

GENERAL INFORMATION

Name: *First*

Middle

Last

Preferred Name:

Date of Birth:

Age:

Gender: Male Female

Genetic Background: African European Native American Mediterranean
 Asian Ashkenazi Middle Eastern

Highest Education Level: High School Under-Graduate Post-Graduate

Job Title:

Nature of Business:

Primary Address: *Number, Street:*

Apt. No.

City

State

Zip

Primary Address: *Number, Street:*

Apt. No.

City

State

Zip

Home Phone 1:

Home Phone 2:

Work Phone:

Cell Phone:

Fax:

E-mail:

Emergency Contact: *Name*

Phone Number:

Address

Apt. No.

City

State

Zip

Physician's Name:

Phone Number

Fax

Referred by:

Google (which words) _____ Media _____

Family Member _____ Friend _____

Other _____

PHARMACY INFORMATION

Primary Pharmacy: *Name* _____ *Phone Number:* _____

Address

City _____ *State* _____ *Zip* _____

E-mail _____ *Fax** _____

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

Compounding/Supplement Pharmacy:

Name _____ *Phone Number:* _____

Address

City _____ *State* _____ *Zip* _____

E-mail _____ *Fax** _____

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

BEND OSTEOPATHIC CARE 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
Example: Post Nasal Drip		X	

Prior Treatment/Approach	Excellent	Good	Fair
Example: Elimination Diet	X		

MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset

GASTROINTESTINAL

- | | |
|---|--|
| <input type="checkbox"/> Irritable Bowel Syndrome _____ | <input type="checkbox"/> Gastritis or Peptic Ulcer Disease _____ |
| <input type="checkbox"/> Inflammatory Bowel Disease _____ | <input type="checkbox"/> GERD (reflux) _____ |
| <input type="checkbox"/> Crohn's _____ | <input type="checkbox"/> Celiac Disease _____ |
| <input type="checkbox"/> Ulcerative Colitis _____ | <input type="checkbox"/> Other _____ |

CARDIOVASCULAR

- | | |
|--|---|
| <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Hypertension (high blood pressure) _____ |
| <input type="checkbox"/> Other Heart Disease _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Mitral Valve Prolapse _____ |
| <input type="checkbox"/> Elevated Cholesterol _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arrhythmia (irregular heart rate) _____ | |

METABOLIC/ENDOCRINE

- | | |
|---|---|
| <input type="checkbox"/> Type 1 Diabetes _____ | <input type="checkbox"/> Weight Gain _____ |
| <input type="checkbox"/> Type 2 Diabetes _____ | <input type="checkbox"/> Weight Loss _____ |
| <input type="checkbox"/> Hypoglycemia _____ | <input type="checkbox"/> Frequent Weight Fluctuations _____ |
| <input type="checkbox"/> Metabolic Syndrome _____ | <input type="checkbox"/> Bulimia _____ |
| <input type="checkbox"/> (Insulin Resistance or Pre-Diabetes) | <input type="checkbox"/> Anorexia _____ |
| <input type="checkbox"/> Hypothyroidism (low thyroid) _____ | <input type="checkbox"/> Binge Eating Disorder _____ |
| <input type="checkbox"/> Hyperthyroidism (overactive thyroid) _____ | <input type="checkbox"/> Night Eating Syndrome _____ |
| <input type="checkbox"/> Endocrine Problems _____ | <input type="checkbox"/> Eating Disorder (non-specific) _____ |
| <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Infertility _____ | |

CANCER

- | | |
|--|--|
| <input type="checkbox"/> Lung Cancer _____ | <input type="checkbox"/> Ovarian Cancer _____ |
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Prostate Cancer _____ |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Skin Cancer _____ |

GENITAL AND URINARY SYSTEMS

- | | |
|--|---|
| <input type="checkbox"/> Kidney Stones _____ | <input type="checkbox"/> Frequent Yeast Infections _____ |
| <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Erectile Dysfunction or Sexual Dysfunction _____ |
| <input type="checkbox"/> Interstitial Cystitis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Frequent Urinary Tract Infections _____ | |

MUSCULOSKELETAL/PAIN

- | | |
|---|---|
| <input type="checkbox"/> Osteoarthritis _____ | <input type="checkbox"/> Chronic Pain _____ |
| <input type="checkbox"/> Fibromyalgia _____ | <input type="checkbox"/> Other _____ |

INFLAMMATORY/AUTOIMMUNE

- | | |
|--|--|
| <input type="checkbox"/> Chronic Fatigue Syndrome _____ | <input type="checkbox"/> Poor Immune Function _____ |
| <input type="checkbox"/> Autoimmune Disease _____ | (frequent infections) |
| <input type="checkbox"/> Rheumatoid Arthritis _____ | <input type="checkbox"/> Food Allergies _____ |
| <input type="checkbox"/> Lupus SLE _____ | <input type="checkbox"/> Environmental Allergies _____ |
| <input type="checkbox"/> Immune Deficiency Disease _____ | <input type="checkbox"/> Multiple Chemical Sensitivities _____ |
| <input type="checkbox"/> Herpes-Genital _____ | <input type="checkbox"/> Latex Allergy _____ |
| <input type="checkbox"/> Severe Infectious Disease _____ | <input type="checkbox"/> Other _____ |

MEDICAL HISTORY (CONTINUED)

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

RESPIRATORY DISEASES

- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Emphysema _____
- Pneumonia _____
- Tuberculosis _____
- Sleep Apnea _____
- Other _____

SKIN DISEASES

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Skin Cancer _____
- Other _____

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 _____
- Hemocult Test-stool test for blood _____
- MRI _____
- CT Scan _____
- Upper Endoscopy _____
- Upper GI Series _____
- Ultrasound _____

INJURIES

Check box if yes: Back Injury Head Injury Neck Injury Broken Bones

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 _____

BLOOD TYPE: A B AB O Rh+ Unknown

HOSPITALIZATIONS

None

Date: _____ Reason: _____

GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

OBSTETRIC HISTORY (Check box if yes and provide number)

- 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
 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

WOMEN'S DISORDERS/HORMONAL IMBALANCES (CONTINUED)

- 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 How many? _____

Implants

Tooth Pain

Bleeding Gums

Gingivitis

Problems with Chewing

Do you floss regularly? Yes No

MEDICATIONS

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

PREVIOUS MEDICATIONS: *Last 10 years*

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

SUPPLEMENT AND BRAND	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

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

Describe: _____

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

Have you had prolonged 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

	MOTHER	FATHER	BROTHER(S)	SISTER(S)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNTS	UNCLES	OTHER
<i>Check family members that apply.</i>												
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												
Thyroid Problems												
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												
Other:												

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

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:

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

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? _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

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

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

Previous alcohol intake? Yes (Mild Moderate High) None

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

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

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

Do you ever take an eye-opener? Yes No

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

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

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

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

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

OTHER SUBSTANCES

Caffeine Intake: Yes No

Coffee cups/day: 1 2-4 > 4 | Tea cups/day: 1 2-4 > 4

Caffeinated Sodas or Diet Sodas Intake: Yes No

12-ounce can/bottle 1 2-4 > 4 per day

List favorite type (Ex. 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: *(List type of activity, number of sessions/week, and duration)*

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

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

List problems that limit activity:

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe:

Do you usually sweat when exercising? Yes No

PSYCHOSOCIAL

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

Are you happy? Yes No

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

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

Do you like the work you do? Yes No

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

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

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

STRESS/COPING

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No

Describe: _____

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

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

Daily Stressors: Rate on scale of 1-10

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

Do you practice meditation or relaxation techniques? Yes No How often? _____

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

Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma?

Yes No

SLEEP/REST

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

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No

Do you use sleeping aids? Yes No

Explain: _____

ROLES/RELATIONSHIP

Marital status:

Single Married Divorced Gay/Lesbian Long Term Partnership Widow

List Children:

Child's Name	Age	Gender

Who is Living in Household? Number: _____

Names: _____

Their employment/Occupations: _____

Resources for emotional support?

Check all that apply:

Spouse Family Friends Religious/Spiritual Pets Other: _____

Are you satisfied with your sex life? Yes No

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 your 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 No

If yes, list all: _____

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 or those present in during the past the 6 months.

GENERAL

- Cold Hands & Feet
- Cold Intolerance
- Low Body Temperature
- Low Blood Pressure
- Daytime Sleepiness
- Difficulty Falling Asleep
- Early Waking
- Fatigue
- Fever
- Flushing
- Heat Intolerance
- Night Waking
- Nightmares
- No Dream Recall

HEAD, EYES & EARS

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

MUSCULOSKELETAL

- Back Muscle Spasm
- Calf Cramps
- Chest Tightness
- Foot Cramps
- Joint Deformity
- Joint Pain
- Joint Redness
- Joint Stiffness
- Muscle Pain
- Muscle Spasms
- Muscle Stiffness
- Muscle Twitches:**
 - Around Eyes

- Arms or Legs
- Muscle Weakness
- Neck Muscle Spasm
- Tendonitis
- Tension Headache
- TMJ Problems

MOOD/NERVES

- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Black-out
- Depression

Difficulty:

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

EATING

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

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 w/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 St

SKIN PROBLEMS

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

ITCHING SKIN

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

SKIN, DRYNESS OF

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

LYMPH NODES

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

NAILS

- Bitten
- Brittle
- Curve Up
- Frayed
- Fungus-Fingers
- Fungus-Toes
- Pitting
- Ragged Cuticles
- Ridges
- Soft
- Thickening of:**
 - Fingernails
 - Toenails
 - White Spots/Lines

RESPIRATORY

- Bad Breath
- Bad Odor in Nose
- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat
- Hay Fever:**
 - Spring
 - Summer
 - Fall
 - Change Of Season
- Nasal Stuffiness
- Nose Bleeds
- Post Nasal Drip
- Sinus Fullness
- Sinus Infection
- Snoring
- Wheezing
- Winter Stuffiness

CARDIOVASCULAR

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

URINARY

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

MALE REPRODUCTIVE

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

FEMALE REPRODUCTIVE

- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex
- Premenstrual:**
 - Bloating Breast Tenderness
 - Carbohydrate Cravings
 - Chocolate Cravings
 - Constipation
 - Decreased Sleep
 - Diarrhea
 - Fatigue
 - Increased Sleep
 - Irritability
- Menstrual:**
 - Cramps
 - Heavy Periods
 - Irregular Periods
 - No Periods
 - Scanty Periods
 - Spotting Between

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..... O 5 O 4 O 3 O 2 O 1
- Take several nutritional supplements each day..... O 5 O 4 O 3 O 2 O 1
- Keep a record of everything you eat each day..... O 5 O 4 O 3 O 2 O 1
- Modify your lifestyle (e.g., work demands, sleep habits) O 5 O 4 O 3 O 2 O 1
- Practice a relaxation technique O 5 O 4 O 3 O 2 O 1
- Engage in regular exercise O 5 O 4 O 3 O 2 O 1
- Have periodic lab tests to assess your progress..... O 5 O 4 O 3 O 2 O 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? O 5 O 4 O 3 O 2 O 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? O 5 O 4 O 3 O 2 O 1

Comments: _____

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

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

O 5 O 4 O 3 O 2 O 1

Comments: _____

3-DAY DIET DIARY INSTRUCTIONS

PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. DO NOT WAIT AND BRING WITH YOU TO THE APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan.

Please complete this Diet Diary for 3 consecutive days including one weekend day.

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

DIET DIARY

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: _____

MSQ - 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 completing this after your first time, then record your symptoms for ONLY the last 48 hours.

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

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

- Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

DIGESTIVE TRACT

- ___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloating 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 or aggressiveness
___ 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 or 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 need to clear throat
___ 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: _____

