Healing InSight

Thank you for choosing Healing InSight!
We're delighted to work with you to help you feel better, look younger and love life.

Please thoughtfully answer these questions so we're able to develop an individualized diagnosis and treatment plan that's right for you!

Today's Date: _____

Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Cell): _____ Phone (Work): _____

E-mail Address: _____

Would you like to join Healing InSight's email list? ☐ Yes ☐ No ☐ I'm already on it!

Date of Birth: _____ Age: _____ Weight: _____ Height: _____ Gender: _____

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

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Have you ever done functional medicine or acupuncture before? _____

Do you have a:

Flex Spending Account (FSA)? ☐ Yes ☐ No

Health Savings Account (HSA)? ☐ Yes ☐ No

Payment is due on the day of your appointment.
Receipts for insurance & healthcare/flex spending accounts reimbursements can be provided, please ask!

Please give us 24 hours advance notice if you need to cancel an appointment.
You may be charged if you cancel an appointment without 24 hours notice.

Current Health Concerns

Please list current and ongoing health concerns and their effect on your life.

Describe Problem	Severity			Effect on Life/Work/Relationships	Severity		
	Mild	Moderate	Severe		Mild	Moderate	Severe
Example: Fatigue		x		Can't focus at work			x
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

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? Do you have any ideas why? _____

_____

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

_____

Medications and Supplements

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

Medication (Rx & OTC)	Dose	Frequency	Start Date	Reason for Use

Vitamins, supplements and herbs

Name and Brand	Dose	Frequency	Start Date	Reason for Use

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

If yes, describe: _____

Blood type: ☐ A ☐ B ☐ O ☐ Don't know

ALLERGIES

Please list any known allergies to medications, foods, pollens, metals, etc.

_____

_____

_____

OTHER:

Do you have a pacemaker? ☐ Yes ☐ No

Do you have a bleeding disorder? ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No

HEALTH HISTORY

Medical History: Illnesses/Conditions

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

Yes	Past	GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome
☐	☐	GERD (reflux)
☐	☐	Crohn's/ulcerative colitis
☐	☐	Peptic ulcer
☐	☐	Celiac disease
☐	☐	Gallstones
☐	☐	Other:

Yes	Past	RESPIRATORY
☐	☐	Bronchitis
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Pneumonia
☐	☐	Sinusitis
☐	☐	Sleep apnea
☐	☐	Other:

Yes	Past	CARDIOVASCULAR
☐	☐	Chest pain
☐	☐	Heart attack
☐	☐	Heart failure
☐ ☐	☐ ☐	Hypertension (high blood pressure)
☐	☐	Stroke
☐	☐	High blood fats (cholesterol, triglycerides)
☐	☐	Rheumatic fever
☐	☐	Arrhythmia (irregular heart rate)
☐	☐	Murmur
☐	☐	Mitral valve prolapse
☐	☐	Other:

Yes	Past	MUSKULOSKELETAL
☐	☐	Fibromyalgia
☐	☐	Osteoarthritis
☐	☐	Chronic pain
☐	☐	Other:

Yes	Past	SKIN
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Acne
☐	☐	Skin cancer
☐	☐	Other:

Yes	Past	CANCER
☐	☐	Lung
☐	☐	Breast
☐	☐	Colon
☐	☐	Ovarian
☐	☐	Other:

Yes	Past	ENDOCRINE/METABOLIC
☐	☐	Diabetes
☐ ☐	☐ ☐	Hyperthyroid (overactive thyroid)
☐	☐	Hypothyroid (low thyroid)
☐	☐	Polycystic Ovarian Syndrome
☐	☐	Infertility
☐	☐	Metabolic syndrome/ insulin resistance
☐	☐	Eating disorder
☐	☐	Hypoglycemia
☐	☐	Other:

Yes	Past	INFLAMMATORY/IMMUNE
☐	☐	Rheumatoid arthritis
☐	☐	Chronic fatigue syndrome
☐	☐	Food allergies
☐	☐	Environmental allergies
☐	☐	Multiple chemical sensitivities
☐	☐	Autoimmune disease
☐	☐	Mononucleosis
☐	☐	Hepatitis
☐	☐	Other:

Yes	Past	NEUROLOGICAL/EMOTIONAL
☐	☐	Epilepsy/seizures
☐	☐	ADD/ADHD
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Autism
☐	☐	Multiple sclerosis
☐	☐	Parkinson's disease
☐	☐	Dementia

Yes	Past	URINARY/GENITAL
☐	☐	Kidney stones
☐	☐	Frequent urinary tract infections
☐	☐	Frequent yeast infections
☐	☐	Sexually transmitted diseases (STDs)
☐	☐	Gout
☐	☐	Sexual dysfunction
☐	☐	Interstitial cystitis

Diagnostic Tests

Check YES = tests you've done and indicate the year performed and any significant findings

DIAGNOSTIC TESTS	Yes	Year	Purpose/Findings
Bone density	☐		
CT scan	☐		
Colonoscopy	☐		
Cardiac stress test	☐		
EKG	☐		
MRI	☐		
Upper endoscopy	☐		
Upper GI series	☐		
Chest x-ray	☐		
Other x-rays	☐		
Barium enema	☐		
Other:	☐		

Birth/Childhood History

Were you 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

Timeline of Major Health/Life Events

	Major Life Changes (stressors, moving, job, relationships)	**Illnesses / Injuries**	**Surgeries / Hospitalizations**
Childhood			
Teens			
20s			
30s			
40s			
50s and older			

Medication Use

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

☐ NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin
☐ Tylenol (acetaminophen)
☐ Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)
☐ Oral Contraceptives

How many times have you taken antibiotics?

	< 5 Times	**> 5 Times**	**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 Times	**> 5 Times**	**Reason for Use**
Infancy/Childhood	☐	☐	
Teen	☐	☐	
Adulthood	☐	☐	

Symptom Review

Mark YES for any mild or moderate symptoms you currently have or have had in the 6 months.
Mark SEVERE if a significant symptom.

YES	SEVERE	TEMPERATURE
☐	☐	Cold hands and feet
☐	☐	Cold nose
☐	☐	Whole body cold
☐	☐	Low body temp
☐	☐	Cold intolerance
☐	☐	Hot flashes
☐	☐	Tend to feel hot
☐	☐	Flushing
☐	☐	Fever
☐	☐	Alternating hot & cold
☐	☐	Fever
☐	☐	Chills

YES	SEVERE	SWEAT & THIRST
☐	☐	Sweat w/ little exertion
☐	☐	Night sweats
☐	☐	Can't sweat
☐	☐	Thirsty and drink cold
☐	☐	Thirsty and drink hot
☐	☐	Thirty and don't drink
☐	☐	Not thirsty

YES	SEVERE	ENERGY
☐	☐	High energy/nervous
☐	☐	Good energy
☐	☐	Okay energy/slightly low
☐	☐	Low energy/fatigue
☐	☐	Energy lull, mid-morning
☐	☐	Energy lull, afternoon
☐	☐	Second wind at night
☐	☐	Doze off sitting down
☐	☐	Frequent yawning
☐	☐	Body heaviness

YES	SEVERE	HEAD
☐	☐	Headache
☐	☐	Migraines
☐	☐	Dizziness (spinning)
☐	☐	Lightheadedness
☐	☐	Foggyheaded
☐	☐	Sinus congestion
☐	☐	Nasal discharge
☐	☐	Sinus infections
☐	☐	Seizures
☐	☐	Nose bleeds
☐	☐	Tremors
☐	☐	Dry, brittle hair
☐	☐	Prematurely gray
☐	☐	Hair loss
☐	☐	Bad teeth
☐	☐	Bleeding gums
☐	☐	Periodontal disease
☐	☐	Dentures with poor chewing
☐	☐	Sore tongue
☐	☐	Swollen lymph nodes

YES	SEVERE	SENSES
☐	☐	Red/itchy eyes
☐	☐	Eye pain
☐	☐	Eyelid margin redness
☐	☐	Light sensitivity
☐	☐	Floaters in vision
☐	☐	Declining vision
☐	☐	Decreased night vision
☐	☐	Itchy nose
☐	☐	Distorted sense of smell
☐	☐	Distorted taste
☐	☐	Hearing loss
☐	☐	Ear ringing/tinnitus
☐	☐	Sensitivity to loud noises
☐	☐	Ear congestion/fullness
☐	☐	Itchy ears

YES	SEVERE	RESPIRATORY
☐	☐	Dry cough
☐	☐	Productive cough
☐	☐	Wheezing
☐	☐	Shortness of breath
☐	☐	Spring allergies
☐	☐	Summer allergies
☐	☐	Fall allergies
☐	☐	Hoarseness
☐	☐	Dry throat
☐	☐	Frequent sore throat
☐	☐	Frequent colds, >2 times/year

YES	SEVERE	CARDIOVASCULAR
☐	☐	Chest tightness
☐	☐	Angina/chest pain
☐	☐	Slow heart rate
☐	☐	Fast heart rate
☐	☐	Low blood pressure
☐	☐	High blood pressure
☐	☐	Palpitations
☐	☐	Mitral valve prolapse
☐	☐	Heart murmur
☐	☐	Irregular pulse
☐	☐	Swollen ankles/feet
☐	☐	Varicose veins

YES	SEVERE	FOOD INTOLERANCES
☐	☐	Lactose
☐	☐	Dairy products
☐	☐	Gluten/wheat
☐	☐	Corn
☐	☐	Eggs
☐	☐	Fatty foods
☐	☐	Yeast

YES	SEVERE	DIGESTION
☐	☐	Bad breath
☐	☐	Bad taste in mouth/throat
☐	☐	Excessive saliva
☐	☐	Dry mouth
☐	☐	Dry lips
☐	☐	Canker sores
☐	☐	Cold sores
☐	☐	Cracking at corner of lips
☐	☐	Dentures
☐	☐	Lump in the throat
☐	☐	Difficulty swallowing
☐	☐	Upper abdominal pain
☐	☐	Upper ab bloating
☐	☐	Heartburn
☐	☐	Reflux of food/acid
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Belching
☐	☐	Hiccups
☐	☐	Bloating in lower ab
☐	☐	Bloating in whole ab
☐	☐	Bloating after meals
☐	☐	Tired after meals
☐	☐	Lower abdominal pain
☐	☐	Flatulence with no odor
☐	☐	Flatulence with strong odor
☐	☐	Pain under ribs
☐	☐	Jaundice (yellow eyes/skin)
☐	☐	Liver disease
☐	☐	Gallstones

YES	SEVERE	BOWEL MOVEMENTS
☐	☐	Constipation
☐	☐	Loose stool
☐	☐	Diarrhea
☐	☐	Alternating constipation and diarrhea
☐	☐	Urgent BM
☐	☐	Abdominal cramps
☐	☐	Rectal spasms
☐	☐	Incomplete BM
☐	☐	Burning with BM
☐	☐	Bowel incontinence
☐	☐	Itchy anus
☐	☐	Fissures
☐	☐	Hemorrhoids
☐	☐	Blood in stool
☐	☐	Mucus in stool
☐	☐	Undigested food in stool

Symptom Review (cont.)

Mark YES for any mild or moderate symptoms you currently have or have had in the 6 months.
Mark SEVERE if a significant symptom.

YES	SEVERE	APPETITE/CRAVINGS
☐	☐	Can't gain weight
☐	☐	Can't lose weight
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Hungry soon after eating
☐	☐	Shaky when hungry
☐	☐	Irritable when hungry
☐	☐	Frequent dieting
☐	☐	Sweet cravings
☐	☐	Carb cravings
☐	☐	Bread cravings
☐	☐	Salt cravings
☐	☐	Crunchy cravings
☐	☐	Fat cravings
☐	☐	Binge eating
☐	☐	Anorexia
☐	☐	Bulimia

YES	SEVERE	URINATION
☐	☐	Dark urine
☐	☐	Cloudy urine
☐	☐	Burning urination
☐	☐	Painful urination
☐	☐	Profuse urination
☐	☐	Frequent urination
☐	☐	Hesitancy
☐	☐	Incomplete voiding
☐	☐	Urgency
☐	☐	Leaking/incontinence
☐	☐	Bladder infections
☐	☐	Kidney disease
☐	☐	Kidney stone
☐	☐	Bed wetting
☐	☐	Urinating at night >2x

YES	SEVERE	SLEEP
☐	☐	Insomnia
☐	☐	Difficulty falling asleep
☐	☐	Tossing and turning
☐	☐	Wake at night
☐	☐	Wake too early
☐	☐	Wake up tired
☐	☐	Groggy in morning
☐	☐	Vivid dreams
☐	☐	Disturbing dreams
☐	☐	Grind teeth/clench jaw
☐	☐	Snoring
☐	☐	Sleep apnea
☐	☐	Stop breathing

YES	SEVERE	MUSKULOSKELETAL
☐	☐	Neck tension
☐	☐	Tension headaches
☐	☐	TMJ problems
☐	☐	Muscle twitches: eye
☐	☐	Muscle twitches: arms/legs
☐	☐	Scoliosis
☐	☐	Weak back
☐	☐	Back pain
☐	☐	Back spasms
☐	☐	Calf cramps
☐	☐	Weak knees
☐	☐	Foot cramps
☐	☐	Joint pain
☐	☐	Joint redness
☐	☐	Joint stiffness
☐	☐	Joint swelling
☐	☐	Tendonitis
☐	☐	Muscle pain
☐	☐	Muscle spasms
☐	☐	Muscle stiffness
☐	☐	Muscle weakness
☐	☐	All over body pain

YES	SEVERE	MOOD/EMOTIONS
☐	☐	Irritable/angry
☐	☐	Restlessness
☐	☐	Excitability
☐	☐	Anxiety
☐	☐	Fearfulness
☐	☐	Can't stop thinking
☐	☐	Easily startled
☐	☐	Worry
☐	☐	Sadness
☐	☐	Weepiness
☐	☐	Panic attacks
☐	☐	Depression
☐	☐	Phobia(s)
☐	☐	Mania
☐	☐	Auditory hallucinations
☐	☐	Visual hallucinations
☐	☐	Blackouts
☐	☐	Paranoia
☐	☐	Suicidal thoughts

YES	SEVERE	NERVES
☐	☐	Poor memory
☐	☐	Poor concentration/focus
☐	☐	Numbness
☐	☐	Tingling
☐	☐	Tremors/trembling
☐	☐	Poor balance
☐	☐	Difficulty thinking
☐	☐	Difficulty with judgment
☐	☐	Difficulty with speech
☐	☐	Fainting

YES	SEVERE	SKIN
☐	☐	Dry skin
☐	☐	Itchy skin
☐	☐	Dry scalp
☐	☐	Dundruff
☐	☐	Bumps on back of upper arms
☐	☐	Red face
☐	☐	Ears get red
☐	☐	Oily skin
☐	☐	Acne on face
☐	☐	Acne on back
☐	☐	Acne on chest
☐	☐	Dark circles under eyes
☐	☐	Dry hands
☐	☐	Itchy hands
☐	☐	Cracking/peeling hands
☐	☐	Dry feet
☐	☐	Itchy feet
☐	☐	Athlete's foot
☐	☐	Cracking/peeling feet
☐	☐	Itchy genitals
☐	☐	Jock itch
☐	☐	CelluliteEczema
☐	☐	Easy bruising
☐	☐	Hives
☐	☐	Psoriasis
☐	☐	Rashes
☐	☐	Sensitive to bug bites
☐	☐	Sensitive to poison ivy/oak
☐	☐	Shingles
☐	☐	Skin darkening
☐	☐	Vitiligo
☐	☐	Strong body odor

YES	SEVERE	NAILS
☐	☐	Dry nails
☐	☐	Bitten
☐	☐	Brittle/splitting
☐	☐	Curve up
☐	☐	Frayed edges
☐	☐	Fingernail fungus
☐	☐	Toenail fungus
☐	☐	Pitting
☐	☐	Ragged cuticles
☐	☐	Ridges
☐	☐	Soft
☐	☐	Thickening fingernails
☐	☐	Thickening toenails
☐	☐	White spots/lines

Women's History

Reproductive History

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

Have you had any high-risk pregnancies, difficult labor/deliveries, postpartum or lactation concerns?
If yes, please explain: _____

Are you currently trying to conceive? ☐ Yes ☐ No Are you currently lactating: ☐ Yes ☐ No

Past or present use of hormonal birth control? ☐ Birth control pills ☐ Patch ☐ Nuva ring ☐ Hormonal IUD
If so, for how long? _____

Any problems with hormonal birth control? ☐ Yes ☐ No If yes, explain: _____

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

Menstrual History (if currently menopausal, answer to the best of your recollection)

Date of start of last period: _____ Age at first period: _____

Length of bleeding: _____ Length of cycle: _____ Ovulation symptoms? ☐ Yes Explain: _____

Menstrual Flow:

☐ Light/spotting on days _____
☐ Medium on days _____
☐ Heavy on days _____
☐ With clots on days _____
☐ Spotting between periods on days _____
☐ Spotting before period on days _____

What color is the blood?

☐ Light red on days _____
☐ Bright red on days _____
☐ Dark red on days _____
☐ Purple on days _____
☐ Brown on days _____
☐ Black on days _____

Gynecological & PMS Symptoms

Mark YES for mild or moderate symptoms you've had in the past 6 months. **Mark SEVERE** if a significant symptom.

GYNECOLOGICAL SYMPTOMS	YES	SEVERE
Low sexual energy	☐	☐
High sexual energy	☐	☐
Vaginal dryness	☐	☐
Vaginal discharge	☐	☐
Frequent yeast infections	☐	☐
Uterine prolapse	☐	☐
Bladder prolapse	☐	☐
Pelvic adhesions	☐	☐
Vaginal pain	☐	☐
Endometriosis	☐	☐
Infertility	☐	☐
Fibroids	☐	☐
Ovarian cysts	☐	☐
Pelvic inflammatory disease	☐	☐
STD	☐	☐
Fibrocystic breasts	☐	☐
Mastitis	☐	☐

PMS	YES	SEVERE
Back pain	☐	☐
Bloating	☐	☐
Breast tenderness	☐	☐
Carbohydrate craving	☐	☐
Chocolate craving	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Cramps	☐	☐
Fatigue	☐	☐
Increased sleep	☐	☐
Decreased sleep	☐	☐
Irritability	☐	☐
Sadness	☐	☐
Mood swings	☐	☐
Fatigue after period	☐	☐

Menopause

Have you gone through menopause? ☐ Yes ☐ No (if No, skip this section) ☐ I might be going through it now

If yes, in what year was your last period? _____

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

Are you on hormone replacement therapy? ☐ Yes ☐ No

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

_____

Current symptoms (*check all that apply*): ☐ Hot flashes ☐ Mood swings ☐ Concentration/memory issues ☐ Headaches ☐ Joint pain ☐ Vaginal dryness ☐ Weight gain ☐ Decreased libido ☐ Loss of control of urine ☐ Palpitations

Family History

Check family members that have/had any of the following:

	Mother	Father	Brother	Brother	Sister	Sister	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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Dental History

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

☐ Mercury fillings _____ ☐ Gold fillings _____ ☐ Root canals _____ ☐ Implants _____ ☐ Caps/Crowns _____

How many fillings did you have as a kid? _____

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

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

Dental issues: ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing issues ☐ Other: _____

Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other odors/chemicals: _____

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

☐ Mold ☐ Water leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic radiation

☐ Carpets or rugs ☐ Old paint ☐ Stagnant or stuffy air ☐ Smoking ☐ Damp environments

☐ Pesticides ☐ Herbicides ☐ Airplane travel ☐ Paints ☐ Cleaning chemicals

☐ Heavy metals (e.g. lead, mercury) ☐ Harsh chemicals (solvents, glues, gas, acids) ☐ 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

Do you feel worse in certain environments? ☐ Damp and muggy ☐ Dry and dusty ☐ Moldy places

Smoking

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

What type? ☐ Cigarettes ☐ Chewing tobacco ☐ Pipe ☐ Cigar ☐ E-Cig/Vaping

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)*

☐ None ☐ 1–3 ☐ 4–6 ☐ 7–10 ☐ >10

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

Have you ever had a problem with alcohol? ☐ Yes ☐ No

If yes, please explain? _____

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

Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No ☐ Prefer not to answer

If yes, type: _____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No ☐ Prefer not to answer

Lifestyle Review

Sleep

Bedtime on weekdays (workdays): _____

Wake time on weekdays (workdays): _____

How many hours of sleep is ideal for you? _____ hours

How much sleep do you get? _____ hours

How long could you sleep if you were allowed to sleep? ☐ <7 hours ☐ 7-8 hours ☐ 9-10 hours ☐ 10+ hours

Do you nap during the day? ☐ Yes ☐ No ☐ I would if I had time ☐ I'm not a napper

Bedtime routine: _____

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 or need long recovery times? ☐ Yes ☐ No

If yes, explain: _____

Diet

Do you eat 3 meals a day? ☐ Yes ☐ No - if No, which meal(s) do you skip? ☐ Breakfast ☐ Lunch ☐ Dinner

Are you hungry for breakfast? ☐ Yes ☐ A little ☐ No

Do you snack at night? ☐ Yes ☐ A little ☐ No

Please list what you eat in a typical day:

Breakfast: _____ Time: _____

Mid-morning snack: _____ Time: _____

Lunch: _____ Time: _____

Afternoon snack: _____ Time: _____

Dinner: _____ Time: _____

Evening snack: _____ Time: _____

Beverages: _____

What are your sources of fat? _____

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

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

Red meat _____ Chicken/turkey: _____ Fish _____ Legumes (beans, peas, etc) _____

Dairy _____ Nuts & Seeds _____ Avocados & Oils _____

Junk food (chips, popcorn, candy, cookies, cake, soda, ice cream, etc.) _____ Bread/potatoes/pasta _____

What kinds of junk food do you snack on? _____

What caloric beverages do you drink (soda, juice, milk, milk alternatives, energy drinks)? _____

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: _____

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
☐ Paleo ☐ 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 ☐ Preservatives ☐ Food colorings
☐ Sulfite–containing foods (wine, dried fruit, salad bars) ☐ Other food substances: _____

Are there any foods that you crave or binge on? ☐ Yes ☐ No
If yes, what foods? _____

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
- ☐ Super hungry at dinnertime
- ☐ Afternoon slump and grab something to eat
- ☐ Eat to stay awake during the day
- ☐ Dislike healthy foods
- ☐ Time constraints
- ☐ Travel frequently
- ☐ Eat more than 50% of meals away from home
- ☐ Don't care to cook
- ☐ Confused about nutrition advice
- ☐ Healthy foods not readily available
- ☐ Too much junk food
- ☐ 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
- ☐ Eat well all day and then blow it at night
- ☐ Eat well during the week and less rigid on the weekends
- ☐ No matter how much I exercise and how little I eat I don't lose weight
- ☐ No matter how much I eat I don't gain weight

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
Do you feel the trauma has been resolved? ☐ Yes ☐ No ☐ Not sure

What are your hobbies or leisure activities that rejuvenate you? _____

Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ 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? _____

Overall Lifestyle

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 significant other	☐	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

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 contributes to that? _____

_____

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: _____

_____

Thank you for taking the time to fill out this questionnaire and educate us about your health history and lifestyle!
With this information and your future visits, we'll partner together to help you achieve the most optimal health possible!