

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 hour's notice.

Current Health Concerns

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

Describe Problem	Severity of Problem	Effect on Life/Work/Relationships
Example: Fatigue	Mild, Moderate, Severe	Can't focus at work
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 (within the last 6 months),

Check PAST = a condition you've had in the past (longer than 6 months ago)

Yes	Past	GASTROINTESTINAL
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	GERD (reflux)
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's/ulcerative colitis
<input type="checkbox"/>	<input type="checkbox"/>	Peptic ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Celiac disease
<input type="checkbox"/>	<input type="checkbox"/>	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Yes	Past	RESPIRATORY
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Yes	Past	CARDIOVASCULAR
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart failure
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	High blood fats (cholesterol, triglycerides)
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia (irregular heart rate)
<input type="checkbox"/>	<input type="checkbox"/>	Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Yes	Past	MUSKULOSKELETAL
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis
<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Yes	Past	SKIN
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	Acne
<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Yes	Past	CANCER
<input type="checkbox"/>	<input type="checkbox"/>	Lung
<input type="checkbox"/>	<input type="checkbox"/>	Breast
<input type="checkbox"/>	<input type="checkbox"/>	Colon
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Yes	Past	ENDOCRINE/METABOLIC
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid (overactive thyroid)
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid (low thyroid)
<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	Metabolic syndrome/insulin resistance
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Yes	Past	INFLAMMATORY/IMMUNE
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Food allergies
<input type="checkbox"/>	<input type="checkbox"/>	Environmental allergies
<input type="checkbox"/>	<input type="checkbox"/>	Multiple chemical sensitivities
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease
<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Yes	Past	NEUROLOGICAL/EMOTIONAL
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizures
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Autism
<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease
<input type="checkbox"/>	<input type="checkbox"/>	Dementia

Yes	Past	URINARY/GENITAL
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urinary tract infections
<input type="checkbox"/>	<input type="checkbox"/>	Frequent yeast infections
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases (STDs)
<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction
<input type="checkbox"/>	<input type="checkbox"/>	Interstitial cystitis

Diagnostic Tests

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

	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 / How long? _____

Tylenol (acetaminophen) / How long? _____

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.) / How long? _____

Oral Contraceptives / How long? _____

How many times have you taken antibiotics?

	< 5 Times	> 5 Times	Reason for Use
Infancy/Childhood	<input type="checkbox"/>	<input type="checkbox"/>	
Teen	<input type="checkbox"/>	<input type="checkbox"/>	
Adulthood	<input type="checkbox"/>	<input type="checkbox"/>	

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	<input type="checkbox"/>	<input type="checkbox"/>	
Teen	<input type="checkbox"/>	<input type="checkbox"/>	
Adulthood	<input type="checkbox"/>	<input type="checkbox"/>	

Symptom Review

Mark **YES** for any mild or moderate symptoms you currently have or have had in the past 6 months.

Mark **SEVERE** if a significant symptom.

YES	SEVERE	TEMPERATURE
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands and feet
<input type="checkbox"/>	<input type="checkbox"/>	Cold nose
<input type="checkbox"/>	<input type="checkbox"/>	Whole body cold
<input type="checkbox"/>	<input type="checkbox"/>	Low body temp
<input type="checkbox"/>	<input type="checkbox"/>	Cold intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Tend to feel hot
<input type="checkbox"/>	<input type="checkbox"/>	Flushing
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Alternating hot & cold
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Chills

YES	SEVERE	SWEAT & THIRST
<input type="checkbox"/>	<input type="checkbox"/>	Sweat w/ little exertion
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Can't sweat
<input type="checkbox"/>	<input type="checkbox"/>	Thirsty and drink cold
<input type="checkbox"/>	<input type="checkbox"/>	Thirsty and drink hot
<input type="checkbox"/>	<input type="checkbox"/>	Thirsty and don't drink
<input type="checkbox"/>	<input type="checkbox"/>	Not thirsty

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

YES	SEVERE	HEAD
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness (spinning)
<input type="checkbox"/>	<input type="checkbox"/>	Lightheadedness
<input type="checkbox"/>	<input type="checkbox"/>	Foggyheaded
<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion
<input type="checkbox"/>	<input type="checkbox"/>	Nasal discharge
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Dry, brittle hair
<input type="checkbox"/>	<input type="checkbox"/>	Prematurely gray
<input type="checkbox"/>	<input type="checkbox"/>	Hair loss
<input type="checkbox"/>	<input type="checkbox"/>	Bad teeth
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums
<input type="checkbox"/>	<input type="checkbox"/>	Periodontal disease
<input type="checkbox"/>	<input type="checkbox"/>	Dentures with poor chewing
<input type="checkbox"/>	<input type="checkbox"/>	Sore or burning tongue
<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes

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

YES	SEVERE	RESPIRATORY
<input type="checkbox"/>	<input type="checkbox"/>	Dry cough
<input type="checkbox"/>	<input type="checkbox"/>	Productive cough
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Spring allergies
<input type="checkbox"/>	<input type="checkbox"/>	Summer allergies
<input type="checkbox"/>	<input type="checkbox"/>	Fall allergies
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Dry throat
<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds, >2 times/year

YES	SEVERE	CARDIOVASCULAR
<input type="checkbox"/>	<input type="checkbox"/>	Chest tightness
<input type="checkbox"/>	<input type="checkbox"/>	Angina/chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Slow heart rate
<input type="checkbox"/>	<input type="checkbox"/>	Fast heart rate
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur
<input type="checkbox"/>	<input type="checkbox"/>	Irregular pulse
<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles/feet
<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins

YES	SEVERE	FOOD INTOLERANCES
<input type="checkbox"/>	<input type="checkbox"/>	Lactose
<input type="checkbox"/>	<input type="checkbox"/>	Dairy products
<input type="checkbox"/>	<input type="checkbox"/>	Gluten/wheat
<input type="checkbox"/>	<input type="checkbox"/>	Corn
<input type="checkbox"/>	<input type="checkbox"/>	Eggs
<input type="checkbox"/>	<input type="checkbox"/>	Fatty foods
<input type="checkbox"/>	<input type="checkbox"/>	Yeast

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

YES	SEVERE	BOWEL MOVEMENTS
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Loose stool
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Alternating constipation and diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Urgent BM
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal cramps
<input type="checkbox"/>	<input type="checkbox"/>	Rectal spasms
<input type="checkbox"/>	<input type="checkbox"/>	Incomplete BM
<input type="checkbox"/>	<input type="checkbox"/>	Burning with BM
<input type="checkbox"/>	<input type="checkbox"/>	Bowel incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Itchy anus
<input type="checkbox"/>	<input type="checkbox"/>	Fissures
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	Mucus in stool
<input type="checkbox"/>	<input type="checkbox"/>	Undigested food in stool
<input type="checkbox"/>	<input type="checkbox"/>	Sticky 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
<input type="checkbox"/>	<input type="checkbox"/>	Can't gain weight
<input type="checkbox"/>	<input type="checkbox"/>	Can't lose weight
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive appetite
<input type="checkbox"/>	<input type="checkbox"/>	Hungry soon after eating
<input type="checkbox"/>	<input type="checkbox"/>	Shaky when hungry
<input type="checkbox"/>	<input type="checkbox"/>	Irritable when hungry
<input type="checkbox"/>	<input type="checkbox"/>	Frequent dieting
<input type="checkbox"/>	<input type="checkbox"/>	Sweet cravings
<input type="checkbox"/>	<input type="checkbox"/>	Carb cravings
<input type="checkbox"/>	<input type="checkbox"/>	Bread cravings
<input type="checkbox"/>	<input type="checkbox"/>	Salt cravings
<input type="checkbox"/>	<input type="checkbox"/>	Crunchy cravings
<input type="checkbox"/>	<input type="checkbox"/>	Fat cravings
<input type="checkbox"/>	<input type="checkbox"/>	Binge eating
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia
<input type="checkbox"/>	<input type="checkbox"/>	Bulimia

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

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

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

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

YES	SEVERE	NERVES
<input type="checkbox"/>	<input type="checkbox"/>	Poor memory
<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration/focus
<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Tremors/trembling
<input type="checkbox"/>	<input type="checkbox"/>	Poor balance
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty thinking
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with judgment
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with speech
<input type="checkbox"/>	<input type="checkbox"/>	Fainting

YES	SEVERE	SKIN
<input type="checkbox"/>	<input type="checkbox"/>	Dry skin
<input type="checkbox"/>	<input type="checkbox"/>	Itchy skin
<input type="checkbox"/>	<input type="checkbox"/>	Dry scalp
<input type="checkbox"/>	<input type="checkbox"/>	Dandruff
<input type="checkbox"/>	<input type="checkbox"/>	Bumps on back of upper arms
<input type="checkbox"/>	<input type="checkbox"/>	Red face
<input type="checkbox"/>	<input type="checkbox"/>	Ears get red
<input type="checkbox"/>	<input type="checkbox"/>	Oily skin
<input type="checkbox"/>	<input type="checkbox"/>	Acne on face
<input type="checkbox"/>	<input type="checkbox"/>	Acne on back
<input type="checkbox"/>	<input type="checkbox"/>	Acne on chest
<input type="checkbox"/>	<input type="checkbox"/>	Dark circles under eyes
<input type="checkbox"/>	<input type="checkbox"/>	Dry hands
<input type="checkbox"/>	<input type="checkbox"/>	Itchy hands
<input type="checkbox"/>	<input type="checkbox"/>	Cracking/peeling hands
<input type="checkbox"/>	<input type="checkbox"/>	Dry feet
<input type="checkbox"/>	<input type="checkbox"/>	Itchy feet
<input type="checkbox"/>	<input type="checkbox"/>	Athlete's foot
<input type="checkbox"/>	<input type="checkbox"/>	Cracking/peeling feet
<input type="checkbox"/>	<input type="checkbox"/>	Itchy genitals
<input type="checkbox"/>	<input type="checkbox"/>	Jock itch
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to bug bites
<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to poison ivy/oak
<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Skin darkening
<input type="checkbox"/>	<input type="checkbox"/>	Vitiligo
<input type="checkbox"/>	<input type="checkbox"/>	Strong body odor
<input type="checkbox"/>	<input type="checkbox"/>	Cellulite
YES	SEVERE	NAILS
<input type="checkbox"/>	<input type="checkbox"/>	Dry nails
<input type="checkbox"/>	<input type="checkbox"/>	Bitten
<input type="checkbox"/>	<input type="checkbox"/>	Brittle/splitting
<input type="checkbox"/>	<input type="checkbox"/>	Curve up
<input type="checkbox"/>	<input type="checkbox"/>	Frayed edges
<input type="checkbox"/>	<input type="checkbox"/>	Fingernail fungus
<input type="checkbox"/>	<input type="checkbox"/>	Toenail fungus
<input type="checkbox"/>	<input type="checkbox"/>	Pitting
<input type="checkbox"/>	<input type="checkbox"/>	Ragged cuticles
<input type="checkbox"/>	<input type="checkbox"/>	Ridges
<input type="checkbox"/>	<input type="checkbox"/>	Soft
<input type="checkbox"/>	<input type="checkbox"/>	Thickening fingernails
<input type="checkbox"/>	<input type="checkbox"/>	Thickening toenails
<input type="checkbox"/>	<input type="checkbox"/>	White spots/lines

Women's History

Reproductive History

Pregnancies: _____

Vaginal deliveries: _____

Miscarriages: _____

Cesarean: _____

Abortions: _____

Term births: _____

Living children: _____

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 Implants

Hormonal IUD Other _____

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 bleed (days): _____ Length of cycle (days): _____ Ovulation symptoms? Yes Explain: _____

Menstrual Flow:

Light/spotting on days _____

Medium on days _____

Heavy on days _____

Spotting between periods on days _____

Spotting before period on days _____

Spotting before period on days _____

With clots on days _____

Clot Size _____

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 _____

What menstrual products do you use?

Tampon / Size _____

Pads / Size _____

Cup or Disc

Menstrual underwear

On your heaviest days, how frequently do you change your product? _____

Have you experienced any: Flooding Gushing Starting/Stopping

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	<input type="checkbox"/>	<input type="checkbox"/>
High sexual energy	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Uterine prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Bladder prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic adhesions	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic inflammatory disease	<input type="checkbox"/>	<input type="checkbox"/>
STD	<input type="checkbox"/>	<input type="checkbox"/>
Fibrocystic breasts	<input type="checkbox"/>	<input type="checkbox"/>
Mastitis	<input type="checkbox"/>	<input type="checkbox"/>
PCOS	<input type="checkbox"/>	<input type="checkbox"/>

PMS	YES	SEVERE
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate craving	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate craving	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Increased sleep	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sleep	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Sadness	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue after period	<input type="checkbox"/>	<input type="checkbox"/>

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	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)											
Age at death (if deceased)											
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History Cont.

	Mother	Father	Brother	Brother	Sister	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

- | | |
|---|---|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Significant other or family members have special dietary needs |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Love to eat |
| <input type="checkbox"/> Late-night eating | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Super hungry at dinnertime | <input type="checkbox"/> Have negative relationship to food |
| <input type="checkbox"/> Afternoon slump and grab something to eat | <input type="checkbox"/> Struggle with eating issues |
| <input type="checkbox"/> Eat to stay awake during the day | <input type="checkbox"/> Emotional eater (eat when sad, lonely, bored, etc.) |
| <input type="checkbox"/> Dislike healthy foods | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Eat too little under stress |
| <input type="checkbox"/> Travel frequently | <input type="checkbox"/> Eat well all day and then blow it at night |
| <input type="checkbox"/> Eat more than 50% of meals away from home | <input type="checkbox"/> Eat well during the week and less rigid on the weekends |
| <input type="checkbox"/> Don't care to cook | <input type="checkbox"/> No matter how much I exercise and how little I eat I don't lose weight |
| <input type="checkbox"/> Confused about nutrition advice | <input type="checkbox"/> No matter how much I eat I don't gain weight |
| <input type="checkbox"/> Healthy foods not readily available | |
| <input type="checkbox"/> Too much junk food | |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | |

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	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At school	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your significant other	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10

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!*