	3
Bathing and dressing yourself	1	2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(Please circle one number on each line.)	**Yes**	**No**
Cut down on the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Were limited in the kind of work or other activities	1	2
Had difficulty performing the work or other activities (i.e., it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (i.e. feeling depressed or anxious)?

(Please circle one number on each line.)	**Yes**	**No**
Cut down on the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Didn't do work or other activities as carefully as usual	1	2

During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? *(Please tick one box.)*

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

How much physical pain have you had during the past 4 weeks? *(Please tick one box.)*

☐ None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? *(Please tick one box.)*

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

(Please circle one number on each line.)	**All of the Time**	**Most of the Time**	**Good bit of the Time**	**Some of the Time**	**Little of the Time**	**None of the Time**
Did you feel full of life?						
Have you been a very nervous person?						
Have you felt so down in the dumps that nothing could cheer you up?						
Have you felt calm and peaceful?						
Did you have a lot of energy?						
Have you felt downhearted and blue?						
Have you been a happy person?						
Did you feel tired or worn out?						

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.) *(Please tick one box.)*

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

How TRUE or FALSE is each of the following statement for you?

(Please circle one number on each line.)	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
I seem to get sick a little easier than other people.	1	2	3	4	5
I am as healthy as anybody I know.	1	2	3	4	5
I expect my health to get worse.	1	2	3	4	5
My health is excellent.	1	2	3	4	5

Thank You!